State Public Records Documents Only

Survey event #Q5L6

Facility: SAPPHIRE OF TUCSON NURSING AND REHAB LLC

Revised 7-2020

QUALITY RATING CERTIFICATE

ARIZONA DEPARTMENT OF HEALTH SERVICES NURSING CARE INSTITUTION



Issued To:

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

The above named facility has met licensure requirements, has been licensed for one year or more and, therefore, has received the following quality rating as required by R9-10-919.

| COMPONENTS | CRITERIA MET | | QUALITY PERFORMANCE SCALE | |
|---------------------------------------|-----------------|----|-----------------------------------|---|
| | Yes | No | "A" Excellent | |
| I. Nursing Services | 20 | 5 | "B" | Х |
| II. Resident Rights | 23 | 2 | "C" | |
| III. Administration | 24 | 1 | "D" | |
| IV. Environment and Infection Control | 13 | 2 | | |
| V. Food Services | 9 | 1 | "A" 90-100 Points | |
| | | | "B" 89-80 Points "C" 70-79 Points | |
| TOTAL CRITERIA MET | 89 | 11 | "D" 69 or fewer Points | |

| - |
|---|



| | | | FOOD SAFE | TY | IN | SF | PE (| CT | ION REPO | DRT | | | Page | 1/4 |
|----------|------------|--|--|------|------|-------|--------------|-------|--|-------------------------|----------|----------------------|--------------|------------------|
| 39 | 50 S. | erned by Pima County Country Club Rd, Ste | 2301 | | lumb | er o | of Pric | ority | /Priority Founda | ition Viol | lations | 4 | Date Time | 01/24/2020 in |
| Tu | cson | AZ 85714 Phone 520 | 0-724-7908, Fax 520-724-959 |)7 N | lumb | er c | of Co | re V | iolations | | | 1 | | 10:29 AM |
| Es | tablis | hment | Address | | | | | | Rating | Educatio | nal | | Time | out 12:55 PM |
| | 1 | RE OF TUCSON 3 & REHAB | 2900 E MILBER ST TUCSON AZ 85714 | | | ŀ | Purp | ose | of Inspection | | Est. | Type and | Risk C | ategory |
| <u> </u> | rmit# | 3180926 | Permit Holder SAPPHIRE TUCSON | | | _ | Stan Educ | | i Frequency inspe nai | ection - | | | | ood 2500sqft |
| | | F001 | DBORNE ILLNESS RISK I | | | SA | ND | PUE | BLIC HEALTH IN | NTERVE | NTION | is | | |
| | <u> </u> | OUT = not in liance compile | ince | | N/A | app | olicab | | COS = corre | ction | | | | lation |
| | | | ion practices and employees ors in foodborne illness outbre | | | mo | ost co | mme | only reported to th | ne Center | s for Di | sease Co | ontrol an | ıd |
| | 1 | | e control measures to preven | | | ne il | Iness | or i | njury | | | | | |
| Cor | npliar | ce Status | • | C | DS F | ₹ Co | ompl | ianc | e Status | | | | | COS R |
| | | Sur | ervision | | | 1 | 5. In | | Food separated | and pro | lected | | | |
| 01. |]n | PIC present, demons | strates knowledge, and | | | 1 | 6. Oı | ut | Food-contact su | rfaces: c | leaned | and sanit | ized | |
|)2. | ln. | performs duties Certified Food Protec | ction Manager | П | | 1 | 7. In | | Proper disposition served, recondition | on of retu loned, an | rned, p | reviously fe food | | |
| J. | [" | | yee Health | | لسا | | Ti | me | Temperature | | | Safety | Food | (TCS |
| 03. | In | Management and foo and conditional emplo | ed employee knowledge, ovee: Knowledge. | | | 18 | 8. N/ | О | Proper cooking t | Foo lime and | • | atures | | |
| | | responsibility and rep | orting | _ | | 19 | 9. N/ | 0 | Proper reheating | g procedu | res for | hot holdir | ng | |
|)4. | Ï | Proper use of restrict | | | | 20 | 0. N/0 | 0 | Proper cooling ti | me and t | empera | lures | | |
| 5. | łn | , | and Diarrheal Events | Ш | | 2 | 1. Ou | ıl | Proper hot holding | ng tempe | ratures | | | |
| | | | ienic Practices | | | 22 | 2. in | | Proper cold hold | ing temp | erature | 8 | | |
| | N/O | | , drinking, or tobacco use | | | 23 | 3. In | | Proper date mark | king and | disposi | tion | | |
| 7. | In | No discharge from ey | | Ш | | 24 | 4. N/A | A | Time as a Public and records | Health C | Control: | procedur | es | |
| | | • | amination by Hands | _ | | | | | Cons | sumer. | Advis | ory | | |
| 8. | 1. | Hands clean and prop | • | | | 25 | 5. N/A | Ą | Consumer adviso | ory provid | | • | | |
| 9. | | No bare nand contact approved alternative proved | with RTE foods or a pre- procedure properly | Ц | | | | | undercooked foo Highly Sus | | le Po | nulatio | ns | |
| 0. | Out | Adequate handwashii supplied and accessit | | V | | 26 | 3. In | | Pasteurized food offered | - | | • | | |
| | | | red Source | | • | | . F | -00 | d/Color Addi | tives a | nd To | xic Su | bstan | ces |
| 1. | in . | Food obtained from a | | | | 27 | . N/A | - | Food additives: a | | | | | |
| | N/O | Food received at prop | er temperature | | | | 3. In | | Toxic substances | s properly | dentifi | ied, store | d, | |
| 3. I | ļņ. | Food in good condition | n, safe, and unadulterated | | | | | | and used; held fo | | • | | | |
| 4. 1 | V/A | Required records available parasite destruction | ilable: shellstock tags, | | | 20 |). N/A | | nformance w Compliance with | | - | | | es |
| | | • | m Contamination | | | | 14177 | • | reduced oxygen p | | | | | |



| | | | FOOD SAFE | ΓY | INS | SPECT | ION REPORT | Page | | 2/4 |
|-----|-----------|--|--|---------|--------|---------------------|--|-----------------------------|--------|-----|
| 395 | 0 S. C | rned by Pima County Country Club Rd, Ste 2 IZ 85714 Phone 520- | | 7 | | Permit# | 3180926 | Date 01/ | 24/202 | 20 |
| SA | | ment RE OF TUCSON 3 & REHAB | Address 2900 E MILBER STTUCSO | N AZ | 8571 | 4 | | | | |
| 1 | | | GÓ | DD R | ETAI | L PRACT | ICES | | | |
| İ | God | od Retail Practices are | preventative measures to cor | ntroi t | he int | roduction o | f pathogens, chemicals, and phys | ical objects into fo | ods. | |
| | | mpliance com | t in N/O = not obs pliance | | | /A = not applica | | | repeat | |
| ;on | plian | ce Status | | CC | SR | Complian | ce Status | | CO | SR |
| | | Safe Foo | od and Water | | | | Utensils, Equipment a | nd Vending | | |
| 30. | . In | Pasteurized eggs use | d used where required | | | 47. In | Food and non-food-contact surf properly designed, constructed | aces cleanable, and used | | |
| Î | In N/A | Water and ice from ap | oproved source specialized processing | | | 48. In | Warewashing facilities, installed used, test strips | i, maintained, | | |
| 34. | IN/A | methods | apoordized processing | لبسا | | 49. In | Non-food-contact surfaces clea | n | | |
| | | Food Temp | erature Control | | _ | | Physical Facili | ties | | |
| 33. | ln | Proper cooling metho equipment for temper | ds used; adequate ature control | Ш | | 50. In | Hot and cold water evailable; ac | dequate pressure | | |
| 34. | N/O | Plant food properly co | ocked for hot holding | | | 51. ln | Plumbing installed; proper back | flow devices | | |
| 35. | N/O | Approved thawing me | thods used | | | 52. in | Sewage and waste water prope | rly disposed | | |
| 36. | In | Thermometers provide | ed and accurate | | | 53. in | Toilet facilities: properly constructean | cted, supplied, | | |
| | | Food Id | entification | | | 54. In | Garbage/refuse properly dispos | ed; facilities | | |
| 37 | ln | Food properly labeled | ; original container | | | | maintained | | | |
| | | Prevention of F | ood Contamination | | | 55. Out | Physical facilities installed, mair | | | |
| 38. | In | insects, rodents, and | animals not present | | | 56. In | Adequate ventilation and lighting areas used | g; designated | П | |
| 39. | ln | Contamination preven storage, and display | ted during food preparation, | | | | Smoke Free | • | | |
| 40. | In | Personal cleanliness | | | | 57. In | Complies with Smoke Free Arize | | | |
| 41. | In | Wiping cloths; properly | y used and stored | | | Pima C | county Code for Mobile F ONLY | ood Establisi | nmer | ıts |
| 42. | N/O | Washing fruits & vege | tables | | | 58. N/A | A1. Exterior | | | |
| | | Proper Us | e of Utensils | | | 59. N/A | A2. Interior | | | |
| 43. | In | in-use utensils; proper | ly stored | | | 60. N/A | B. Additional operating permit re | quirements | | |
| 44. | In | Utensils, equipment & dried, & handled | linens; properly stored, | | | 61. N/A | C. Operations | | | |
| 45. | In | Single-use/single-serv | ice articles; properly stored, | | | 62. N/A | D. Commissary | | | |
| 46 | in | Gloves used properly | | П | П | | | | | |



| - | | | | | | · · · · · · · · · · · · · · · · · · · | | 3/ |
|-------|--|---|--|--|--|---------------------------------------|------------|------|
| | | | FOOD SAFETY | INSPECTION REP | ORT | | Page | 3 |
| 395 | 0 S. Country | Pima County Club Rd, Ste Phone 520 | | Permit# 3180926 | | Date | 01/24/2 | 020 |
| SAI | ablishment PPHIRE OF T RSING & REI | | Address 2900 E MILBER STTUCSON AZ | 85714 | | | | |
| | | | TEMPERAT | URE OBSERVATIONS | | | | - |
| Item | /Location | | Temperature in Fahrenheit | Item/Location | Tempe | rature in Fa | hrenheil | : |
| l s | alad | | 40 | RI cheese | 40 | | | |
| ed | cut tomatoes | | 40 | iced lettuce cut | 40 | | | |
| IH s | oup | | 157 | HH hamburger | 147 | | | |
| IH q | uesadilla | | 158 | WI milk | 40 | | | |
| VI SE | alad mix | | 37 | WI cheese | 37 | | | |
| VI ḥa | am | | 32 | WI lettuce | 37 | | | |
| l let | tuce cut | | 40 | | | | | |
| | | | OBSERVATIONS A | ND CORRECTIVE ACTIONS | • | | | |
| tem | P /Pf/ C | | Violations cited in this report must | ne corrected in the frames below: | as indicated. | Co | rrection (| Date |
| | Priority Foundation | employees to 6-301.12 Eac with: (A) Indiv | s: Hand washing sink by the war use. In HANDWASHING SINK or group vidual, disposable towels; ctions: PIC provided a roll of disp ill be installed soon. | of adjacent HANDWASHING SI | INKS shall be pro | ovided | | |
| 8 | Priority Foundation | debris on the 4-601.11 (A) i | s: Observed a rusted shelving un a the shelving unit inside the Wi. EQUIPMENT FOOD-CONTACT SU | | | | | |
| | | touch. Corrective A cleaning the | ctions: PIC had shelving unit rep shelving units inside the WI. | laced during the inspections. P | iC had employee | start | | |
| 6 | Priority | temperature 4-703.11 After | s: Hot temperature sanitizer had to of 160F; first attempt 146, second being cleaned, EQUIPMENT FO | d attempt 154, third attempt 16.6 DD-CONTACT SURFACES and | 60f. UTENSILS shall | be | | |
| | | SANITIZED in as specified u of 71°C (160° | n: (B) Hot water mechanical operati nder §§ 4-501.15, 4-501.112, and 4 F) as measured by an irreversible r | ons by being cycled through EQU -501.113 and achieving a UTENS egistering temperature indicator; | IIPMENT that is s SIL surface tempe | et up rature | | |
| | | that high tem before saniti | ctions: PIC called Ecolab technic perature sanitize machine meets zing utensiis and equipment. Ute t sink using a chemical sanitizer. | and maintains a utensil surfac | e temperature of | 160F | | |

21 Priority

Observations: Observed bean burrito hot holding at 1120-120F on the steam table.

3-501.16 (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under $\S 3$ -501.19, and except as specified under $\S (C)$ of this section,



| | | | FOOD SAFET | Y INSPECTION REI | PORT | P | age | 4/4 |
|--------|-----------------------------|--|--|---|--|--------------|--------------|--------|
| 3950 8 | S. Country | Pima County Club Rd, Ste 4 Phone 520 | | Permit# 3180926 | | Date | 01/24/202 | 20 |
| Estab | lishment | | Address | | | | | |
| | PHIRE OF T SING & REH | | 2900 E MILBER STTUCSON | I AZ 85714 | | | | |
| | | except that re specified in ¶ | pasts cooked to a temperature : | FETY FOOD shall be maintained: (and for a time specified in ¶ 3-401.1 temperature of 54°C (130°F) or abo urritos to 165F. | I1(B) or reheated as | above, | | |
| 55 (| Core | 6-201.11 Exc | amaged wall panels by the co ept as specified under § 6-20 used for safety reasons, floors | 1.14 and except for antislip floor of floor coverings, walls, wall covering | overings or applications, and ceilings shall t | ns | | |
| | | designed, co | nstructed, and installed so they actions: Correct by resurfaci ays so that they are smooth a | are SMOOTH and EASILY CLEA ng damaged/missing floor tiles a nd easily cleanable. | NABLE. | | | |
| | | | | ACTIONS TAKEN | | | • | |
| Phot | tos Taken | for File | | First Routine Inspec | tion packet provided |] | | ; |
| | | | CL | OSING COMMENTS | | | · | |
| his is | a scheduled utine inspec | d inspection, ar | nd will be assigned a rating of E | EDUCATIONAL INSPECTION, the v | iolations noted must s | still be con | rected by ti | he |
| Perso | n in Charg | e (Print Name |): Richard Mariscal | l | | | | |
| Perso | on In Charg | e (Signature): | · | Re ma | Date | 01/2 | 24/2020 | |
| Inspe | ctor (Print | Name): | Shelsie Dabdout | | | | | |
| | ector (Signa | | | SubiRDL. | Date | 01/2 | 4/2020 | |
| | | | INSPECTI | ON ADDITIONAL DETAILS | | • | | |
| Votice | of Inspection | n Rights Provi | ded? | Yes | | | | |
| 1 | | | oodborne illness investigation | No | | | | |



CITY OF TUCSON

FIRE DEPARTMENT

JOE GULOTTA INTERIM FIRE CHIEF

FIRE PREVENTION DIVISION

FRMS#035893

August 15, 2019

SAPPHIRE of Tucson 2900 E Milber St

Occupancy I-2 240 Beds

Attn: Ron Wolf

Re: Fire inspection

On August 15, 2019 a fire safety inspection was conducted at the above location. The following violations were discovered and shall be corrected to gain compliance with the 2018 International Fire Code is below.

- 1. IFC 105.6.47 **Permit required.** An operational permit will be required for this State Licensed Facility.
- 2. IFC 604.1 Abatement of electrical hazards. Identified electrical hazards shall be abated. Identified hazardous electrical conditions in permanent wiring shall be brought to the attention of the responsible code official.
 - Breakroom shall have a GFI install by the sink.
 - Hallway C-1 in the utility closet shall have a GFI installed by the sink.
 - Hallway A-2 in the clean utility Closet shall have a GFI installed by the sink. (Check all utility closets for a GFI by the sink.)
- 3. IFC 604.4.2 **Power Supply.** Relocatable power taps shall be directly connected to a permanently installed receptacle.
 - PT room has a surge protector plugged into another X2.
 - Nurse's station on first floor had a surge protector plug in to a light.
 Surge protector shall be directly connected to a permanently installed receptacle.
- 4. IFC 705.2 Inspection and maintenance. Opening protectives in fire-resistance-rated assemblies shall be inspected and maintained in accordance with NFPA 80. Opening protectives in smoke barriers shall be inspected and maintained in accordance with NFPA 80 and NFPA 105. Openings in smoke partitions shall be inspected and maintained in accordance with NFPA 105.





CITY OF TUCSON

FIRE DEPARTMENT

JOE GULOTTA INTERIM FIRE CHIEF

FIRE PREVENTION DIVISION

Fire doors and smoke and draft control doors shall not be blocked, obstructed, or otherwise made inoperable. Fusible links shall be replaced promptly whenever fused or damaged. Opening protectives and smoke and draft control doors shall not be modified.

- Inspection report dated 3-15-19 numerous fire doors are out of service. All fire doors shall be inspected and tested and repaired or replaced as needed. A clean inspection report shall be sent to the fire Code official.
- 5. IFC 904.3.5 **Monitoring.** Where a building fire alarm system is installed, automatic fire-extinguishing systems shall be monitored by the building fire alarm system in accordance with NFPA 72.
 - Inspection report dated 3-19-2019 states the kitchen hood fire suppression system is not hook to the fire alarm system. The kitchen hood system shall be monitored by the fire alarm system.

Please note that all required operational permit fees must be paid prior to a re inspection and before any permit will be issued. A re-inspection shall be conducted on or after September 17, 2019. If you have any questions please call or email.

Sincerely,

Anthony G. Smith

Anthony G. Smith MA24 Fire Code Inspector Tucson Fire Department Office (520)837-7109 Cell 520-539-4843

Captains Signature____





FIRE CODE PERMIT

FIRE DEPARTMENT



Permit Activity Number: <u>T19F000647</u>

Structure Address: 2900 E MILBER ST TUC

Project Description: 240 BEDS

Permit Type: State Llc Facls Annual Inspectio

Occupancy Group: 1-1

Applicable Fire Code: 2018 IFC

Expiration Date: 09/05/2020

- or - Until Revoked: N

Permit Conditions:

Anthony Smith

Fire Code Official / Fire Inspector

09/06/2019 Issued Date





April 28, 2021

IMPORTANT NOTICE- PLEASE READ CAREFULLY

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

Dear Mr. Balliet:

On April 28, 2021, an offsite revisit survey **#Q5L612** 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 the State participation requirements to operate a nursing home in the State of Arizona. Enclosed is the **State Revisit Report form** which indicates the licensee to be **in substantial compliance** based on an allegation of compliance and acceptable plan of correction. A copy of this form will become a part of the facility's public file. Please keep this current inspection report in the facility and available for review.

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

Sincerely,

Monica Miller

Program Project Specialist II

\mm

Enclosure

PRINTED: 04/28/2021 FORM APPROVED ADHS LICENSING SERVICES STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ R B. WING NCI-2643 04/28/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2900 EAST MILBER STREET SAPPHIRE OF TUCSON NURSING AND REHAE **TUCSON, AZ 85714** PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) **{Y 000}** {Y 000} Initial Comments An offsite follow-up survey was conducted on April 28, 2021. No deficiencies were cited.

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

TITLE

(X6) DATE 04/12/21

Q5L612

| | | | | | STAT | E FO | RM: RE | VISIT | REPORT | | | | |
|---------------------|--------------|---------------------------------------|------------------|--|---------------|---------|-------------|----------|--|---------------|--------------------------------|----------|----------------------|
| | ATI | SUPPLIER / | | MULTIPLE CON A. Building B. Wing | NSTRUCTIO | N | | | | | Y2 | DATE 0 | OF REVISIT |
| NAME OF SAPPHIR | | | N NUR | SING AND REF | HAB, LLC | | | 2900 E | ET ADDRESS, C EAST MILBER S ON, AZ 85714 | • | , ZIP CODE | | |
| corrective | e ac tion | tion was a | ccompli | state surveyor to shed. Each de susly shown on | ficiency sho | ould be | fully iden | tified u | sing either the | regulation | or LSC provision | on numbe | er and the |
| ITEN Y4 | A | | | DATE Y5 | ITEM Y4 | | | | DATE Y5 | ITEM Y4 | | | DATE Y5 |
| ID Prefix | Y03 | 39 | | Correction | ID Prefix | Y0342 | 2 | | Correction | ID Prefix | Y1045 | | Correction |
| Reg. # | R9-1 | 0-403.C.2.I | o. | Completed 04/20/2021 | Reg. # LSC | R9-10- | 403.C.2.e. | | Completed 04/20/2021 | Reg.# | R9-10-410.B.4.d | . | Completed 04/20/2021 |
| ID Prefix | Y11 | 47 | | Correction | ID Prefix | Y1235 | 5 | | Correction | ID Prefix | Y1477 | | Correction |
| Reg. # | R9-1 | 0-411.C.9. | | Completed 04/20/2021 | Reg. # LSC | R9-10- | -412.B.7. | | Completed 04/20/2021 | Reg.# LSC | R9-10-414.B.3.L |). | Completed 04/20/2021 |
| ID Prefix | Y19 | 11 | | Correction | ID Prefix | Y2159 |) | | Correction | ID Prefix | Y2301 | | Correction |
| Reg. # | R9-1 | 0-419.2.e. | | Completed 04/20/2021 | Reg. # LSC | R9-10- | -421.D.3.a. | | Completed 04/20/2021 | Reg.# | R9-10-423.A.1. | | Completed 04/20/2021 |
| ID Prefix | Y23 | 49 | | Correction | ID Prefix | | | | Correction | ID Prefix | | | Correction |
| Reg. # | R9-1 | 0-423.B.6. | | Completed 04/20/2021 | Reg. # LSC | | | | Completed | Reg.# LSC | | | Completed |
| ID Prefix | | | | Correction | ID Prefix | | | | Correction | ID Prefix | | | Correction |
| Reg. # LSC | | · · · · · · · · · · · · · · · · · · · | | Completed | Reg. # LSC | | | | Completed | Reg. # LSC | | | Completed |
| | | | | | | | | | | | | | |
| REVIEWE STATE AG | | | REVIE | WED BY | DATE 4/28/ | 121 | | IRE OF | SURVEYOR | | | DATE | 28/21 |
| REVIEWE CMS RO | D B | Y 🗆 | REVIE (INITIA | WED BY .LS) | DATE | | TITLE | | 0 | | | DATE | |
| FOLLOW 3/11/202 | | ro surve | Y COMP | LETED ON | | | | | CTED DEFICIEN ES (CMS-2567) | | S A SUMMARY O THE FACILITY? | | s 🗆 NO |

Page 1 of 1

EVENT ID:

Q5L612



Gmail

Matt Connolly <matthew.connolly@azdhs.gov>

Sapphire of Tucson Plan of Correction (POC)

1 message

ARIZONA DEPARTMENT OF HEALTH DIVISION OF PUBLIC HEALTH TICENSING

Matt Connolly <matthew.connolly@azdhs.gov> To: Brian Balliet
balliet@sapphireestatesrc.com> Mon, Apr 12, 2021 at 12:04 PM

APR 1 2 ZUZ1

Hey Brian,

LONG TEHNI CARE 150 N. 18TH AV

I got your POC and there are some things I need to have you fix/change before Ligar at

I will need to see all your in-service and audit documentation. I realize you are likely in the middle of that, so send it over when it is done.

As far as the 2567, there are some changes I need you to make. They include the following:

- -Change the wording on Y000 reflect the following: "This Plan of Correction is submitted to meet the requirements established by State law. This Plan of Correction constitutes this facility's demonstration of compliance for the deficiencies cited. Submission of this Plan of Correction is not an admission that a deficiency existed or that one was correctly cited."
- -Also for the Ytags, I am missing page 50 which includes your correction for Y2159. Please provide this.
- -F609: I need more. How will those responsible for reporting injuries of unknown origin to the state, ombudsmen, APS, etc. be able to ensure this happens within 2 hours of the event and how will you ensure the investigation is submitted to the State within 5 days? Doing a daily review of falls is good, but you might miss the window for reporting. Ensure you show that staff responsible for these tasks have been educated on this (not sure who exactly does this in your building).
- -F610: I need more on this one as well. Will education for the staff cover the investigation piece? Will it ensure that staff are educated that witnesses and other staff interviews need to be completed as part of the investigation? How will incidents be investigated thoroughly?
- -F689/Y339: Also need a bit more on this one. I believe the citation goes beyond safety devices as the resident fell once and there wasn't much noted on that first fall including the condition of the resident, who was notified, etc. Perhaps if you covered fall protocol in the POC.
- -F758/Y1235: The POC is not addressing what was cited. Change this to reflect side effect and target behavior monitoring.
- -F806/Y2349: There seems to be a mistake as the POC reflects similar wording as F758 and does not address the resident's religious food preferences.
- -F886: just clarify what a Sign-in sheet is. The POC says that sign-in sheets will be audited does the sign in sheet have to do with the staff COVID testing in some way?

This isn't as much as it appears and I think you will be able to make these changes pretty easily. You can just email me the materials as you finish them. Be sure to sign page one of both 2567s.

Thanks Brian!

Matt Connolly, RD

ARIZONA DEPARTMENT PRINT F. 04/01/2021 DIVISION OF PUBLIC HEADYM APPROVED

ADHS LICENSING SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ APR 1 2 2021 B. WING NCI-2643 LONG TERM 03/11/2021 150 N. 18TH AVE # 440 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE PHOENIX, AZ 85007 2900 EAST MILBER STREET SAPPHIRE OF TUCSON NURSING AND REHAB, LLC TUCSON, AZ 85714 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY Y 000 Initial Comments Y 000 This Plan of Correction is submitted to The State compliance survey was conducted on meet the requirements established by March 1 through 5, 2021 and March 8 through 11, State law. This Plan of Correction 2021. Resident census was 164. The following constitutes this facility's demonstration of deficiencies were cited: compliance for the deficiencies cited. Submission of this Plan of Correction is Y 339 R9-10-403.C.2.b. Administration Y 339 not an admission that a deficiency existed or that one was correctly cited. R9-10-403.C. An administrator shall ensure that: R9-10-403.C.2. Policies and procedures for physical health services and behavioral health services are established, documented, and implemented to protect the health and safety of a resident that: Y339 4/20/2021 R9-10-403.C.2.b. Cover the provision of physical What corrective action(s) will be health services and behavioral health services; accomplished for those residents found to have been affected by the deficient practice, on both a temporary and permanent basis, including the date the correction will be accomplished? Resident #131 found to be affected. This RULE is not met as evidenced by: Safety devices updated on 3/11/21. Based on observations, clinical record review, staff interviews, and policy review, the facility How will you identify other residents failed to implement their policy to ensure a fall for having the potential to be affected by the one resident (#131) was thoroughly addressed same deficient practice and what and acted upon and that interventions were corrective action will be taken? implemented. The DON and/or designee conducted a Findings include: full house audit for safety devices related to fall on 4/1/2021. No other residents Resident #131 was admitted to the facility on found to be affected. February 8, 2021 with diagnoses that included pneumonia, dependence on supplemental oxygen, personal history of self-harm. schizophrenia, bipolar disorder, and unspecified

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

Din Children Supplier Representatives Signati

ADMINISTRATOR_

TITLE

4/10/2021

STATE FORM

FORM APPROVED ADHS LICENSING SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING NCI-2643 03/11/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2800 EAST MILBER STREET SAPPHIRE OF TUCSON NURSING AND REHAB, LLC **TUCSON, AZ 85714** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (XS) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 339 Y 339 Continued From page 1 What measures will be put into place or dementia without behavioral disturbance. what systemic changes will you make to ensure that the deficient practice does not Review of the Morse Fall Scale dated February 8, recur? 2021 revealed the resident was at high risk for falling with a score of 80 (45 and above equals DON and/or Designee conducted an inhigh risk). The assessment included the resident service to nursing staff related to safety had fallen before; used crutches, a cane, or a devices completed on 4/3/2021. DON walker, had a weak gait; and overestimates or and/or designee conducted an in service forgets limits. to licensed staff on fall documentation. notification and monitoring of resident A second Morse Fall scale was completed on post fall. February 9, 2021 and included the resident continued to be at high risk for falling. How will the corrective action(s) be monitored to ensure the deficient practice Review the care plan dated February 9, 2021 will not recur, i.e., what quality assurance revealed the resident was at risk for falls related to confusion, weakness, and unaware of safety program will be put into place; and the title, or position, of the person responsible needs. Resident chooses to lay on the floor beside her bed and stated that she is more for implementing/monitoring the comfortable on the floor. The provider is aware of corrective action? the preference. Resident does have the bed in low position and can self-adjust the height of the The DON and/or Designee will audit all bed. The goal was that the resident would be free new orders for safety devices daily for 21 of falls. Interventions included to anticipate the days. The DON and/or Designee will resident's needs: be sure the resident's call light audit all fall for proper documentation, was within reach and encourage the resident to notification, and monitoring post fail. use it for assistance as needed; the resident Any resident found to be out of needs prompt response to all requests for compliance will be reported to the DON assistance; ensure the resident is wearing and/or Designee for immediate correction appropriate footwear when ambulating or and re-education to nursing staff. The mobilizing in the wheelchair. DON and/or Designee will report any patterns or trends to our monthly QA&A Another care plan dated February 9, 2021 committee. revealed the resident was at risk for falls related to weakness, confusion, potential side effects of medication. The goal stated the resident would be free from falls. The interventions included to

anticipate and meet the needs of the resident: ensure the resident call light is within reach at all times and encourage/remind the resident to use

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | (X3) DATE | SURVEY LETED |
|--------------------------|--|--|------------------------------|---|-----------|--------------------------|
| | | | A. BOILDING | | | |
| | | NCI-2643 | B. WING | | 03/ | 11/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, ST | ATE, ZIP CODE | | |
| SAPPHIR | E OF TUCSON NURSING | AND REHAB. LLC | MILBER STE | REET | | |
| | 1 | TUCSON, | 42 85714 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY) | D BE | (X5) COMPLETE DATE |
| Y 339 | Continued From page | 2 | Y 339 | | | |
| | the call light for assist | ance as needed; maintain sident can self-adjust height | | | | |
| | 9, 2021 at 9:38 a.m. re status post fall with no related to the fall. "Pat | gress note dated February evealed the resident was o injuries, pain or discomfort tient chooses to lay on the note did not include the time | | | | |
| | Review of an Interdisciplinary team (IDT) note dated February 9, 2021 at 10:13 a.m. revealed the IDT met to discuss the resident and the recent incident. The noted stated that the resident was newly admitted, pending therapy evaluations. Staff to continue to orient to surroundings, encourage call light use, provide and encourage use of appropriate footwear. Care Plan reviewed and updated. The note did not include the time of the fall. | | | | | |
| | provided about this fall | ocumentation was found or I regarding the condition in is found, or notification to ily. | | | | |
| | 9, 2021 at 11:02 p.m. I out of bed at approxim came to notify the nurs the floor. Upon enterin was laying comfortably under her head and be This nurse, along with resident back onto her the current time, vitals and were within normal complain about pain. | gress note dated February revealed the resident rolled sately "1025" and the aide se that the resident was on g the room, the resident y on the floor with her pillowed at the lowest position. another nurse, helped the bed. No injuries noted at were taken by this nurse al levels, resident did not Provider and DON were a. Resident is currently on | | | | |

PRINTED: 04/01/2021 FORM APPROVED **ADHS LICENSING SERVICES** STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING NCI-2643 03/11/2021 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** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 339 Continued From page 3 Y 339 neurologic checks for a fall on February 8, 2021. Aide came to notify this nurse once again that she witnessed the resident roll herself off of her bed. This nurse and aide helped the resident back on to her bed. Bilateral floor mats order was approved by the provider and were placed. Review of the physician's orders revealed orders dated February 9, 2021 for bilateral floor mats for falls and for a progress note status post fall every shift. The interventions of the fall care plan were revised on February 10, 2021 to include bed in low position, patient can self-adjust height of the bed; bilateral floor mats as resident allows/tolerates; bed located on the left wall by the window per resident preference for safety and increased living space; change room configuration to reduce the risk of physical injury due to resident putting self on the floor. Review of a psychiatry note dated February 11, 2021 revealed the resident was admitted to the facility post emergency department visit for increased behavioral disturbance at assisted living home with patient throwing self on the flow multiple times. Per staff, patient with impulsivity and difficult to redirect, high fall risk with recent fall present. Review of the admission Minimum Data Set (MDS) assessment dated February 15, 2021 revealed a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident

had severely impaired cognition. The assessment included the resident required extensive assist with bed mobility and limited assist with transfers and walking in the room. The resident was coded as steady at all times with transitions and walking.

| | NT OF DEFICIENCIES N OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | (X3) DATE : COMPI | |
|--------------------------|--|--|------------------------------|--|----------------------|--------------------------|
| | | | B. WING | | | |
| | | NCI-2643 | D. WING | | 03/ | 11/2021 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, ST | ATE, ZIP CODE | | |
| SAPPHI | RE OF TUCSON NURSING | AND REHAB. LLC | MILBER STR | EET | | |
| | | TUCSON, A | NZ 85714 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | BE | (X5) COMPLETE DATE |
| Y 33 | Continued From page | 4 | Y 339 | | | |
| | The resident was code | ed as having a fall in the | | | | |
| | last month, and the la | | | | | |
| | | ty and a fall with an injury | | | | |
| | since admission to the | e facility. | | | | |
| | Review of an IDT note | e dated February 18, 2021 | | | | |
| | | p, change in elevation | | | | |
| | | sident has had no further | | | | |
| | , • | The resident continues to | | | | |
| | received therapies to | | | | | |
| | interventions remain in | n place. | | | | |
| | An observation was co | onducted of resident #131 | | | | |
| | | 10:34 a.m. The resident | | | | |
| | The state of the s | a room with a roommate, | | | | |
| | | earest the room door and | | | | |
| | | t the wall. There were no | | | | |
| | | y the sides of the bed and | | | | 1 |
| | was observed in the ro | and in the room. A walker | | | | |
| | opposite the foot of the | _ | | | | |
| | opposite and root of the | | | | | |
| | Another observation w | as conducted of resident | | | | |
| | #131 on March 11, 20 | | | | | |
| | | to transfer out of the bed | | | | |
| | and ambulate to the si | | | | | |
| | the call light and did no | r assist verbally or by using | | | | |
| | use can ngin and did in | or acc nic trainer. | | | i | |
| | An interview was cond | lucted on March 11, 2021 at | | | | |
| | | ified Nursing Assistant | | | | |
| | (CNA/staff #125), who | | | | | |
| | | as at risk for falls from the | | | | |
| | | rse. Staff #125 stated that, | | | | |
| | fall. The CNA stated th | sident #131 had not had a | | | İ | |
| | around pretty well, was | = | | | | |
| | | nember to use the call light. | | | | |
| | | he did not remember fall | | | | |
| | | is resident and that she | | | | |

PRINTED: 04/01/2021 **FORM APPROVED** ADHS LICENSING SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING NCI-2643 03/11/2021 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** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY Y 339 Y 339 Continued From page 5 thought the resident came from another unit. Staff #125 stated that during her care for the resident, the resident had been in the current bed, with the bed in the current position. An interview was conducted on March 11, 2021 at 1:03 p.m. with a Licensed Practical Nurse (LPN/staff #81). The LPN stated that after a resident has had a fall, the nurse would conduct a head to toe assessment, a neurologic check, try to determine why the resident fell, do vital signs. check to see if the call light was in reach and that the resident was wearing appropriate footwear. She stated that the nurse would notify the physician, the family, the Director of Nursing (DON), the case manager and the nurse manager. The LPN stated that the facility would conduct a risk assessment which would determine if the resident needed further interventions (i.e. fall mat, call light reminder sign, frequent checks) and the nurse manager would put any changes into the care plan. She stated that she would usually find out that a resident was a falls risk through report. The LPN further stated that she would also be aware because the staff knows the residents really well. Staff #81 stated that she did not know resident #131 as she had not been assigned to care for her. She stated that

she had observed resident #131 come into the hallway at a very fast pace and that she would have to remind the resident to slow down. She stated that she had limited interaction with resident #131 and did not know if the resident had fallen. Staff #81 stated that the resident recently came to the current hall and room from a private room in a different section of the facility and that the care plan may not have been updated vet. The LPN stated that the resident should have floor mats in place if they were ordered by the physician and in the care plan.

| | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|---------------------|---|-----|-------------------------------|--|
| | | NCI-2643 | B. WING | | 03/ | 11/2021 | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADD | DRESS, CITY, ST | ATE, ZIP CODE | | | |
| SAPPHIR | E OF TUCSON NURSING | AND REHAB. LLC | MILBER STE | REET | | | |
| _ | | TUCSON, | AZ 85714 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | 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 APPROPE DEFICIENCY) | BE | (X5) COMPLETE DATE | |
| Y 339 | Continued From page | 6 | Y 339 | | | | |
| | 1:16 p.m. with the LPI Nursing (ADON/staff ander listing report was Interdisciplinary Team changes for a resident plan. The ADON state to follow the physician information in the care accurate and followed that if clinical staff felt changed the physician stated that the staff we about what was going a change was needed resident #131 had and and was care planned therefore, the mats shifthat staff had not follow plan, which put the resident #143 conducted an ob (#131) room and confirmats present by the resident staff to a to put intervention in peffectiveness. She state that an intervention(s) wo physician's orders and | ould be in place. She stated wed the order and the care sident at risk for injury. Staff servation of the resident's med that there were no fall sident's bed or in the room. Ited on March 11, 2021 at N (staff #51), the DON ed residents falls to be assess for interventions and lace and assess their ted that if it is determined was needed, she expected uld be implemented as per /or the care plan. She is staff to follow physician's stated that if an mined to no longer be | | | | | |
| | | e care plan and orders as d that resident #131 should | | | | | |

| AURO LI | ICENSING SERVICES | | | | |
|--------------------------|-------------------------------------|---|-------------------------------|---|-------------------------------|
| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| | | NCI-2643 | B. WING | | 03/11/2021 |
| NAME OF P | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, STA | ATF. ZIP CODE | |
| | | 2900 EAS | T MILBER STR | • | |
| | E OF TUCSON NURSING | S AND REHAB, LLC TUCSON, | AZ 85714 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE COMPLETE |
| Y 339 | Continued From page | 7 | Y 339 | | |
| | have had floor mats a | e ordered and care | İ | | |
| 1 | | expectations were not met. | 1 | | |
| | 1 • | esident would be at risk for | 1 | | |
| | | entions for fall prevention | • | | 1 |
| | were not followed. | cilions for fail prevention | ' | | |
| | Wole Hot Johnston. | | • | | |
| | Review of the facility's | s policy for assessing falls | • | | |
| | 1 | ealed: The purpose of this | ' | ļ | |
| | | le guidelines for assessing a | | 1 | |
| | resident after a fall and | | ' | | |
| | | the fall. General Guidelines | 1 | | |
| 1 | | eading cause of morbidity | 1 | | |
| | and mortality among t | | , | | |
| - 1 | homes; falling may be | | 1 ' | | |
| | | nditions, overall functional | 1 | | |
| | decline, medication sig | | 1 ' | | |
| | | ctors; residents must be | ' | | |
| 1 | | r potential risk of falls and | ' | | |
| | | nust be addressed properly. | · | | |
| | | probable fall, clarify the | ļ , | | |
| | | h as when the fall occurred | | | Ì |
| | | al was trying to do at the | | | Ì |
| | | Within 24 hours of a fall, | 1 | | |
| | | possible or likely causes of | | | |
| | | resident fall, the following | 1 | | |
| | | recorded in the resident's | | | |
| | medical record: The co | | 1 | | |
| | | ssessment data, including | 1) | | |
| | | vious injuries; Interventions, | 1 | | |
| | | administered; Notification of | 1 | | |
| | the physician and fami | | 1 1 | | |
| | Completion of a falls ri | | 1 1 | | |
| | | ons taken to prevent future | 1 1 | | |
| | falls; The signature and | | 1 1 | | |
| | recording the data. | a the of the person | 1 1 | | |
| | 1000rding are data. | ; | | | |
| Y 342 | R9-10-403.C.2.e. Adm | inistration | Y 342 | | |
| | R9-10-403.C. An adm | ninistrator shall ensure that: | | | |

| 1 | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|--------------------------|--|--|--------------------------|---|--|
| i | | NCI-2643 | B. WING | | 03/11/2021 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AC | DRESS, CITY, ST | ATE, ZIP CODE | |
| SAPPHIR | e of Tucson Nursing | AND REHAB. LLC | T MILBER STF AZ 85714 | REET | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE COMPLETE |
| | R9-10-403.C.2. Policiphysical health services are establish implemented to protect resident that: R9-10-403.C.2.e. Control of the facility failed to implemented to implemented during of screening for COVID-staff appropriately don | ies and procedures for es and behavioral health ed, documented, and ct the health and safety of a ver infection control; as evidenced by: s, staff interviews, facility es and procedures, and the control (CDC) guidelines, plement their policies to control measures were ommunal dining, staff 19 was complete, and that uned and doffed personal (PPE), performed hand | Y 342 | What corrective action(s) will be accomplished for those residents for have been affected by the deficient practice, on both a temporary and permanent basis, including the date correction will be accomplished? No Residents found to be affected. How will you identify other residents having the potential to be affected by same deficient practice and what corrective action will be taken? All residents have the potential to be affected. What measures will be put into place what systemic changes will you make ensure that the deficient practice docrecur? All staff will be in-serviced on scree process by ICP for COVID-19 regard | 4/20/2021 and to the the triangle ding |
| | -Regarding Communa | _ | | temperatures, proper donning and do of PPE, and hand hygiene. | TIME |
| | a.m. with the Administ Administrator (staff #2 Nursing (DON/staff #5 most recent positive of occurred over the wee Indicating that the facil outbreak status. | on March 1, 2021 at 10:53 rator (staff #216), Assistant 17), and the Director of 1), they stated that the ase of COVID-19 had kend (February 27, 2021), | | Reception screeners in-service by IC conducting screening and reviewing documentation for completeness. ICP to in-service all staff on "Keep COVID-19 OUT!", "Use PPE Correfor COVID-19", and "Clean Hands: Combat COVID-19!" | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | 1 . | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--|--|---|----------------|--|--|---|
| | | NCI-2643 | B. WING | | 03/11/2021 | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, ST | ATE, ZIP CODE | | |
| SAPPHIR | E OF TUCSON NURSING | AND REHAB, LLC 2800 EAST TUCSON, A | MILBER STR | REET | | |
| (X4) ID | SUMMARY ST | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | I (X5) | _ |
| PREFIX TAG | (EACH DEFICIENC) | YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE COMPLETE | |
| Y 342 | was conducted on the dementia unit. Upon a of the doorway, the re observed. It was noted 7 square tables, 1 small round table. 19 reside were observed in the development of table. 4 square tables with a table. 4 square tables with a table. 5 square tables with a table. 5 small round table witable. 6 table. 6 table withere. 6 the residents of was observed as he at resident who was seat touching his table-top in the first resident who was seat touching his table-top in the dining his table-top in the dining room, one observed to be serving containers from a heat delivered to the resident members. The fourth seat drinks and providing the moved the heating table member of staff began | B-100 hall/secure entering the unit, to the left sident dining room was d that the dining room held all round table, and 1 larger ints and 4 staff members dining room, including: B residents seated at each 2 residents seated at each ith 1 resident seated at the ith no residents seated in the far side of the room te his meal. A female ed to his right began and attempting to grab at lent swatted at her and she if the 19 residents in the eating independently, and eximately 2-3 feet from in new residents (Persons II) who were on droplet mediate left of the entrance es staff member was infood into Styrofoam food ing table. The food was ints by two of the other staff taff member was pouring em to the residents. After inks had been served, the been serving the food te off of the unit. One to wipe down the d the other two to help the | Y 342 | All Staff will have training on CDC "Preparing for COVID-19 in Nursin Homes", Hand Hygiene Recommendations and Hand hygien Guidance. IDT team conducted a root cause and on reasons for non-compliance. How will the corrective action(s) be monitored to ensure the deficient probability assurprogram will be put into place; and to title, or position, of the person responsor implementing/monitoring the corrective action? ICP and/or designee will conduct observations daily to ensure proper adonning and doffing, screening for COVID-19 and hand hygiene for 3 months. If expectations met, this will reduced to monthly observations und consecutive rounds of monthly monitoring have sustained compliant approved by QA committee and med director. Any staff members found to be out of compliance will be reported to the IC and/or Designee for immediate correand re-education to licensed staff. The ICP and/or Designee will report patterns or trends to our monthly QA committee. | actice rance he insible PPE I be iii 3 ce lical of CP ction any | |

PRINTED: 04/01/2021 FORM APPROVED ADH'S LICENSING SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING NCI-2643 03/11/2021 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** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) (D (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) Y 342 Continued From page 10 Y 342 meals On March 1, 2021 at 12:49 p.m. an interview was conducted with a Licensed Practical Nurse (LPN/staff #144). She stated that the residents eat in the dining room and then have activities there because the residents wander. She stated that the residents like to socialize in the dining room At 1:06 p.m. on March 1, 2021 an interview was conducted with the Director of Maintenance (staff #6). Utilizing his measuring tape, he stated that each of the 7 square tables in the room measured 42 inches by 42 inches; the small round table measured 41 1/2 inches in diameter, and that the larger round table measured 48 inches in diameter. On March 3, 2021 at 8:43 a.m., an observation of the dining room on the B-100 hall was conducted. There were 7 square tables in the dining room with two residents seated at each table. The 2 round tables were noted to have been removed from the room, 2 over-the-bed tables were in the dining room with 1 resident seated at each table, for a total of 16 residents, including the PUI residents on droplet precautions. Staff were observed to assist 2 of the residents with their meals. The other residents ate independently. An interview was conducted on March 4, 2021 with the Infection Preventionist (IP/staff #143). She stated that dining on the B-1 hall was

communal due to the unit housing wandering dementia residents. She stated that the maximum residents allowed in the dining room would be 10 to 12 residents with 2-3 staff members, more or less. She stated that it would not meet her expectations for 19 residents to be eating in the

| CTATEMENT OF DESIGNATION OF THE PROPERTY AND ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY ADDRE | | | | · | | | |
|--|----------------------------------|---|------------------|---------------------------------|----------|-------------------------------|--|
| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER: | 1 | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
| WALL FOR | DF CORRECTION | (DEMICIONION NOMBER. | A. BUILDING: | | COMPL | EIEU | |
| | | 1 | | | 1 | | |
| | | NCI-2643 | B. WING | | 03/1 | 11/2021 | |
| NAME OF P | PROVIDER OR SUPPLIER | STREET A | ODRESS, CITY, ST | ATE. ZIP CODE | | | |
| | | 2900 EAS | ST MILBER STR | | | | |
| SAPPHIR | E OF TUCSON NURSING | AND REHAB. LLC | , AZ 85714 | | | | |
| ~A\ ID | SUMMARY ST | ATEMENT OF DEFICIENCIES | · | PROVIDER'S PLAN OF CORRECTION | <u> </u> | ~6 | |
| (X4) ID PREFIX | (EACH DEFICIENCY | Y MUST BE PRECEDED BY FULL | ID PREFIX | (EACH CORRECTIVE ACTION SHOULD | BE | (X5) COMPLETE | |
| TAG | REGULATORY OR I | LSC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPROPR | HATE | DATE | |
| | | | | DEFICIENCY) | | | |
| Y 342 | Continued From page | ∍ 11 | Y 342 | | | | |
| | | | | | | | |
| | , - | ne. She stated that the risks | | | | | |
| | , . | esidents in the dining room contamination and/or the | | | | | |
| | possible spread of CC | | 1 | | ļ | | |
| | possing spiead of oc |]AID-18' | | | j | İ | |
| | On March 5, 2021 at 1 | 8:42 a.m., an interview was | | | 1 | | |
| | | ON (staff #51). She stated | į | İ | } | | |
| | that communal dining | • | | | | | |
| | | ited that residents are to | | 1 | | | |
| | remain 6 feet apart. | | | | | | |
| ł | 1900 | | 1 | | | | |
| | However, an observat | tion of the B-100 hall dining | | | | | |
| | | larch 10, 2021 at 12:25 p.m. | | | | | |
| | | lents were observed in the | | | 1 | | |
| | | waiting their meals. 12 out | | | | | |
| | | aring masks, and multiple | | | 1 | | |
| 1 | | to be seated less than 6 | İ | | | | |
| | | other and included the PUI | 1 | | 1 | | |
| | residents on droplet pr | recautions. | 1 | | | | |
| 1 | | | 1 | | 1 | | |
| | | ed Social Distancing Policy, | İ | | | | |
| | | 20, stated that in the event | | | ĺ | | |
| | | ghly infectious and/or deadly | 1 | | | | |
| | | andemic, the facility will | | | | | |
| | | ncing Policy in an attempt to ease through human to | 1 | | | | |
| | human contact. Action | | 1 | | | | |
| | between infected and | | | | | | |
| | | sick time, and limitation or | | | 1 | | |
| | | owing, including activities | | | | | |
| | involving groups and g | | | | 1 | | |
| | | health practice designed to | j | | | | |
| | | ction by ensuring sufficient | | | | | |
| | | veen individuals. Taking | 1 | | 1 | | |
| | | ocial distancing decreases | 1 | | 1 | | |
| | | contact among persons, | 1 | | | I | |
| | thereby decreasing the | | 1 | | - | | |
| | transmission among pe | | | | | | |
| | | cial distancing measures | | | | | |
| | | nended minimum distance | 1 | | | | |

| ADUS L | ICENSING SERVICES | | | | | |
|----------|--------------------------|--------------------------------|-----------------|--|-----------|--|
| | NT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPL | E CONSTRUCTION | (X3) DATE | |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A BUILDING: | | COMP | LETED |
| | | } | | | | |
| | | NCI-2643 | B. WING | | 02/ | 11/2021 |
| | | 1101-2540 | _ l | | 1 03/ | 11/2021 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AL | DRESS, CITY, ST | ATE, ZIP CODE | | |
| 0400 | | 2900 EAS | T MILBER STR | REET | | |
| SAPPHIR | RE OF TUCSON NURSING | TUCSON | AZ 85714 | | | |
| (X4) (D | SUMMARY STA | ATEMENT OF DEFICIENCIES | ID. | PROVIDER'S PLAN OF CORRECTION | N | (X5) |
| PREFIX | | Y MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD | | COMPLETE |
| TAG | REGULATORY OR L | SC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | RIATE | DATE |
| | | | | DEI TOLENOTY | | |
| Y 342 | Continued From page | 12 | Y 342 | | | |
| | 1 | | | | | |
| | of three to six feet. | | | | | |
| | The CDOIs Considers | tions for Moment Core | 1 | | | |
| | | itions for Memory Care | | | | |
| | | re Facilities updated May | | | | |
| | | ting the number of residents | | | |) |
| | 1 . | least 6 feet apart as much | | | | |
| | | common area, and gently | | | | 1 |
| | , | are ambulatory and are in | | | | |
| | close proximity to other | er residents or personnel. | 1 | | | |
| | Pavious of the CDC au | ildance titled Preparing for | | | | 1 |
| | _ | Homes, updated November | | | | |
| | | it given their congregate | | | | |
| | | opulation served, nursing | | | | |
| | home populations are | | | | | |
| | | pathogens like COVID-19 | | | | |
| | | As demonstrated by the | 1 | | | |
| | COVID-19 pandemic, | - | | | | |
| | 1 | I (IPC) program is critical to | | | | |
| | 1 - | and HCP. The guidance | | | | |
| | | tation of aggressive social | 1 | 1 | | |
| | | hat included remaining at | İ | | | |
| | least 6 feet apart from | | 1 | | | |
| | | group activities, such as | 1 | | | |
| | internal and external a | | | | ļ | |
| | | ocial distancing, wear a | | | | |
| | • | tolerated), and performing | 1 | | | |
| | hand hygiene. | tororatory, and portoning | | | | |
| | , and any greater | | | | | |
| | Regarding staff screer | ning for COVID-19: | | | İ | |
| į | | - | | | | |
| | Review of the staff scr | eening documentation | | | | |
| | | 1 through February 28, | | | | |
| | | names for more than 140 | | | | |
| | | temperatures for more | | | | |
| | than 23 occasions. | | | | | |
| | | | | | | |
| | | lucted with the receptionist | | | | |
| | | , 2021 at 11:47 a.m. Staff | | | | |
| | #16 stated the process | s for COVID-19 screening | | | | |

| NAME OF PROVIDER OR SUPPLIER SAPPHIRE OF TUCSON NURSING AND REHAB, LLC PAGE DEPOSITOR OF TUCSON NURSING AND REHAB, LLC SUMMARY STATEMENT OF DEPOSITOR MAY BE PRECEDED BY PILL PAGE DEPOSITOR OF THE PROVIDER OF THE PRECEDED BY PILL PAGE DEPOSITOR OF THE PRECEDED BY PILL PAGE DEPOSITOR OF THE PRECEDED BY PILL PAGE DEPOSITOR OF THE PRECEDED BY PILL PAGE DEPOSITOR OF THE PRECEDED BY PILL PAGE DEPOSITOR OF THE PRECEDED BY PILL PAGE DEPOSITOR OF THE PRECEDED BY PILL PAGE DEPOSITOR OF THE PRECEDED BY PILL PAGE DEPOSITOR OF THE PAGE DEPOSITOR | | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|--|-----------|--|---|-----------------|--|-----|-------------------------------|--|
| An interview was conducted on March 4, 2021 at 12:38 p.m. with the IP (staff #143). The IP stated the staff enter and earl expectations, which expectations and the stated that she would conduct further screening. She stated staff a name and temperatures should be documentation did not meet her expectation. On March 5, 2021 at 8:38 a.m., a follow-up interview was conducted with the receptionst (staff #16) staff #16 staff stated, To NON, or IP would receive a text notification. In an interview was conducted with the precatures should be documentation did not meet her expectations. On March 5, 2021 at 8:38 a.m., a follow-up interview conducted with the processor a text notification. In an interview conducted with the DON, or IP would receive a text notification. In an interview conducted with the processor and the reception of the conducting the processor and the reception of the conducting the processor and the reception of the conducting the processor and the reception of the conduction of the processor and the reception of the conduction of the processor and the reception of the conduction of the processor and the processor and the staff of the administrator and the staff or the administrator and the she would conduct further screening. She stated staff a names and temperatures should be documentation did not meet her expectations. On March 5, 2021 at 8:38 a.m., a follow-up interview was conducted with the receptionist (staff #16). Staff #16 stated that if an Individual did not enter their name or temperature when conducting the administrator, DON, or IP would receive a text notification. In an interview conducted with the DON (staff #51) on March 6, 2021 at 8:42 a.m., the DON stated that the expectation that the expectation that the expectation that the expectation that the expectation that the expectation that the expectation that the expectation that the expectation that the expectation that the expectation that the expectation that the expectation that the expectation that the expectation that the ex | | | NCI-2643 | B. WING | | 03/ | 11/2021 | |
| TUCSON, AZ 86714 Continued From page 13 Y 342 Included washing hands prior to entry at the portable handwashing station located outside the main entrance to the building then entering the lobby. Staff #16 stated that if anyone answered a screening questions with a "yes" response, indicating they had either symptoms of COVID-19 or close contact outside the front entering the lobby. Staff #16 stated that if anyone answered a screening question with a "yes" response, indicating they had either symptoms of COVID-19 or close contact outside the facility with an individual confirmed to have COVID-19, she believed the administrator, DON, or IP would be sent an elect or notification. An interview was conducted on March 4, 2021 at 12:38 p.m. with the IP (staff #143). The IP stated the staff enter are expected to be screened for COVID-19. The IP stated that if someone marked "yes" on the screening questionnaire, the receptionist would call herself or the administrator, and that she would conduct further screening. She stated staff's names and temperatures should be documentation did not meet her expectations. On March 5, 2021 at 8:36 a.m., a follow-up interview was conducted with the receptionist (staff #16). Staff #16 stated that if an individual did not enter their name or temperature when conducting the screening for COVID-19, she thought the administrator, DON, or IP would receive a text notification. | NAME OF P | ROVIDER OR SUPPLIER | STREET AL | DRESS, CITY, ST | ATE, ZIP CODE | | | |
| PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FILL TAG PREFIX TAG Continued From page 13 Included washing hands prior to entry at the portable handwashing station located outside the main entrance to the building then entering the lobby. Staff #16 stated the person would then enter their name, take their temperature, and complete the screening questions on the klosik. Staff #16 stated the person would then enter their name, take their response, indicating they had either symptoms of COVID-19 or close contact outside the facility with an individual confirmed to have COVID-19, she believed the administrator, DON, or iP would be sent an alert or notification. An Interview was conducted on March 4, 2021 at 12:38 p.m. with the IP (staff #143). The IP stated the staff enter and exit the facility through the front entrance and are expected to be screened for COVID-19. The IP stated that if someone marked yes" on the screening questionnaire, the receptionist would call herself or the administrator and that she would conduct further screening. She stated staff's names and temperatures should be documented. Shaff #143 stated the incomplete documentation did not meet her expectations. On March 5, 2021 at 8:36 a.m., a follow-up interview was conducted with the receptionist (staff #16). Staff #16 stated that if a Individual did not enter their name or temperature when conducting the screening for COVID-19, she thought the administrator, DON, or IP would receive a text notification. In an interview conducted with the DON (staff ##51) on March 5, 2021 at 8:42 a.m., the DON stated that she evolded that she evolded that she evolded that she evolded that she evolded that she evolded that she evolded that she evolded that she evolded that she evolded that she evolded that she evolded that she evolded the she are should be documented with the DON stated that she evolded the stage should be should be should be should be should be should be should be should be should be should be should be | SAPPHIR | E OF TUCSON NURSING | AND REHABILIC 2900 EAS | T MILBER STI | REET | | | |
| PRESENT TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Y 342 Continued From page 13 Included washing hands prior to entry at the portable handwashing station located outside the main entrance to the building then entering the lobby. Staff #16 stated that if arryone answered a screening question with a "yes" response, indicating they had either symptoms of COVID-19 or close contact outside the facility with an individual confirmed to have COVID-19, she believed the administrator, DON, or IP would be sent an elert or notification. An interview was conducted on March 4, 2021 at 12:38 p.m. with the IP (staff #143). The IP stated the staff enter and exit the facility through the front entrance and are expected to be screened for COVID-19. The IP stated that if someone marked "yes" on the screening questionnaire, the receptionist would call herself or the administrator and that she would conduct further screening. She stated staff's names and temperatures should be documented. Staff #149 stated the incomplete documentation did not meet her expectations. On March 5, 2021 at 8:36 a.m., a follow-up interview was conducted with the receptionist (staff #16). Staff #16 stated that if an individual did not enter their name or temperature when conducting the screening for COVID-19, she thought the administrator, DON, or IP would receive a text notification. In an interview conducted with the DON (staff #51) on March 5, 2021 at 8:42 a.m., the DON stated that she expected the screening for | | , , , , , , , , , , , , , , , , , , , | TUCSON, | AZ 85714 | | | | |
| Included washing hands prior to entry at the portable handwashing station located outside the main entrance to the building then entering the lobby. Staff #16 stated the person would then enter their name, take their temperature, and complete the screening questions on the klosk. Staff #16 stated that if anyone answered a screening question with a "yes" response, indicating they had either symptoms of COVID-19 or close contact outside the facility with an individual confirmed to have COVID-19, she believed the administrator, DON, or IP would be sent an alert or notification. An interview was conducted on March 4, 2021 at 12:38 p.m. with the IP (staff #143). The IP stated the staff enter and exit the facility through the front entrance and are expected to be screened for COVID-19. The IP stated that if someone marked "yes" on the screening questionnaire, the receptionist would call herself or the administrator and that she would conduct further screening. She stated staff is names and temperatures should be documented. Staff #143 stated the incomplete documentation did not meet her expectations. On March 5, 2021 at 8:36 a.m., a follow-up interview was conducted with the receptionist (staff #16). Staff #16 stated that if an individual did not enter their name or temperature when conducting the screening for COVID-19, she thought the administrator, DON, or IP would receive a text notification. In an interview conducted with the DON (staff #51) on March 5, 2021 at 8:24 a.m., the DON stated that sine expected the screening for | PREFIX | (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR | BE | COMPLETE | |
| COVID-19 be accurate and complete. The DON | | Included washing han portable handwashing main entrance to the leading of the lea | ds prior to entry at the gration located outside the building then entering the difference their temperature, and ag questions on the kiosk. If anyone answered a this a "yes" response, ther symptoms of COVID-19 de the facility with an or have COVID-19, she rator, DON, or IP would be action. Stucted on March 4, 2021 at (staff #143). The IP stated at the facility through the expected to be screened or stated that if someone creening questionnaire, the liberself or the administrator induct further screening. The liberself or the administrator induct further screening. The liberself or the administrator induct further screening. The liberself or the administrator induct further screening. The liberself or the administrator induct further screening. The liberself or the administrator induct further screening. The liberself or the administrator induct further screening. The liberself or the administrator induct further screening. The liberself or the administrator induct further screening. The liberself or the administrator induct further screening. The liberself or the administrator induct further screening. The liberself or the administrator induct further screening. The liberself or the administrator induct further screening. The liberself or the administrator induct further screening. The liberself or the administrator induction of the screening of the screening for covident in the liberself or | Y 342 | | | | |

| | NT OF DEFICIENCIES N OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|---|---------------------|---|-------------------------------|--------------------------|
| | | NCI-2643 | B. WING | | 03/ | 11/2021 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, ST | ATE, ZIP CODE | | |
| SAPPHI | RE OF TUCSON NURSING | AND REHAB, LLC 2900 EAST TUCSON, A | MILBER STF | REET | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETE DATE |
| Y 342 | temperatures on the sexpectation. The facility's policy title (COVID-19) stated the education, surveillance prevention strategies of transmission of COVID and implement recome in accordance with the Department of Public I Department of Health. everyone entering the including, all visitors, retrips out, and employe facility, including obtain. The CDC guidelines tit COVID-19 in Nursing I 20, 2020, included confermaln in place even a normal activities, including managing healthcare proceeds that all HCP shot beginning of their shift COVID-19, that tempe taken, and the absence with COVID-19 docum. Regarding PPE and have review of the facility of 2021 revealed there we on the B-100 hall/secureview revealed 5 out onew admissions and we observation/droplet presymptoms of COVID-1 | ed Coronavirus Disease e facility will conduct e, and infection control and to reduce the risk of 0-19. The facility will follow mendations and guidelines e CDC, the State Health, and County The policy stated that facility will be screened esidents returning from les before they enter the ning a temperature. Itted Preparing for Homes, updated November re practices which should as nursing homes resume ding evaluating and personnel. The guidance build be screened at the for fever and symptoms of ratures should be actively e of symptoms consistent fented. In the policy stated that facility will be screened esidents resume ding a temperature. Itted Preparing for Homes, updated November re practices which should as nursing homes resume ding evaluating and personnel. The guidance build be screened at the for fever and symptoms of ratures should be actively e of symptoms consistent fented. In the policy stated that facility will follow mendations and guidelines the policy stated that facility will follow mendations and guidelines the policy will follow | Y 342 | | | |
| | | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|---|--------------------------------------|---|---|---|-------------------------------|------------|
| | | | A BUILDING | A BOILDING. | | |
| | | NCI-2643 | B. WING | | 03/ | 11/2021 |
| NAME OF P | PROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, ST | ATE, ZIP CODE | | |
| | | 2900 EAST | MILBER ST | REET | | |
| SAPPHIR | E OF TUCSON NURSING | AND REHAB, LLC TUCSON, A | | | | |
| (X4) ID | SUMMARY ST | ATEMENT OF DEFICIENCIES | ΙD | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD | BE | COMPLETE |
| TAG | REGULATORY OR I | SC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | IATE | DATE |
| | | | | DEFICIENCY | | |
| Y 342 | Continued From page | e 15 | Y 342 | | | |
| | was conducted of the | B-100 hall. PPE carts were | | | | |
| | observed outside of the | | | | | |
| | 1 | ew admissions resided. In | | | | |
| | 1 | e doorframe of each of their | [| | | |
| | | gn. The sign stated to stop | | | | |
| ì | | se before entering, and to | | ļ | | |
| i | | PPE requirements to enter | | | | |
| | | ide of the sign stated that | | | | |
| | | om was a Person Under | | | | |
| | | structions included that | | | | |
| ļ | | ust wear N95 or KN95 | | | | |
| | | over the N95 or KN95 mask, | | | | |
| | gown, face shield or g | oggles, and gloves, that | | | | |
| | staff should wash han | ds with soap and water, or | | | | |
| | | er, and that staff should | | | | |
| | clean face shield/gogg | gles when they were done in | | | | |
| | the room. | | | | | |
| | On March 1, 2021 at 1 | 12:28 p.m., a housekeeper | | | | |
| | | rved to clean a room of one | | | | |
| | of the resident's on ob | servation/droplet | | | | |
| | precautions. The hous | sekeeper was observed to | | | , | |
| | | mask with a surgical mask | | | | |
| | covering it, goggles, g | loves, and a gown. | | | | |
| | | eper's gown was observed | | | | |
| İ | | and not at the neck. As the | | | | ļ] |
| | | the floor, the gown was | | | | |
| | | r shoulders, covering only | | | | |
| | | r arms. The housekeeper's | | | | |
| | | r arms were completely | | | | j |
| | exposed. At approximately bounded by | | | | | J |
| | nurses' station. The ho | er gown and walked to the | | | Ì | l |
| | | ousekeeper was not loves and surgical mask, | | | | I |
| | and she did not clean i | | | | | i |
| | | ner goggles. The nurse the resident required | | | | |
| | | followed the housekeeper | | | | 1 |
| | back to the resident's r | | | | | l |
| | | to entering the resident's | | | | i |
| | | er doffed her gloves at the | | | | ĺ |

| | IT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | CV2N MULTIPLE | E CONSTRUCTION | OVA) DATE | CURREY |
|-----------|---|--|------------------|--------------------------------|-------------------|----------|
| | OF CORRECTION | IDENTIFICATION NUMBER: | 1 ' ' | | (X3) DATE COMP | LETED |
| | | | A. BUILDING. | A. BUILDING: | | |
| | | Í | | D 11910 | | |
| | | NCI-2643 | B. WING | | 03/ | 11/2021 |
| NAME OF P | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | ATE, ZIP CODE | | |
| | | 2900 EA | ST MILBER STE | REET | | |
| SAPPHIR | E OF TUCSON NURSING | AND REHAB, LLC | , AZ 85714 | | | |
| (X4) ID | SUMMARY ST | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN | OF CORRECTION | (X5) |
| PREFIX | (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE A | ACTION SHOULD BE | COMPLETE |
| TAG | REGULATORY OR L | LSC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO DEFICIE | | DATE |
| | | and the second s | | DEFICIE | | |
| Y 342 | Continued From page | 16 | Y 342 | | | |
| | door to the realdentle | norm did not norform bond | | | | |
| | | room, did not perform hand the surgical mask, and did | | | | |
| | | . The housekeeper was | | | | |
| | | a clean pair of gloves and | | | | |
| | | loorway of a resident's room | | | | |
| | | ion precautions. She took a | | | | |
| | | into the resident's room and | | | | |
| | began to clean it. | | | 1 | | |
| | | | | | | |
| | At 12:49 p.m. on Marc | ch 1, 2021, an interview was | 1 | | | |
| | conducted with the ho | ousekeeper (staff #196). | | | | 1 |
| | Staff #196 stated that | she was not supposed to | | | | |
| | wear her gown untied | at the neck and that she | | | | |
| | was taught to tie her g | jown at the neck and the | | | | |
| | waist when entering a | | | | | |
| | housekeeper stated th | nat when she exits the | | | | |
| | resident's room, she to | <u> </u> | | | | |
| | | out it. She stated that she | | | | |
| | | to clean them with window | | | | |
| | cleaner before going in | | | | | |
| | | ed that she was told to clean | | | | |
| | | ow cleaner. She said she | | | | |
| | | en she is finished in one | 1 | | | |
| | | rill wash her hands again next resident's room. The | | | | |
| | *************************************** | nat she still needed to wash | | | | |
| | her hands. | iat one suit needed to wash | | | | |
| | Hallav | | | | | |
| | On March 4, 2021 at 1 | 10:44 a.m., an interview was | | | | |
| | | (staff #143). The IP stated | | | | |
| | | about PPE in January | 1 | | : | |
| | 2021. She stated her | | | | į | |
| | | to don the double masks, | | | | ĺ |
| | | , gown, and gloves. The IP | | | | |
| | | leave the PUI room, her | | | | |
| | • | ff doff the gown, gloves, | | | | |
| | | ore they exit. She stated | | | | |
| | | ace shield or goggles with | | | | |
|]] | | the room before they | | | | |
| | leave, or right as they | exit. The IP stated that the | 1 | | | |

| | T OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|---|---|--|----------------------------|-------------------------------------|----------|------------------|--|
| AND PLAN | LAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: | | СОМ | PLETED | | | |
| | | | | | | | |
| | | NCI-2643 | B. WNG | | 03 | /11/2021 | |
| NAME OF B | ROVIDER OR SUPPLIER | STREET AN | DRESS, CITY, ST | TATE ZIP CODE | - | | |
| Wall Of t | NOVIDER ON OUT LIER | | MILBER ST | | | | |
| SAPPHIR | E OF TUCSON NURSING | AND REHAB, LLC | | VAL I | | | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES | | · | 7 | PROVIDER'S PLAN OF CO | PRECTION | | |
| PREFIX | | Y MUST BE PRECEDED BY FULL | ID PREFIX | (EACH CORRECTIVE ACTIO | | (X5) COMPLETE | |
| TAG | REGULATORY OR I | LSC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE DEFICIENCY) | | DATE | |
| | | | ļ | | | | |
| Y 342 | Continued From page | 17 | Y 342 | | | | |
| | risk for not following to | hat process would be | | | | | |
| | possible cross contan | • | Í | | | | |
| | , | | | | | | |
| | | ducted on March 5, 2021 at | | · | | } | |
| | | ector of Nursing (DON/staff | | | | | |
| | | her expectation for staff | | | | | |
| | • | ncluded to don a gown that | ļ | | | | |
| | was tied at the neck a | I gloves if providing care. | | | | | |
| | sincia or goggics, and | gioves ii providing care. | | | | | |
| | The facility policy's titled Handwashing/Hand | | | | | | |
| | Hygiene/Hand Hygien | e Monitoring revised March | | | | | |
| | | acility considered hand | | | | | |
| | | neans to prevent the spread | | | | | |
| | | cy stated that all personnel | ł | | | 1 | |
| | | egularly in-serviced on the giene in preventing the | | | | | |
| | | care-associated infections. | | | | | |
| | | ow the handwashing/hand | | | | | |
| | | help prevent the spread of | | | | | |
| | infections to other pers | | | | | } | |
| | visitors which included | i to use an alcohol-based | | | | | |
| | hand rub containing at | | | | | | |
| | alternatively, soap and | water in the following | | | | | |
| | | ing gloves and before and | | | | | |
| ĺ | _ | precaution settings. The | | | | | |
| | after removing and dis | hygiene is the final step | | | | | |
| | and tomorning and the | pooning of 1 1 L. | | | | | |
| | The facility's COVID-1 | 9 Reference Binder | | | | | |
| 1 | included the use of fac | e shields for Persons | | | | | |
| | | Uls). The cleaning of face | | | | | |
| | | ng gloves and using alcohol | | | | | |
| | wipes to disinfect the s | | | | | 1 | |
| | | of the face shield, allow to | | | |] | |
| | | oves, and perform hand | | | | | |
| | | was that the face shield | | | | | |
| | must be cleaned after | leaving each PUI room. | | | | | |
| | The facility's COVID-19 | 9 Reference Binder | | | | | |

| | T OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLI | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | |
|---------------|--|---|-----------------|---|-------------------|------------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | A BUILDING: | | PLETED | |
| | | NCI-2643 | B. WING | | 03. | /11/2021 | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET AN | DRESS, CITY, ST | ATE ZIP CODE | | | |
| TANKE OF F | NOVIDER ON GOLF LIER | | T MILBER STR | • | | | |
| SAPPHIR | E OF TUCSON NURSING | AND REHAB. LLC | AZ 85714 | | | | |
| (X4) ID | SUMMARY ST | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN | OF CORRECTION | (X5) | |
| PREFIX TAG | (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE | O THE APPROPRIATE | COMPLETE DATE | |
| Y 342 | Continued From page | 18 | Y 342 | | | | |
| | included the CDC qui | dance titled Use of PPE | | | | | |
| | | ents with Confirmed or | | | | | |
| | | . The guidance stated that | | | | | |
| | PPE must be donned | correctly before entering | | | | 1 | |
| | | ding tying all the ties on the | | | | | |
| | | ain in place and be worn | | | | | |
| | - | ion of work in potentially | | | | | |
| | | and PPE must be removed | 1 | | | • | |
| | slowly and deliberatel | | | | | | |
| | prevents self-contami instructions included t | | 1 | | | | |
| | removed prior to exiting | | 1 | | | | |
| | removed prior to exitti | ig the patient room. | ı | | | | |
| | The CDC Interim Infe | ction Prevention and Control | İ | | | | |
| | Recommendations for | r Healthcare Personnel | | | | | |
| | During the Coronaviru | | 1 | | | | |
| | • | c updated December 14, | 1 | | | | |
| | | DC recommended using | ŀ | | | 1 | |
| | additional infection pro | | | | | | |
| | | OVID-19 pandemic, along | | | | | |
| | with standard practice healthcare delivery to | | | | | | |
| | | I to apply to all patients, not | | | | | |
| | just those with suspec | | | | | 1 | |
| | • | n. The guidance stated that | | | | | |
| | employers should sele | ect appropriate PPE and | | | | | |
| | provide it to HCP. HC | P must receive training on | | | | | |
| 11 | | nderstanding of when to | | | | | |
| 1 [| | necessary, how to properly | | | | | |
| | | E in a manner to prevent | | | | | |
| | | Iditionally, any reusable | | | | | |
| | and maintained after a | cleaned, decontaminated, | | | | ! | |
| | and manifallied allel t | and pethodii doco. | | | | | |
| | | | | | | | |
| | | conducted of the facility | | | | <u> </u> | |
| | | s on March 4, 2021 at 7:10 | | | | | |
| | | rsing Assistant (CNA/staff esting, was observed to don | | | | j i | |
| | | cure/tie the gown at the | | | | | |

PRINTED: 04/01/2021 FORM APPROVED

ADHS LICENSING SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING NCI-2643 03/11/2021 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** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) Y 342 Continued From page 19 Y 342 waist prior to starting the COVID-19 testing for 5 staff members. An interview was conducted with the CNA (staff #95) on March 4, 2021 at 7:40 a.m. The CNA stated that she has received training regarding donning and doffing of PPE. The CNA stated the proper procedure for placing on a gown would include tying the gown in the back at the waist. Staff #95 stated that for the last five tests she conducted, she did not tie the gowns at the waist. The CNA stated that when a gown is not tied in the back during COVID-19 testing, it could be an infection control issue. An interview was conducted on March 4, 2021 at 10:15 a.m. with the IP (staff #143). She stated that staff have been in-serviced on PPE donning and doffing. The IP stated her expectations for donning gowns would include tying the gown at the waist. She stated that it does not meet her expectations to perform COVID-19 testing without tying the gown at the waist, prior to starting the test. She stated that it would be an infection control risk for contamination. Review of the facility's policy titled, Policy and Procedure COVID 19, revealed that to put on an isolation gown, all the ties must be tied. The CDC Sequence for Putting on PPE included the gown must fully cover the torso from neck to knees, arms to end of wrists, and wrap around the back; fasten in the back at the neck and waist. A review of the CDC guidance titled, COVID-19 Using Personal Protective Equipment (PPE). updated August 19, 2020, revealed when donning an isolation gown, tie all the ties on the gown.

| | NT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | | | (X3) DATE SURVEY | E SURVEY | |
|---------------|--------------------------|---|----------------|--|------------------|----------------|--|
| ANDPLAN | N OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | A. BUILDING: | | | |
| | | | BIMMO | | | | |
| | | NCI-2643 | B. WING | | 03/11/202 | 21 | |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, ST | ATE, ZIP CODE | | | |
| CARDUIT | RE OF TUCSON NURSING | AND BEHAR LLC 2900 EAST | MILBER STR | REET | | | |
| SAFFOI | RE OF TUCSON NURSING | TUCSON, A | NZ 85714 | | | | |
| (X4) ID | | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX TAG | | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | | APLETE DATE | |
| Y104 | 5 R9-10-410.B.4.c. Res | ident Rights ninistrator shall ensure that: | Y1045 | <u>Y1045</u> | 4/20, | /2021 | |
| | | | | What corrective action(s) will be | _ | | |
| | R9-10-410.B.4. A res | ident or the resident's | | accomplished for those residents fou | nd to | | |
| | representative: | | | have been affected by the deficient | | | |
| | DO 40 440 D 4 5 5 | | | practice, on both a temporary and permanent basis, including the date | .h.a | | |
| | | ept in an emergency, is alternatives to psychotropic | | correction will be accomplished? | ле | | |
| | medication or a surgic | | j | correction will be accomplished: | | | |
| | | possible complications of | | Resident # 58, #74, and #106 found | to be | | |
| | the psychotropic medi | | | affected, all consents corrected and | | | |
| | procedure; | _ | | obtained for these residents. | | | |
| | | | | | | | |
| | | | | How will you identify other residents | | | |
| | This RULE is not met | | | having the potential to be affected by the | | | |
| | | rd review, staff interviews, | | same deficient practice and what | | | |
| | | facility failed to ensure f74, and #106) and/or their | | corrective action will be taken? | | | |
| ľ | | nformed of the risks and | | | | | |
| | possible complications | | | The DON and/or designee conducted | | | |
| | | iministration and failed to | | medical record review for all residen | | | |
| | | edication classification for | | psychotropics on 4/5/2021. No other | | | |
| | one resident (#58) who | en consent was obtained. | | residents were found to be affected | | | |
| | | | | What measures will be put into place | l l | | |
| | Findings include: | | | what systemic changes will you make | 1 | | |
| | Desident #50 was add | mitted to the facility on light | | ensure that the deficient practice do | s not | | |
| | 1 | nitted to the facility on July ted on July 31, 2020 with | | recur? | | | |
| | diagnoses that include | | | DON and/or Dasismas conducted an | in l | i | |
| | depressive disorder, a | | | DON and/or Designee conducted an service on Psychotropic consents to | ш- | | |
| | post-traumatic stress of | | | licensed nurses. | | i | |
| | | | | nechised nuises. | | | |
| | | n's orders revealed an | | How will the corrective action(s) be | | | |
| | | 30, 2020 for Aripiprazole | | monitored to ensure the deficient pra | ctice | | |
| | | ram (mg) tablet give 0.5 | | will not recur, i.e., what quality assur | l l | | |
| | | time for severe depression | | program will be put into place; and th | | | |
| 1 | 1 - | enced by (AEB) suicidal | | title, or position, of the person respon | | | |
| | ideation. | | | | | | |
| | | | | | | | |

PRINTED: 04/01/2021 **FORM APPROVED** ADHS LICENSING SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING NCI-2643 03/11/2021 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** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY for implementing/monitoring the Y1045 Y1045 Continued From page 21 corrective action? Review of the Medication Administration Record (MAR) dated December 2020 revealed the The DON and/or Designee will audit all resident received the Aripiprazole as ordered on orders daily of psychotropics for December 30 and 31, 2020. completion and accuracy of consent for 21 days. Any consent found to be out of Review of a quarterly Minimum Data Set (MDS) compliance will be reported to the DON assessment dated January 11, 2021 revealed the and/or Designee for immediate correction resident had a Brief Interview for Mental Status and re-education to licensed staff. (BIMS) score of 10, which indicated the resident had moderately impaired cognition. The assessment included the diagnoses of dementia, Parkinson's disease, anxiety disorder. depression, and PTSD. The assessment revealed the resident received seven days of an antipsychotic medication. Review of the MAR dated January 2021 revealed

However, further review of the clinical record did not reveal the resident or the resident's representative was informed of the risks and benefits of Aripiprazole prior to the administration of the medication.

the resident received the Aripiprazole as ordered

from January 1 through 21, 2021.

Review of the physician's orders revealed an order dated January 22, 2021 for Aripiprazole 5 mg tablet by mouth at bedtime for severe depression augmentation AEB suicidal ideation.

Review of the MAR dated January 2021 revealed the resident received the Aripiprazole as ordered from January 22 through 24, 2021.

However, review of the clinical record did not reveal that informed consent for the medication was obtained from the resident or the resident's representative prior to the administration of the medication.

| NAME OF PROVIDER OR SUPPLIER SAPPHIRE OF TUCSON NURSING AND REHAB, LLC 200 D PROSTOR SALAMARY STATEMENT OF REPORTANCES SECULATORY OR LSC IDENTIFYING INFORMATION) Y10 45 Continued From page 22 Y1045 Y10 45 Continued From page 22 Y1045 Y10 46 Continued From page 22 Y1045 Review of the physician's orders revealed an order dated January 25, 2021 for Aripiprazole 5 mg tablet by mouth at bedtime for severe depression sugmentation AEB suicidal Ideation. Review of the MAR dated January 2021 revealed the resident received the Aripiprazole as ordered on January 25, 2021. However, continued review of the risks and benefits of Aripiprazole until January 26, 2021. Review of the facility forms titled Psychotropic Medications, dated January 26, 2021 and February 26, 2021, revealed the resident consented to the use of Ability/Aripiprazole to treat depression. The drugs was desided to nami-depressant and the side effects listed were sedation, droveliness, fast heartbeat, tremors, agilation, headers, weight gain, addin rash, and sensitivity to the sun. With special attention if heart classes, chronic constitution, selzure disorder, or edema is present. However, Aripiprazole/Ability is an anti-psychotic medication which, por the above forms, has side effects of sedetion, droveliness, dry mouth, constipation, burney from the constitution, extrapyramidal reaction, discreption, during presention, extrapyramidal reaction, discreption, developed to the constitution of the constitution, extrapyramidal reaction, discrepti | | NT OF DEFICIENCIES N OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--|---------|--|--|------------------------------|--|-------------------------------|--|
| SAPPHIRE OF TUCSON NURSING AND REHAB, LLC 2800 EAST MILBER STREET TUCSON, AZ 85714 PREFIX REGULATORY ORLS DENTIFYING INFORMATION) PREFIX TAC 10 10 PREFIX TAC 11 12 PROVIDERS PLIN OF CORRECTION OR CORRECTION PRINTING INFORMATION) TAC 12 PROVIDERS PLIN OF CORRECTION OR CORR | | | NCI-2643 | B. WING | | 03/11/2021 | |
| SAPPHIRE OF TUCSON NURSING AND REHAB, LLC TUCSON, AZ 85714 SUMMARY STATEMENT OR DEFICIORS PLAIL REGULATORY OR LSC IDENTIFINAS INFORMATION) PRETEX TAX TYC CONTINUED From page 22 Y1045 Continued From page 22 Review of the physician's orders revealed an order dated January 25, 2021 for Artipiprazole 5 mg tablet by mouth at bedtime for severe depression augmentation AEB suicidal ideation. Review of the MAR dated January 2021 revealed the resident received the Artipiprazole as ordered on January 25, 2021. However, continued review of the clinical record revealed the resident or the resident's representative was not informed of the risks and benefits of Artipiprazole until January 26, 2021. Review of the facility forms titled Psychotropic Medications, dated January 28, 2021 and February 28, 2021, revealed the resident consented to the use of Ability-Airpiprazole to treat depressant medication. The side effects marked on the forms were those related to an anti-depressant medication. The side effects listed were sedation, drowsiness, fast heartbeat, tremors, agitation, headache, weight gain, skin rash, and sensitivity to the sun. With special attention if heart disease, chronic constipation, seizure disorder, or edema is present. However, Aripiprazole/Ability is an anti-psychotic medication which, per the above forms, has side effects of sedation, drowsiness, dry mouth, constipation, burred vision, weight gain, edema, seating, loss of appetite, urinary retention, extrapyremidal reaction, dizzy or light-headed when standing up. With special attention: Tardive | NAME OF | PROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, ST | ATE, ZIP CODE | | |
| PRETIX TAG CANO DEFICIENCY MUST BE PRECEDED BY FULL PRODUCT TAG CONTINUED FROM LSC IDENTIFYING INFORMATION) PRETIX TAG CONTINUED FROM PAGE 22 Review of the physician's orders revealed an order dated January 25, 2021 for Aripiprazole 5 mg tablet by mouth at bedtime for severe depression augmentation AEB suicidal ideation. Review of the MAR dated January 2021 revealed the resident received the Aripiprazole as ordered on January 25, 2021. However, continued review of the clinical record revealed the resident or the resident's representative was not Informed of the risks and benefits of Aripiprazole until January 26, 2021. Review of the facility forms titled Psychotropic Medications, dated January 26, 2021 and February 26, 2021, revealed the resident consented to the use of Ability/Aripiprazole to treat depressant medication. The side effects marked on the forms were those related to an anti-depressant medication. The side effects marked on the forms were those related to an anti-depressant medication, flowsiness, fast heartbeat, tremors, agitation, headeache, weight gain, skin rash, and sensitivity to the sun. With special attention if heart disease, chronic constitution, selzure disorder, or edema is present. However, Aripiprazole/Ability is an anti-psychotic medication which, per the above forms, has side effects of specific, uninary retention, extrapyramidal reaction, dizzy or light-headed when standing up. With special attention: Tardive | SAPPHI | RE OF TUCSON NURSING | AND DEUAR LIC | | REET | | |
| Review of the physician's orders revealed an order dated January 25, 2021 for Aripiprazole 5 mg tablet by mouth at bedtime for severe depression augmentation AEB suicidal Ideation. Review of the MAR dated January 2021 revealed the resident received the Aripiprazole as ordered on January 25, 2021. However, continued review of the clinical record revealed the resident or the resident's representative was not informed of the risks and benefits of Aripiprazole until January 28, 2021. Review of the facility forms titled Psychotropic Medications, dated January 28, 2021 and February 28, 2021, revealed the resident consented to the use of Ability/Aripiprazole to treat depression. The drug was classified on the forms as an antidepressant and the side effects marked on the forms were those related to an anti-depressant medication. The side effects listed were sedation, drowsiness, fast heartbeat, tremors, agitation, headache, weight gain, skin rash, and sensitivity to the sun. With special attention if heart disease, chronic constituation, selzure disorder, or edema is present. However, Aripiprazole/Ability is an anti-psychotic medication which, per the above forms, has side effects of sedation, drowsiness, dry mouth, constipation, junted vision, weight gain, edema, seating, loss of appetite, urinary retention, extrapyramidal reaction, dizzy or light-headed when standing up. With special attention: Tarcive | PREFIX | (EACH DEFICIENCY | Y MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI | BE COMPLETE | |
| order dated January 25, 2021 for Aripiprazole 5 mg tablet by mouth at bedtime for severe depression augmentation AEB suicidal Ideation. Review of the MAR dated January 2021 revealed the resident received the Aripiprazole as ordered on January 25, 2021. However, continued review of the clinical record revealed the resident or the resident's representative was not informed of the risks and benefits of Aripiprazole until January 26, 2021. Review of the facility forms titled Psychotropic Medications, dated January 28, 2021 and February 26, 2021, revealed the resident consented to the use of Abliffy/Aripiprazole to treat depression. The drug was classified on the forms as an antidepressant and the side effects marked on the forms were those related to an anti-depressant medication. The side effects listed were seation, drowsiness, fast heartbeat, tremors, agitation, headache, weight gain, skin rash, and sensitivity to the sun. With special attention if heart disease, chronic constipation, seizure disorder, or edema is present. However, Aripiprazole/Abliffy is an anti-psychotic medication which, per the above forms, has side effects of sedation, drowsiness, dry mouth, constipation, blurred vision, weight gain, edema, seating, loss of appetite, urinary retention, extrapyramidal reaction, dizzy or light-headed when standing up. With special attention: Tardive | Y104 | Continued From page | 22 | Y1045 | | | |
| constipation, glaucoma, diabetes, skin plgmentation, yellowing of the skin. | | order dated January 2 mg tablet by mouth at depression augmental Review of the MAR dathe resident received to January 25, 2021. However, continued revealed the resident representative was no benefits of Ariplprazole Review of the facility for Medications, dated January 26, 2021, reconsented to the use of treat depression. The forms as an antidepression and the forms wanti-depressant medic listed were sedation, dot tremors, agitation, hear rash, and sensitivity to attention if heart diseaseizure disorder, or ed However, Aripiprazole, medication which, per effects of sedation, droconstipation, blurred viseating, loss of appetitie extrapyramidal reaction when standing up. With Dyskinesia, seizure disconstipation, glaucomatic depression, glaucomatic depression, glaucomatic depression, glaucomatic depression, glaucomatic depression, glaucomatic depression, glaucomatic depression, glaucomatic depression, glaucomatic depression, glaucomatic depression, glaucomatic depression, glaucomatic depression, glaucomatic depression augmentation, glaucomatic depression augmentation, glaucomatic depression augmentation, glaucomatic depression augmentation augmen | 25, 2021 for Aripiprazole 5 bedtime for severe tion AEB suicidal ideation. ated January 2021 revealed the Aripiprazole as ordered eview of the clinical record or the resident's t informed of the risks and e until January 26, 2021. coms titled Psychotropic nuary 26, 2021 and evealed the resident of Abilify/Aripiprazole to drug was classified on the essant and the side effects evere those related to an ation. The side effects frowsiness, fast heartbeat, idache, weight gain, skin ithe sun. With special se, chronic constipation, lema is present. (Abilify is an anti-psychotic the above forms, has side business, dry mouth, ision, weight gain, edema, ie, urinary retention, in, dizzy or light-headed in special attention: Tardive sorder, chronic a, diabetes, skin | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | OWN AND THE | 5 AGNOTON ATTOM | T | | |
|---|---------------------------|--|-----------------|--|-----------|------------------|
| | OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1, , | E CONSTRUCTION | (X3) DATE | SURVEY |
| | | 10-111111111111111111111111111111111111 | A. BUILDING: | | " | |
| | | | l | | ì | |
| | | NCI-2643 | B. WING | | 03/ | 11/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET AC | DRESS, CITY, ST | ATE ZIP CODE | | |
| | | | T MILBER STI | • | | |
| SAPPHIR | E OF TUCSON NURSING | AND REHAB. LLC | AZ 85714 | NEE I | | |
| | | <u> </u> | AZ 03/14 | | | ··· |
| (X4) ID PREFIX | | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD | | (X5) COMPLETE |
| TAG | | SC IDENTIFYING INFORMATION) | PREFIX TAG | CROSS-REFERENCED TO THE APPROPR | | DATE |
| | | | 1 | DEFICIENCY) | | |
| Y1045 | Continued From page | . 22 | Y1045 | | | İ |
| 11045 | page | | 11045 | | | |
| | Review of the current | care plan, last revised | 1 | | | |
| | March 2, 2021, reveal | ed the resident used | 1 | | | |
| | psychotropic medicati | ons related to major | 1 | | | |
| | depression AEB passi | ive suicidal ideation. | 1 | | | |
| | | | | | | |
| | An interview was cond | ducted on March 9, 2021 at | į | | | |
| | 11:32 a.m. with a Lice | nsed Practical Nurse | | | | |
| | (LPN/staff #180). She | stated that staff must | | | | |
| | obtain consent from th | ne resident or the resident | 1 | | | 1 |
| | representative to rece | | | | | |
| | medication before the | medication could be | | | | |
| | administered. She sta | ted that the consent | | | | |
| | included the name of t | the medication, the dose | | | | |
| | ordered, why the med | ication was being used, the | | | | |
| | classification of the me | edication and potential side | | | | |
| | effects of the medicati | on. She stated that the | | | | |
| | medication classification | on marked on the consent | Ī | | | |
| - | form should match the | actual classification of the | 1 | | | |
| ļ | medication that was or | rdered, even if the | | | | |
| | medication is being us | ed for a different reason. | 1 | | | |
| | She stated that the un | it manager would let the | | | | |
| İ | floor nurse know that t | he resident would be | ŀ | | | |
| | getting a psychotropic | medication and would | 1 | | | |
| | obtain the consent if sl | he was able, if unable, the | 1 | | | |
| | unit manager would as | sign a nurse to obtain the | | | | |
| 1 | consent. | | | | | |
| | | | | | | |
| | | ucted on March 11, 2021 at | | | | |
| | | ctor of Nursing (DON/staff | İ | | | i |
| | | she expects staff to obtain | | | ļ | |
| | informed consent from | | 1 | | | |
| | | ve when a psychotropic | | | | ļ |
| | | and before the medication | | | | 1 |
| | is administered. She st | | | | I | |
| | | dication being given, what | | | | ľ |
| | the medication is being | | | | | ŀ |
| | potential side effects, a | | | | | j |
| | classification for the me | edication. For the | | | į | ł |
| | | resident #58, she stated | 1 | | | 1 |
| | that the consent should | d have been obtained | <u> </u> | | | I |

| STATEMEN | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|---|--------------------------|---|-------------------------------|--|
| | | NCI-2643 | B. WING | | 03/11/2021 | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, ST | ATE, ZIP CODE | | |
| SAPPHIR | E OF TUCSON NURSING | AND REHAB, LLC 2900 EAS' TUCSON, | T MILBER STF AZ 85714 | REET | | |
| (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 APPROPE DEFICIENCY) | BE COMPLETE | |
| Y1045 | before the medication December of 2020 and the consent was not of 2021 and that her exp. She stated that the medication on the consent form at that the side effects rewould not have been cordered. Resident #74 was add February 8, 2020, with alcohol abuse, acute putract infection. Regarding Fluoxetine A physician's order daincluded for Fluoxetine tablet by mouth in the evidenced by restless. Traumatic Stress Discoorder was discontinued. A physician's order daincluded for Fluoxetine tablet by mouth in the evidenced by lack of into Post Traumatic Strest This order was discontinued. A physician's order daincluded for Fluoxetine tablet by mouth in the evidenced by lack of into Post Traumatic Stresthis order was discontinued. A physician's order daincluded for Fluoxetine tablets by mouth in the evidenced by lack of into Post Traumatic Stresthis order was discontinued. A physician's order daincluded for Fluoxetine tablets by mouth in the evidenced by lack of into Post Traumatic Stresthis order was discontinued. | was administered in d that it was not. She stated obtained until January 26, sectations were not met. edication was an uld not have been marked as an antidepressant and eviewed with the resident correct for the medication mitted to the facility on a diagnoses that included by elonephritis, and urinary detected November 14, 2020 at HCL Tablet 20 mg give 1 moming for anxiety as ness related to Post order, Unspecified. This d on November 17, 2020. At HCL Tablet 20 mg give 1 moming for Depression as neess in activities related as Disorder, Unspecified. It is the contract of the contract | Y1045 | | | |
| | March 2021 revealed t | the resident was | | | | |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|-----------------------|---|-------------------------------|--------------------------|
| | | NCI-2643 | B. WING | | 03/ | 11/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, ST | ATE, ZIP CODE | | |
| SAPPHIR | E OF TUCSON NURSING | AND REHAB, LLC 2900 EAST TUCSON, A | MILBER STA Z 85714 | REET | | |
| (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 APPROPR DEFICIENCY) | BE | (X5) COMPLETE DATE |
| Y1045 | administered Fluoxetii The Consultant Pharm Regimen Reviews for December 2020, and resident #74 was rece and that the pharmaci consent for the medici charting system. Continued review of the consent for Fluoxetine 11, 2021. Regarding Quetiapine A physician's order dat included for Quetiapine 50 mg give 1 tablet by psychosis related to Pro Disorder as evidenced was discontinued on N A physician's order dat included for Quetiapine tablet by mouth one tin physical aggression for A physician's order dat included for Quetiapine 50, give 1.5 tablet by m psychosis related to Pro Disorder as evidenced was discontinued on N A Physician's Order dat included for Quetiapine 50, give 1.5 tablet by m psychosis related to Pro Disorder as evidenced was discontinued on N A Physician's Order dat included Quetiapine Fu | nacist's Medication November 2020, January 2021 included intly started on Fluoxetine st was unable to find a ation in the electronic de clinical record revealed a rewas obtained on February Furnarate ted October 21, 2020 be Furnarate (antipsychotic) mouth at bedtime for lost Traumatic Stress by delusions. This order lovember 18, 2020. ded November 7, 2020 be Furnarate give 50 mg line only for verbal and or 1 day. led November 18, 2020 be Furnarate 50 mg tablet mouth at bedtime for lost Traumatic Stress by delusions. This order | Y1045 | | | |
| | to Post Traumatic Stres by delusions. | es Disorder as evidenced | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MULTIPLI | CONSTRUCTION | | (X3) DATE SURVEY | |
|---|--|---|---------------------|---|-----------|--------------------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | СОМР | LETED | |
| | | İ | | | | | |
| | | NCI-2643 | B. WING | | 03/ | 11/2021 | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, STA | ATE, ZIP CODE | | | |
| SAPPHIR | E OF TUCSON NURSING | AND REHABLILC 2900 EAST | MILBER STR | EET | | | |
| | | TUCSON, A | XZ 85714 | | | | |
| (X4) ID PREFIX TAG | PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREFIX TAG | PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETE DATE | |
| Y1045 | Continued From page | 26 | Y1045 | | | | |
| | Review of the MARs of December 2020, and revealed the resident Quetiapine Fumarate The Consultant Pharm Regimen Reviews dat December 2020, and consent form for residindicated a specific do had changed, and that obtaining an updated Quetiapine. However, no consents in dosage to 50 mg in dosage to 75 mg in No. 2021 An interview was conducted by the pharmac conducted b | for November and January and February 2021 was administered as ordered. macist's Medication ted November and January 2021 included the tent #74 for Quetiapine use of 25 mg, that the dose at facility should consider consent for the use of were found for the change October or the change in ovember until February 11, ducted on March 11, 2021 at esident's LPN (staff #171), by medication reviews are rmacist and then sent to utes to them to staff to the provider. The LPN stated ts if they want to change said that regarding teview the chart to locate for there was not a consent, the resident or the resident's the said that it could | | | | | |
| | 3:22 p.m. with the DO | ducted on March 11, 2021 at N (staff #51), who said the en a new psychotropic | | | | | |

ADHS LICENSING SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING NCI-2643 03/11/2021 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** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY Y1045 Continued From page 27 Y1045 medication is ordered, there should be a consent. The DON stated it is the nurses' responsibility to obtain consent for psychotropic medications. The DON stated her expectations is that nursing should have obtained informed consent at the time the new medication was ordered and before the medication was administered. The DON stated that this resident should have had an informed consent for both the Quetiapine and the Fluoxetine. -Resident #106 was admitted to the facility on September 21, 2019 with diagnosis that included dementia with Behavioral Disturbance. Alzheimer's Disease, and unspecified psychosis. Review of the physician's orders revealed an order dated January 11, 2021, for Mirtazapine (antidepressant) 7.5 mg to be given by mouth at A review of the MAR for January 2021, revealed the resident was administered the medication Mirtazapine as ordered, starting on January 11, 2021. A review of the quarterly MDS assessment dated February 1, 2021, revealed the resident had a Brief Interview for Mental status (BIMS) Score of 01, which indicated the resident's cognition was severely impaired. The MDS assessment also included the resident was administered an antidepressant medication. Continued review of the clinical record revealed a psychotropic medication consent dated February 12, 2021 for Mirtazapine. However, further review of the clinical record revealed no evidence that the resident or the

| NAME OF PROVIDER OR SUPPLIER SAPPHIRE OF TUCSON NURSING AND REHAB, LLC O(4) ID PREERY AREQUATORY OR SUPPLIER SUMMARY STATEMENT OF DEPTICIENCES GRACH DEPTICIENCY MUST BE PRECEDED BY PULL PREERY TAG O(4) ID PREERY TAG AREQUATORY OR SUPPLIER SUMMARY STATEMENT OF DEPTICIENCES GRACH DEPTICIENCY MUST BE PRECEDED BY PULL PREERY TAG PRECIDENCY OR SUPPLIES OF THAT THE STATE THE STATE OF THAT THE STATE OF THE S | | ENT OF DEFICIENCIES NN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|--|--------|--|--|-----------------|--|-------------------------------|
| NAME OF PROMORE OR SUPPLIER SAPPHIRE OF TUCSON NURSING AND REHAB, LLC COUNTY SUMMARY STATEMENT OF DEPICIPACIES REGULATORY OF LOS DESTITYMEN AFORMATION PRIEFY THA COUNTY THA COUNTY COUNTY THA CONTINUED FROM THE OF TUCSON NURSING AND REHAB, LLC CONTINUED FROM THE OF DEPICIPACIES REGULATORY OF LOS DESTITYMEN AFORMATION THA CONTINUED FROM THE AFROPMART CROSS-REFERENCED OF THALL REGULATORY OF LOS DESTITYMEN AFORMATION THA CONTINUED FROM THE AFROPMART CROSS-REFERENCED OF THALL CROSS-REFERE | | | | | | |
| SAPPHIRE OF TUCSON NURSING AND REHAB, LLC O(A) D PREFIX TVG SUMMARY STATELENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TVG TVG Continued From page 2B resident's representative were informed of the risks and benefits of the anticepressant/psychotropic medication Mirtzagpine prior to February 12, 2021. An Interview was conducted on March 9, 2021 at 2:10 p.m., with an LPN (staff #189). The LPN stated consent for a psychotropic medication should be obtained prior to administering the first dose of the medication. The LPN stated resident #100 was administered the first dose of Mirtzagpine prior to the consent for a psychotropic medication prior to the consent for Mirtzagpine prior to the consent for Mirtzagpine prior to the consent for Mirtzagpine prior to the consent for Mirtzagpine prior to the consent for Mirtzagpine prior to the consent for Mirtzagpine prior to the consent for Mirtzagpine prior to the consent for Mirtzagpine prior to the consent for Mirtzagpine prior to the consent for Mirtzagpine prior to the consent for Mirtzagpine prior to the consent for Mirtzagpine prior to the consent for Mirtzagpine prior to the consent for Mirtzagpine prior to the consent for Mirtzagpine prior to the consent for Mirtzagpine prior to the Consent Was not that it is her expectation that one the order is written for a psychotropic medication shall be the consent was not obtained until February 12, 2021. The DON stated the Mirtzagpine consent was obtained after the resident #106 was started on January 11, 2021, per a physician order, and the consent was not obtained until February 12, 2021. The DON stated the Mirtzagpine consent was obtained after the resident was administered the medication. The DON stated the Mirtzagpine consent was obtained after the resident was administered the medication. The DON stated the Mirtzagpine consent was obtained after the resident was administered the medication. The DON stated the Mirtzagpine consent was obtained after the resident was administered to the r | | | NCI-2643 | B. WING | | 03/11/2021 |
| APPINITE OF TUCSON NURSING AND REMAR, LLC TUCSON, AZ 85714 Continued From page 28 Y1045 | NAME O | F PROVIDER OR SUPPLIER | STREET ADD | DRESS, CITY, ST | ATE, ZIP CODE | |
| PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CONSS-REFERENCE OT THE APPROPRIATE DY1045 Consider the presentative were informed of the risks and benefits of the antidepressant/psychotropic medication Mirtazapine prior to February 12, 2021. An Interview was conducted on March 9, 2021 at 2:10 p.m., with an LPN (staff #189). The LPN stated consent for a psychotropic medication should be obtained prior to administering the first dose of the medication. The LPN stated resident #106 was administered the first dose of Mirtazapine or January 11, 2021 and that she was unable to locate a consent for Mirtazapine prior to the consent for Mirtazapine prior to the consent for Mirtazapine dated February 12, 2021. On March 11, 2021 at 4:05 p.m., an interview was conducted with the Director of Nursing (DON/staff #51). The DON stated the nursing staff are responsible for obtained, one sent for the medication be obtained. The DON acknowledged that the Mirtazapine for resident #106 was stanted on January 11, 2021, per a physician order, and the consent was not obtained until February 12, 2021. The DON stated the Mirtazapine should not have been administered the medication. The DON stated the Mirtazapine should not have been administered to the resident without the consent twas administered to the resident without the consent being obtained. A review of the facility's policy titled, Medication Management, revealed that the medical record should show evidence that the resident, family member or representative is aware of and | SAPPH | IRE OF TUCSON NURSING | AND REHAB, LLC | | REET | |
| resident's representative were informed of the risks and benefits of the antidepressant/psychotropic medication Mirtazapine prior to February 12, 2021. An Interview was conducted on March 9, 2021 at 2:10 p.m., with an LPN (staff #189). The LPN stated consent for a psychotropic medication should be obtained prior to administering the first dose of the medication. The LPN stated resident #106 was administered the first dose of Mirtazapine on January 11, 2021 and that she was unable to locate a consent for Mirtazapine prior to the consent for Mirtazapine prior to the consent for Mirtazapine dated February 12, 2021. On March 11, 2021 at 4:05 p.m., an interview was conducted with the Director of Nursing (DON/staff #51). The DON stated the nursing staff are responsible for obtaining consents for psychotropic medications and that it is her expectation that once the order is written for a psychotropic medication that the consent for the medication be obtained. The DON acknowledged that the Mirtazapine for resident #106 was started on January 11, 2021, per a physician order, and the consent was not obtained until February 12, 2021. The DON stated that it did not meet her expectations that the Mirtazapine consent was obtained after the resident was administered to the resident without the consent for the medication. The DON stated the Mirtazapine should not have been administered to the resident without the consent the consent for the resident without the consent the properties of the resident without the consent the properties of the resident without the consent the properties of the resident without the consent bring obtained. A review of the facility's policy titled, Medication Management, revealed that the medical record should show evidence that the resident, family member or representative is aware of and | PREFIX | (EACH DEFICIENCY | MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI | BE COMPLETE |
| | Y104 | resident's representate risks and benefits of the antidepressant/psychology in the consent for a part of the medication and the consent for a part of the medication and the consent for a part of the medication and the consent for a part of the medication and the consent for a part of the consent for the consent for the consent for February 12, 2021. On March 11, 2021 at conducted with the Direct of the consent for psychotropic medication psychotropic medication psychotropic medication that once the consent was not of 2021. The DON stated expectations that the floot of the consent was not of 2021. The DON stated expectations that the floot of the consent was not of 2021. The DON stated expectations that the floot of the consent was not of 2021. The DON stated expectation. The DON should not have been a resident without the consent was not of 2021 and 2021. The DON stated expectations that the floot of the facility's floor of the facility floor of the floor of the facility floor of the facility floor of the flo | ive were informed of the ne obropic medication ebruary 12, 2021. ducted on March 9, 2021 at N (staff #189). The LPN sychotropic medication for to administering the first in. The LPN stated resident id the first dose of y 11, 2021 and that she is consent for Mirtazapine of Mirtazapine dated 4:05 p.m., an interview was rector of Nursing (DON/staff the nursing staff are no consents for one and that it is her the order is written for a on that the consent for the d. The DON acknowledged or resident #106 was started for a physician order, and obtained until February 12, that it did not meet her Mirtazapine consent was dent was administered the stated the Mirtazapine administered to the insent being obtained. Is policy titled, Medication of that the medical record that the resident, family tive is aware of and | Y1045 | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | 1 | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|---|--|--|----------------------------|---|----------------------------|
| | | | A. BUILDING | | |
| | | NCI-2643 | B. WING | | 03/11/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET A | DRESS, CITY, S | TATE, ZIP CODE | |
| SAPPHIR | E OF TUCSON NURSING | AND REHAB. LLC | ST MILBER ST , AZ 85714 | REET | |
| (X4) ID | SUMMARY ST | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | J (X5) |
| PREFIX TAG | | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE COMPLETE |
| Y1045 | Continued From page | 29 | Y1045 | | |
| | the resident's condition; treatment options, relative risks and benefits of treatment, required monitoring, expected outcomes of the treatment; and has the right to refuse care and treatment. | | | | |
| Y1147 | R9-10-411.C.9. Medic | cal Records | Y1147 | <u>Y1147</u> | 4/20/2021 |
| | R9-10-411.C. An administrator shall ensure that a resident's medical record contains: R9-10-411.C.9. Orders; | | | What corrective action(s) will be accomplished for those residents fou have been affected by the deficient practice, on both a temporary and permanent basis, including the date correction will be accomplished? | |
| | This RULE is not met as evidenced by: Based on clinical record review, staff interviews, and policy review, the facility failed to ensure one resident (#16) medical record contained an order for hospice care. Findings include: Resident #16 was admitted to the facility on June 15, 2020 and readmitted on November 20, 2020 with diagnoses that included encounter for palliative care and type 2 diabetes mellitus with hyperglycemia. Review of the care plan initiated June 17, 2020 revealed the resident was on hospice services. The goal was that the resident would have all needs met related to end of life care with the intervention that staff will anticipate and meet the needs of the resident and contact the hospice agency as needed. The quarterly Minimum Data Set (MDS) assessment dated December 10, 2020 revealed a Brief Interview for Mental Status (BIMS) score | | | Resident #16 found to be affected. (already updated previously.) How will you identify other residents having the potential to be affected by same deficient practice and what corrective action will be taken? The Social Service Director and/or designee conducted a medical record review for all hospice residents in ho on 3/30/2021. No other residents we found to be affected. What measures will be put into place what systemic changes will you make ensure that the deficient practice doe recur? Administrator and/or Designee conduction in-service on hospice orders to ID 3/18/2021. | y the luse are or to s not |

| NAME OF PROMDER OR SUPPLIER SAPPHIRE OF TUCSON NURBING AND REHAB, LLC 200 EAST MILIBER STREET TUCSON. AZ 85714 COULD PRIEST SEQUENT PROMOTER PLANGE CORRECTION AS A SUMMAY STREET TUCSON. AZ 85714 Y1147 Continued From page 30 of 13, indicating the resident had intact cognition. The assessment included the resident received hospice care. Review of the resident's hospice plan of care revealed the start of care date was on June 15, 2020. Further review of the Chinical record did not reveal a physician order for hospice documentation did not reveal an initial evaluation had been conducted. An interview was conducted on March 4, 2021 at 10:29 A.M. with a Licensed Practical Nurse (LPNstaff #87). Who stated that a physician order is needed to admit a resident to hospice. An interview was conducted on March 5, 2021 at 10:29 A.M. with the Social Service Coordinator (staff #207), who stated that a physician order is needed to admit a resident to hospice agency will then provide hospice plan of care and orders. Staff #207 stated the hospice agency will then provide hospice plan of care and orders. Staff #207 stated date hospice agency will then provide hospice plan of care and orders. Staff #207 stated date hospice plan of care and orders. Staff #207 stated date hospice plan of care and orders. Staff #207 stated the hospice plan of care and orders. Staff #207 stated date hospice plan of care and orders. Staff #207 stated the hospice provider notes, care plans, and hospice care orders. In an interview conducted with the Director of Nursing (DON/staff #851) on March 11, 2021 at 3:22 P.M., the DON stated that it is her expectation that hospice application and review of the conducted order to be admitted to hospice. Staff #307 stated the hospice provider notes, care plans, and hospice are orders. | STATEMEN | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | I | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--|-----------|---|--|-----------------|--|--|--|
| An interview was conducted on March 4, 2021 at 10:29 A.M. with a Licensed Practical Name (LPW) staff #81), who stated that prospect or sendent in hospice care included or March 5, 2021 at 8:42 A.M. with the Social Service Coordinator (staff #207), who stated that on hospice sagency will then provide hospice care included with the Director of Nursing (DON) stated the hospice care on thospice care on the spice agency will then provide hospice care in a miterview conducted with the Director of Nursing (DON) stated the hospice care on the spice agency will then provide hospice care in a miterview conducted with the Director of Nursing (DON) stated the hospice care on thospice has a hospice hospice care included with the Director of Nursing (DON) stated the hospice care on the provision order to be admitted to hospice. Staff #512 at 32.22 P.M., the DON stated the process physician order applysician order to be admitted to hospice. Staff #527 at 3.22 P.M., the DON stated the process physician order applysician order to be admitted to hospice. Staff #52 at 3.22 P.M., the DON stated the hospice care on the spice agency will send the provision order applysician order to the process the place of the provide hospice care on t | | | NCI-2643 | B. WING | | 03/11/2021 | |
| TUCSON, AZ 85714 TUCSON, AZ 8 | NAME OF F | PROVIDER OR SUPPLIER | STREET AL | DRESS, CITY, ST | ATE, ZIP CODE | | |
| PREFIX TAG TAG CANDIDATE REQUIRENCY NUTS THE PRECEDED BY PILL REQUIRENCY NUTS THE APPROPRIATE DATE TAG TAG CONTINUED From page 30 of 13, indicating the resident had intact cognition. The assessment included the resident received hospice care. However, further review of the clinical record did not reveal a physician order for hospice care. Review of the resident's hospice plan of care revealed the start of care date was on June 16, 2020. Further review of the hospice documentation did not reveal an initial evaluation had been conducted. An interview was conducted on March 4, 2021 at 10.29 A.M. with a Licensed Practical Nurse (LPN/staff #61), who stated that a physician order is needed to admit a resident to hospice. An Interview was conducted on March 5, 2021 at 8:42 A.M. with the Social Service Coordinator (staff #207), who stated the process for placing a resident in hospice care included obtaining a physician order. Staff #207 stated the hospice agency per resident's or family's preference is contacted and will come and evaluate the resident in hospice care included obtaining a physician order. Staff #207 stated the hospice agency per resident's or family's preference is contacted and will come and evaluate the resident on hospice has a hospice book, which contains hospice provider notes, care plans, and hospice care orders. In an interview conducted with the Director of Nursing (DOM/staff #81) on March 11, 2021 at 3:22 P.M., the DON stated that it is her expectation that hospice residents have a physician order to be admitted to hospice. Staff #51 echnowledged there was no physician order. | SAPPHIR | E OF TUCSON NURSING | AND REHAB. LLC | | REET | | |
| of 13, indicating the resident had intact cognition. The assessment included the resident received hospice care. However, further review of the clinical record did not reveal a physician order for hospice care. Review of the resident's hospice plan of care revealed the start of care date was on June 15, 2020. Further review of the hospice documentation did not reveal an initial evaluation had been conducted. An interview was conducted on March 4, 2021 at 10.29 A.M. with a Licensed Practical Nurse (LPN/staff #81), who stated that a physician order is needed to admit a resident to hospice. An interview was conducted on March 5, 2021 at 8.42 A.M. with the Social Service Coordinator (staff #207), who stated the process for placing a resident in hospice care included obtaining a physician order. Staff #207 stated the hospice agency will then provide hospice plan focare and orders. Staff #207 stated the hospice agency will then provide hospice plan hospice care orders. In an interview conducted with the Director of Nursing (DON/staff #51) on March 11, 2021 at 3:22 P.M., the DON stated that it is her expectation that hospice residents have a physician order to be admitted to hospice. Staff #51 acknowledged there was no physician order. | PREFIX | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE COMPLETE MATE DATE | |
| The facility's hospice policy revised January 2014 | Y11 47 | of 13, indicating the retail The assessment inclusions hospice care. However, further review of the resident revealed the start of commentation did not had been conducted. An interview was conducted. An interview was conducted. An interview was conducted. An interview was conducted. An interview was conducted. An interview was conducted. An interview was conducted. An interview was conducted. An interview was conducted. An interview was conducted. An interview was conducted. An interview was conducted. Staff #207), who state resident in hospice care physician order. Staff agency per resident's contacted and will controlled the resident. Staff #207 stated each hospice book, which contes, care plans, and in an interview conducted. In an interview conducted. In an interview conducted. In an interview conducted. Staff #207 stated each hospice book, which contes, care plans, and interview conducted. In an interview conducted. | esident had intact cognition. ded the resident received aw of the clinical record did order for hospice care. It's hospice plan of care are date was on June 15, of the hospice t reveal an initial evaluation flucted on March 4, 2021 at ansed Practical Nurse stated that a physician order esident to hospice. Ituated on March 5, 2021 at clal Service Coordinator and the process for placing a are included obtaining a #207 stated the hospice or family's preference is an eand evaluate the ated the hospice agency are plan of care and orders. A resident on hospice has a contains hospice provider I hospice care orders. Atted with the Director of A1) on March 11, 2021 at ated that it is her are residents have a admitted to hospice. Staff are was no physician order admitted to hospice. | Y1147 | How will the corrective action(s) be monitored to ensure the deficient provided will not recur, i.e., what quality assure program will be put into place; and to title, or position, of the person respector implementing/monitoring the corrective action? The Social Service Director and/or Designee will audit all new Hospice admits for correct orders for 28 days hospice residents found to be out of compliance will be reported to the I and/or Designee for immediate corrections. | ractice trance the possible s. Any | |

PRINTED: 04/01/2021 FORM APPROVED ADHS LICENSING SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING NCI-2643 03/11/2021 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** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) Y1147 Y1147 Continued From page 31 revealed that when a resident has been diagnosed as terminally ill, the DON will contact the hospice agency the facility contracts with and request that a visit/interview with the resident/family be conducted to determine the resident's wishes relative to participation in the hospice program. The policy did not include obtaining a physician order for hospice. 4/20/2021 Y1235 What corrective action(s) will be Y1235 R9-10-412.B.7. Nursing Services Y1235 accomplished for those residents found to have been affected by the deficient R9-10-412.B. A director of nursing shall ensure practice, on both a temporary and that permanent basis, including the date the correction will be accomplished? R9-10-412.B.7. An unnecessary drug is not administered to a resident. Resident #58, #74 and #78 found to be affected. Orders corrected 3/23/21. How will you identify other residents This RULE is not met as evidenced by: Based on clinical record review, staff interviews, having the potential to be affected by the same deficient practice and what and policy review, the facility failed to ensure corrective action will be taken? three residents (#58, #74, and #78) were not administered unnecessary drugs by falling to consistently monitor for adverse side effects of The DON and/or designee conducted a use and targeted behaviors. medical record review for all residents on psychotropics on 4/5/2021 no other Findings include: residents found to be affected. -Resident #58 was admitted to the facility on July What measures will be put into place or 10. 2020 and re-admitted on July 31, 2020 with what systemic changes will you make to diagnoses that included dementia, major ensure that the deficient practice does not depressive disorder, anxiety disorder, and recur?

STATE FORM Q5L611 If continuation sheet 32 of 58

DON and/or Designee conducted an in-

orders and proper monitoring of target

behaviors and side effects.

service to licensed nurses on Psychotropic

post-traumatic stress disorder (PTSD).

Review of the physician's orders revealed:

hydrochloride (HCL) (antidepressant) 60

-An order dated December 3, 2020 for Duloxetine

milligram (mg) capsule by mouth two times a day

| 7101101 | JOEHOHO OFILLIOFO | | | | | |
|--------------------------|--|---|------------------------------|--|--------------------------------------|--------------------------|
| | NT OF DEFICIENCIES I OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| | | NCI-2843 | B. WING | B. WING | | 1/2021 |
| NAME OF | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | ATE, ZIP CODE | | |
| SAPPHII | RE OF TUCSON NURSING | AND REHAB. LLC | ST MILBER STF N, AZ 85714 | REET | | |
| (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 APPROPR DEFICIENCY) | BE | (X5) COMPLETE DATE |
| Y1235 | Continued From page | 32 | Y1235 | | | |
| | ideations. -A second order dated Aripiprazole (antipsyc tablet by mouth at bed augmentation as evide ideation. | denced by passive suicidal December 30, 2020 for hotic) 5 mg tablet give 0.5 dtime for severe depression enced by (AEB) suicidal | | How will the corrective action(s) be monitored to ensure the deficient prival not recur, i.e., what quality assurprogram will be put into place; and title, or position, of the person respot for implementing/monitoring the corrective action? | rance he | |
| | Review of the Medication Administration Record (MAR) dated December 2020 revealed: -The resident received Duloxetine as ordered December 4-31, 2020. -The resident received Aripiprazole as ordered December 30 and 31, 2020. Review of the "Monitors" record for December 2020 revealed: -Anti-Depressant target behavior crying. Monitor episodes of targeted behavior every shift for medication management. -Anti-Depressant target behavior verbalization of sadness. Monitor episodes of targeted behavior every shift for medication management. -Monitor for side effects of Anti-Depressants every shift. -Psychotropic target behavior, monitor episodes of delusions targeted behavior every shift for medication management. -Monitor for statements of sulcidal ideations every shift for passive suicidal ideations, depression. | | | The DON and/or Designee will audi psychotropics orders daily for 21 day proper target behavior monitoring an side effects on EMAR. Any psychot found to be out of compliance will be reported to the DON and/or Designee | ys for ad tropic e e for | |
| | | | | immediate correction and re-education licensed staff. The DON and/or Deswill report any patterns or trends to committee. | ignee | |
| | above monitoring on the state of the state o | o documentation of the he "day" shift for December no documentation on the 25 and 30, 2020, and no apsychotic side effects. Minimum Data Set (MDS) heary 11, 2021 revealed the terview for Mental Status | | | | |

| STATEMEN | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | (X3) DATE | SURVEY LETED |
|--------------------------|---|--|---------------------|--|-----------|--------------------------|
| | | | _ | | | |
| | | NCI-2643 | B. WING | B. WING | | 11/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, STA | TE, ZIP CODE | | |
| SAPPHIR | E OF TUCSON NURSING | AND REHAB. LLC | ST MILBER STRE | EET | | |
| | , | TUCSON | I, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| Y1235 | Continued From page | 33 | Y1235 | | | |
| | resident had moderat | rhich indicated that the ely impaired cognition. The the resident received seven and antidepressant | | | | |
| | mouth at bedtime for augmentation AEB su-January 25, 2021, Ar mouth at bedtime for augmentation AEB su-January 26, 2021, Ar closely for significant medical doctor every subject of the magnetical doctor every subject of the magnetation augmentation augmentation augmentation augmentation received. The resident received The resident received Review of the "Monitor revealed: Anti-Depressant targeted by medication managementation managementation." | ipiprazole 5 mg tablet by severe depression icidal ideation. ipiprazole 5 mg tablet by severe depression icidal ideation. itipsychotic use: Observe side effects and report to shift ipiprazole 5 mg tablet, give edtime for severe tion AEB suicidal ideation. It Duloxetine as ordered. I Aripiprazole as ordered. I Aripiprazole as ordered. If the area ordered is the behavior crying. Monitor ehavior every shift for ent. | | | | |
| | of delusions targeted to medication manageme -Monitor for statement | ehavior, monitor episodes ehavior every shift for | | | | |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLI A. BUILDING: | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|---|-------------------------------|---|-------------------------------|--------------------------|
| | | | | | | |
| | | NCI-2643 | B. WING | | 03/ | 11/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, STA | ATE, ZIP CODE | | |
| SABBUID | E OF TUCSON NURSING | AND REHABILIC 2900 EAST | MILBER STR | EET | | |
| SAFFIIIN | LOI 10000N NONOING | TUCSON, A | Z 85714 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | 3E | (X5) COMPLETE DATE |
| Y1235 | Continued From page | 34 | Y1235 | | | |
| | above monitoring on t 10, 16, and 18, 2021, "night" shift on Januar | o documentation of the he "day" shift on January no documentation on the y 8-10, 14, and 22, 2021, antipsychotic side effects 21. | | | | |
| | Further review of the "Monitors" record for January 2021 revealed: -Antipsychotic use: Observe closely for significant side effects and report to medical doctor every shift starting January 26, 2021. | | | | | |
| | 2020): The resident us medications related to passive suicidal ideatic be/remain free of psycomplications through interventions included medications as ordere monitor for side effects shift and to monitor/do any adverse reactions medications. -Revised March 2, 202 The resident uses antirelated to depression and sadness. Goal: The rediscomfort or adverse antidepressant therapy The Interventions includents and the same antidepressant medical physician, to monitor/or | 2021(initiated August 3, see psychotropic amajor depression AEB on. Goal: The resident will shotropic drug related review date. The to administer psychotropic d by physician and to s and effectiveness every acument/report as needed of psychotropic 21 (initiated July 11, 2020): depressant medication AEB verbalization of sident will be free from reactions related to y through the review date. Indeed to administer ations as ordered by the document side effects and | | | | |
| | effectiveness every sh monitor/document/report reactions to antidepress monitor/record for occi- | ort as needed adverse | | | | |

| ADUS FI | CENSING SERVICES | | | | | |
|-------------------|---|---|-----------------|--|------------------|------------------|
| | T OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPI | LE CONSTRUCTION | (X3) DATE SURVEY | |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | : | COMPL | LETED |
| | | | 1 | | | |
| | | NCI 2042 | B. WING | | | 4410004 |
| | | NCI-2643 | | | 03/ | 11/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, ST | TATE, ZIP CODE | | |
| | | 2900 EAS | T MILBER ST | REET | | |
| SAPPHIR | SAPPHIRE OF TUCSON NURSING AND REHAB, LLC TUCSO | | | | | |
| | OUR MADY ST | <u></u> | | 2001425210 Dt 411 07 002750750 | | |
| (X4) ID PREFIX | | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD | | (X5) COMPLETE |
| TAG | | LSC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPROPR | | DATE |
| | | | i | DEFICIENCY) | | 1 |
| Y1235 | Continued From page | . 2E | Y1235 | | | |
| 1 1200 | Continued From page | : 39 | 1 1235 | | | |
| | symptoms. | | 1 | | | |
| | | | 1 | | i | 1 |
| | An interview was cond | ducted on March 9, 2021 at | | | | |
| | 11:32 a.m. with a Lice | ensed Practical Nurse | | | | |
| | (LPN/staff #180). The | | | | | İ |
| | psychotropic medicati | on order needed to include | 1 | | | |
| | the targeted behavior | for the medication. Staff | ł | | | |
| | | would monitor for side | | | | |
| | effects and target beh | aviors, and would | ľ | | | |
| | document on the "mor | nitors" record twice each | | | | |
| | shift. Staff #180 stated | that the documentation | | | | |
| | should be filled in and | should not have blanks. | | | | |
| | She stated that if there | | | | | i |
| | | would not be able to show | 1 | | | |
| | | s done. After review of the | 1 | | | |
| | behavior and side effe | ct monitoring for resident | | | | |
| | #58, she stated that st | taff did not follow facility | } | 1 | | |
| | | entation. The LPN stated | | | | |
| | | nonitor the resident for side | | | | |
| | effects and behaviors | | | | | |
| | | ve for the resident's needs | | | | |
| | | the resident was having | 1 | | | |
| | side effects. | | | | | |
| | | | | | | |
| | | ucted on March 11, 2021 at | | | | |
| | 3:22 p.m. with the Dire | ector of Nursing (DON/staff | | | | |
| | #51). The DON stated | | | | | ł |
| | residents who are rece | | | | 1 | |
| İ | | itored every shift for side | | | | |
| | | aviors. The DON stated | | | | |
| | | ould be documented in one | | | | |
| | | ecords (i.e. Monitors, MAR, | | | | |
| | | on Record) and needs to | | | İ | i |
| | | ed nurse, not a Certified | | | 1 | j |
| | | A). The DON reviewed the | | | | 1 |
| | | or resident #58 and stated | | | ŀ | İ |
| 1 | | expectations related to the | | | | j |
| | | of side effect and target | | | | ì |
| | behavior monitoring. | l | | | | l |
| 1 | | | | | j | |

| | | FOF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|-----------------------|---|---|--|------------------------|--|-------------------|--------------------------|
| | | | NCI-2643 | B. WING | | 03 | /11/2021 |
| NAME (|)F Pi | ROVIDER OR SUPPLIER | STREET ADD | PRESS, CITY, ST | ATE, ZIP CODE | | |
| SAPPI | HIRI | E OF TUCSON NURSING | AND REHAB, LLC 2900 EAST TUCSON, A | MILBER STR AZ 85714 | REET | | |
| (X4) (PREF TAG | IX | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETE DATE |
| Y12 | 35 | Continued From page | 36 | Y1235 | | | |
| | | | | | | | |
| | A review of physician's orders revealed orders with a start date December 21, 2020 for citalopram hydrobromide (antidepressant) 40 mg one tablet by mouth in the morning for depression AEB negative statements; monitoring for antidepressant target behavior AEB negative statements; monitoring for side-effects of the antidepressant, including sedation, drowsiness, headache, decreased appetite, dry mouth, blurred vision, urinary retention, and pyramidal side-effects, and monitoring for adverse reactions for use of the antidepressant medication including, dizziness, nausea, diarrhea, anxiety, nervousness, insomnia, somnolence, weight gain, and anorexia. | | | | | | |
| | | Review of the MARs for January 2021 revealed administered citalopra | | | | | |
| | 1 1 | January 12, 2021 reve BIMS, indicating the re cognitive impairment. | The assessment included antidepressant medication | | | | |
| | | for January 2021 reveal indicate whether or not antidepressant target to | the Monitors documentation aled no documentation to the resident had exhibited behaviors, side-effects, and 2 out of 31 day shifts and 5 | | | | |

FORM APPROVED ADHS LICENSING SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING NCI-2643 03/11/2021 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) COMPLETE (X4) (D ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y1235 Y1235 Continued From page 37 out of the 31-night shifts. An interview was conducted on March 11, 2021 at 10:51 a.m. with an LPN (staff #47), who stated daily monitoring of psychotropic medications for adverse side effects and behaviors are conducted and documented by every nurse. The LPN stated that monitoring ensures the medication is working and rules out any complications. On March 11, 2021 at 3:25 p.m., an interview was conducted with the DON (staff #51). The DON stated that her expectation is that monitoring for behaviors and adverse side effects related to psychotropic medications be conducted and documented every shift. Staff #51 stated that the expectation is that monitoring is started when the medication is started. The DON reviewed the January 2021 monitoring record for resident #78 and stated that it did not meet her expectations. -Resident #74 was admitted to the facility on February 8, 2020 and readmitted on September 28. 2020 with diagnoses that included unspecified dementia with behavioral disturbance. post-traumatic stress (PTSD) disorder, major depressive disorder and anxiety disorder. Review of the clinical record revealed a physician order dated November 14, 2020 for Fluoxetine (antidepressant) 20 mg one tablet by mouth in the morning for anxiety AEB restlessness related to On November 18, 2020, the order for Fluoxetine was changed to Fluoxetine 20 mg tablet by mouth

in the morning for depression AEB lack of interest

in activities related to PTSD.

| NCI-2643 B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2800 EAST MILBER STREET TUCSON, AZ 85714 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Y1235 Continued From page 38 Review of the MARs for November 2020 and | Ϋ́ |
|--|--------|
| 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) Y1235 Continued From page 38 2800 EAST MILBER STREET TUCSON, AZ 85714 ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE | 21 |
| SAPPHIRE OF TUCSON NURSING AND REHAB, LLC (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Y1235 Continued From page 38 TUCSON, AZ 85714 TUCSON, AZ 85714 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Y1235 | |
| PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE COMPLE CROSS-REFERENCED TO THE APPROPRIATE DATE OFFICIENCY) Y1235 Continued From page 38 Y1235 | |
| | MPLETE |
| December 2020 revealed the resident was administered Fluoxetine as ordered. However, further review of the MARs and the Treatment Administration Record (TARs) for November 2020 and December 2020, did not reveal the resident was being monitored for adverse side effects and the targeted behavior of Fluoxetine. The physician order dated January 7, 2021 included for Fluoxetine 20 mg two tablets by mouth in the morning for depression AEB tack of interest in activities. Review of the annual MDS assessment dated January 23, 2021 revealed a BIMS score of 7, Indicating the resident had severe cognitive impairment. The assessment included the resident received antipsychotic and antidepressant medications during the 7-day look-back period. A review of the MARs for January 2021 and February 2021 revealed the resident was administered Fluoxetine. Further review of the MARs and the TARs for January 2021 revealed the resident was administered Fluoxetine. Further review of the MARs and the TARs for January 2021 and February 2021 revealed the resident was administered Fluoxetine. Further review of the MARs and the TARs for January 2021 and February 2021 did not reveal the resident was sadministered Fluoxetine. An interview was conducted on March 10, 2021 at 11:50 A.M. with the LPN Unit Manager (staff #126), who stated monitoring for side effects, adverse reactions and behaviors for psychotropic medications should be documented on the MARTAR in the monitoring section. | |

| | ICENSING SERVICES | | | | | |
|---------------|---------------------------|---|------------------|---|-----------|----------|
| | IT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | E CONSTRUCTION | (X3) DATE | |
| ANDPLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMP | LETED |
| İ | | ļ | | | | |
| ĺ | | NCI-2643 | B. WNG | | 03/ | 11/2021 |
| | | | | | | 11,202. |
| NAME OF P | PROVIDER OR SUPPLIER | | DRESS, CITY, STA | | | |
| SAPPHIR | RE OF TUCSON NURSING | S AND REHAB. LLC | T MILBER STR | REET | | |
| | | TUCSON, | AZ 85714 | | | |
| (X4) ID | | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | 1 ' | CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX | (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR | | COMPLETE |
| IAG | THE SECTION OF SECTION | 200 DEATH THOUR COMMITTEE | TAG | DEFICIENCY) | IAIE | |
| | <u> </u> | | | | | |
| Y1235 | Continued From page | ∌ 39 | Y1235 | | | |
| | | | | | | |
| | In an interview condu | cted with the LPN Unit | | | | |
| | | on March 11, 2021 at 10:55 | | | | |
| | | ed that monitoring for side | | | | |
| | | tions and targeted behaviors | | | | j |
| | would be documented | | | | | |
| | | | | | | |
| | An interview was con- | ducted on March 11, 2021 at | 1 | | | |
| | 1 | or of Nursing (DON, Staff | | | | |
| 1 | | all residents receiving | 1 | | | |
| | , . | ions should be monitored for | 1 | | | |
| . 1 | | side effects. Staff #51 stated | | | | |
| | | ler to monitor for side effects | 1 | } | | |
| [| | The DON stated that when | 1 | | | |
| 1 | | e psychotropic medication, | ' | | : | |
| | | monitoring of targeted | | | I | |
| 1 | | fects at that same time. The | ' | | | |
| | | expectation that all residents | 1 | | ļ | |
| | | nonitored starting from the | ' | | ŀ | |
| | time the medication is | | ! | | ļ | |
| | | nted in the TAR. The DON | | | ļ | |
| | acknowledged residen | | | | į | |
| | | ects and targeted behaviors | | | | |
| | | 020 through March 1, 2021. | | | | |
| | i | | 1 | | ļ | |
| | | ed Medication Monitoring | 1 | | | |
| | Medication Manageme | ent stated that each | 1) | | - | Ì |
| | resident's drug regime | en is reviewed to ensure it is | 1 | | | ı |
| | free from unnecessary | y drugs. This includes any | 1 | | | |
| | drug without adequate | monitoring. In addition, the | 1 | | | |
| | policy stated that the fa | | 1 | | ĺ | |
| 1 | management supports | and promotes the | 1 | | | |
| | monitoring of medication | | 1 | | I | |
| | adverse consequences | | 1 1 | | I | |
| | requirement is that each | | 1 1 | | 1 | |
| | drug/medication regime | en is managed and | 1 1 | | 1 | |
| | monitored to promote | or maintain the resident's | 1 | | | |
| | highest practicable me | ental, physical, and | 1 | | | |
| | psychosocial wellbeing | g. When monitoring a | <i>i</i> 1 | | 1 | |
| | resident receiving psyc | chotropic medications, the | 1 1 | | | I |

| | ICENSING GENVICES | · | | | |
|-----------|----------------------------------|---|-----------------|--|-------------------------------|
| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| | | | A BUILDING: | | |
| | | | B. WNG | | |
| | | NCI-2643 | B. WING | | 03/11/2021 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, ST | ATE, ZIP CODE | |
| 0.000 | r or thoson Midding | 2900 EAS | T MILBER ST | REET | |
| SAPPHIR | E OF TUCSON NURSING | TUCSON, | AZ 85714 | | |
| (X4) ID | SUMMARY ST | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (5) |
| PREFIX | | Y MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI | BE COMPLETE |
| TAG | REGULATORY | SC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | AIE ONE |
| 244000 | | | 1/4005 | | |
| Y1235 | Continued From page | 9 40 | Y1235 | 1 | |
| | facility must evaluate | the effectiveness of the | İ | | |
| | medications as well a | s look for potential adverse | [| | |
| | consequences. | | | | |
| | | 1 P P | | | |
| | | 's policy on medication | | | |
| | management stated n | ons only if they are ordered | 1 | | |
| | | necessity is documented in | Í | | |
| | | record and in the care | 1 | | |
| | planning process. The | | | | |
| | planning team reasse | ss the continued need for | | | |
| | the ordered medicatio | | | | |
| | | mented as a part of the care | | | |
| | planning process. Nor | | | | |
| | | behavior modification or | | | |
| | as a part of the care p | eir effects are documented | 1 | | |
| | | anagement supports and | | | |
| | | of medications for efficacy | | | |
| | | ences. For each resident | | | |
| | | medications, the resident's | | | |
| | entire drug/medication | regimen is managed and | 1 | | |
| | | or maintain the resident's | İ | | |
| İ | highest practicable me | | | | |
| | psychosocial wellbeing | | l | | |
| | response to therapy as | re monitored and lident's medical record. | | <u>Y1477</u> | 4/20/2021 |
| | documented in the res | ident's medical record. | | | |
| \(\(\) | D0 40 444 D 0 b 0 | | Y1477 | What corrective action(s) will be | |
| ¥14// | | prehensive Assessment; | 11477 | accomplished for those residents four | nd to |
| | Care Plan | | | have been affected by the deficient | |
| | R9-10-414 R An adm | inistrator shall ensure that | | practice, on both a temporary and | |
| | a care plan for a reside | | | permanent basis, including the date ti | he |
| | | | | correction will be accomplished? | |
| | R9-10-414.B.3. Ensur | | | Booklant #74 and #16 form 44: 1- | |
| | provided nursing care | institution services that: | | Resident #74, and #16 found to be | ,, |
| | | | | affected. Care Plan updated 3/12/202 | ·1. |
| | R9-10-414.B.3.b. Ass | | | | |
| | maintaining the reside | nt's highest practicable | | | |
| 1 1 | | | | 1 | , , |

| STATEMEN | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|--------------------------|---|---|---------------------|---|---|
| | | NCI-2643 | B. WING | | 03/11/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, ST | TATE, ZIP CODE | |
| | | 2800 EAS | T MILBER STI | REET | |
| SAPPHIR | E OF TUCSON NURSING | AND REHAB, LLC 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE COMPLETE NATE DATE |
| | interviews, and review the facility failed to en developed to assist twin maintaining their highly failing to address dantidepressant medicareligious dietary preferencings include: Resident #74 was ad February 8, 2020 and 28, 2020 with diagnos dementia with behavior post-traumatic stress (depressive disorder and Regarding depression Review of the admission (MDS) assessment daincluded a Resident Mealth Questionaire-9 Score was 11, which in moderate depression. Included the Mood State on the Care Area Asset | to the resident's sment. as evidenced by: and review, resident and staff of policy and procedures, sure a care plan was to residents (#74 and #16) ghest practicable well-being epression and the use of an ation for resident #74 and rences for resident #16. mitted to the facility on readmitted on September es that included unspecified and disturbance, (PTSD) disorder, major and anxiety disorder. on Minimum Data Set ted February 15, 2020, ood Interview Patient (PHQ-9) total Severity adicated the resident had | Y1477 | How will you identify other residents having the potential to be affected be same deficient practice and what corrective action will be taken? The Social Service Director and/or designee conducted a medical recorreview for all residents in house on 3/30/2021. No other residents were to be affected. What measures will be put into place what systemic changes will you make ensure that the deficient practice docrecur? Administrator and/or Designee cond an in-service on Comprehensive Car Plan for religion and depression to S Services Department on 3/19/2021. How will the corrective action(s) be monitored to ensure the deficient provided in the program will be put into place; and the title, or position, of the person responsion implementing/monitoring the corrective action? The Social Service Director and/or Designee will audit all new admits for completion and accuracy of care plan related to depression and religion for days. Any Care Plans found to be or compliance will be reported to the Administrator and/or Designee for immediate correction and re-education. | found found found found found for found for found for found for for for for for for for for for for |
| | However, review of the | care plan initiated | | Social services department. | |

| | T OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPL | E CONSTRUCTION | (X3) DATE S | |
|--------------------------|----------------------------|--|---------------------|---|-------------|--------------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMPL | ETED |
| ! | | | | | | |
| | | NCI-2643 | B. WING | | 03/ | 11/2021 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, ST | ATE, ZIP CODE | | |
| CADDUID | E OF TUCSON NURSING | AND PEHAR LLC 2900 EAST | MILBER STR | REET | | |
| OAI I IIIN | | TUCSON, A | Z 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETE DATE |
| Y1477 | Continued From page | 42 | Y1477 | | | |
| | | | | | | |
| | February 27, 2020 did | d not include depression. | | | | |
| | | ducted on March 10, 2021 at OS Registered Nurse (staff | | | | |
| | l . | when a resident is admitted, | | | | |
| | ▼ - | ssessment period is from | | | | |
| | day 1 to day 8, and the | en they have 7 days after | | | | |
| | • | mprehensive care plan. | | | | |
| | | nt #74's clinical record, staff | | | | |
| | | care area was triggered due | | | | |
| | completes that area of | 87 stated Social Services | | | | |
| | completes that area of | Ture care plan. | | | | |
| | | ducted on March 11, 2021 at ector of Nursing (DON/staff | | | | |
| | #51), who said the car | | | | | |
| | | assessment. The DON | | | 1 | |
| | | review the resident's clinical | | | | |
| | record regarding the d | epression score. | | | | |
| | • | vas conducted on March 11, | | | | |
| | | the DON (staff #51). The | | | | |
| | | ectation is that the staff a care plan for this resident | | | į | |
| | as the score indicated | | | | ł | |
| | as are soore marcated | | | | | |
| | | | | | | |
| | Regarding an antidepr | ressant medication | | | | |
| | | record revealed a physician | | | | |
| | | r 14, 2020 for Fluoxetine | | | Ì | } |
| | | illigrams (mg) one tablet by | | | | |
| | | for anxiety as evidenced by | | | | |
| | (AEB) restlessness rel | aleu (U F I OL). | | | | |
| | On November 18, 202 | 0, the order for Fluoxetine | | | | |
| | | etine 20 mg tablet by mouth | | | | |
| | in the morning for depr | ression AEB lack of interest | | | | ļ |
| | in activities related to f | PTSD. | | | | |
| | | | | | | |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | (X3) DATE COMP | |
|--------------------------|--|--|------------------------------|---|-------------------|--------------------------|
| | | NCI-2643 | B. WING | | 03/ | 11/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | | RESS, CITY, ST | ATE, ZIP CODE | 1 03/ | 11/2021 |
| SAPPHIR | E OF TUCSON NURSING | AND REHAB. LLC | MILBER STR | REET | | |
| | | TUCSON, A | 1 | | | |
| (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 APPROPR DEFICIENCY) | BE | (X5) COMPLETE DATE |
| Y1477 | Continued From page | 43 | Y1477 | | | |
| | Review of the Medica | tion Administration Records r 2020 and December 2020 was administered | | | | |
| | | ated January 7, 2021 e 20 mg two tablets by for depression AEB lack of | | | | |
| | January 23, 2021 reveindicating the resident impairment. The asset | ssment included the depressant medications | | | | |
| | A review of the MARs February 2021 reveals administered Fluoxetin | ed the resident was | | | | |
| | plan was developed to antidepressant medica The interventions inclu | lan did not reveal a care or the use of an ation until March 1, 2021. uded monitoring for adverse et behavior symptoms. | | | | |
| | 11:50 A.M. with the Lic (LPN) Unit Manager (s monitoring for side effe | ects, adverse reactions and opic medications should be | | | | |
| | A.M., staff #171 stated antidepressant would I stated the care plan we | ated with the LPN Unit on March 11, 2021 at 10:55 I a new medication like an oe care planned. Staff #171 ould include monitoring for eactions and behaviors | | | | |

| STATEMEN | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|--------------------------|--|---|--------------------------|---|-------------------------------|
| | | NCI-2643 | B. WING | | 03/11/2021 |
| NAME OF P | PROVIDER OR SUPPLIER | | DRESS, CITY, STA | • | |
| SAPPHIR | E OF TUCSON NURSING | AND REHAB, LLC | T MILBER STR AZ 85714 | EET | |
| (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 APPROPR DEFICIENCY) | BE COMPLETE |
| Y1477 | associated with the m An interview was cond 3:22 P.M. with DON (spsychotropic medicatic effects, adverse reactic associated with those planned. The DON stathat any psychotropics resident #74 be care packnowledged the ant not addressed in resid March 1, 2021. Resident #16 was add 15, 2020 and readmitt with diagnoses that inepalliative care and typhyperglycemia. Review of the resident revealed Jewish as the A review of the clinical nutritional assessment the resident's meal plarespect Jewish prefere with meats. The assess the dietician (staff #12) The quarterly Minimum assessment dated Deca Brief Interview for Moof 13, indicating the resident developed to Jewish preferences religiously as the care planot been developed to Jewish preferences religiously as the care planot been developed to Jewish preferences religiously as the care planot been developed to Jewish preferences religiously as the care planot been developed to Jewish preferences religiously as the care planot been developed to Jewish preferences religiously as the care planot been developed to Jewish preferences religiously as the care planot been developed to Jewish preferences religiously as the care planot been developed to Jewish preferences religiously as the care planot been developed to Jewish preferences religiously as the care planot been developed to Jewish preferences religiously as the care planot been developed to Jewish preferences religiously as the care planot been developed to Jewish preferences religiously as the care planot been developed to Jewish preferences religiously as the care planot been developed to Jewish preferences religiously as the care planot been developed to Jewish preferences religiously as the care planot been developed to Jewish preferences religiously as the care planot been developed to Jewish preferences religiously as the care planot been developed to Jewish preferences religiously as the care planot been developed to Jewish preferences religiously as the care planot been developed to Jewish preferences re | edication. ducted on March 11, 2021 at staff #51), who stated ons and monitoring for side ions and behaviors medications should be care ated it is her expectation is medications ordered for planned. The DON idepressant medication was lent #74's care plan until mitted to the facility on June ed on November 20, 2020 cluded encounter for e 2 diabetes mellitus with at information face sheet e resident's religion. The record revealed an initial at dated June 16, 2020 that in would be adjusted to ences: no pork, no dairy isment was completed by 4). The Data Set (MDS) completed by 4). The Data Set (MDS) completed in the context of | Y1477 | DEFICIENCY) | |
| | An interview was cond | ucteu on March 4, 2021 at | | | |

| <u> </u> | OFHORIO OFICAIOFO | | | | | |
|--------------------------|--|--|---------------------|---|--------------------|--------------------------|
| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMPI | |
| | | NCI-2643 | B. WING | | 03/ | 11/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | ATE, ZIP CODE | | |
| | | 2900 EA | ST MILBER STR | REET | | |
| SAPPHIR | E OF TUCSON NURSING | AND REHAB, LLC TUCSON | , AZ 85714 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETE DATE |
| | stated a dietary assess residents which include food preferences. State preferences and religibly visits to the resident facility has not had may residents with a preference requests in of any residents with a moment." Staff #124 stated if she was await faith and his preference #124 responded "I wait #124 stated she would plan with his Jewish did in an interview conduct March 11, 2021 at 1:10 that he is active in the An interview was conducted as a conducted and with the DO is her expectation that plan would include religious for the staff #51 stated her expectation and kitchen may aware of resident #16 preferences and honor preferences. The facility's Comprehences are president for the state of t | tician (staff #124), who isment is conducted for new les discussing the resident's ff #124 stated that dietary ous beliefs are determined at. Staff #124 stated that the any residents with religious in the past and is "not aware religious preferences at this stated she completes the ff the care plan. When are of resident #16 Jewish are for a Jewish diet, staff is not aware of that." Staff is not aware of that." Staff is not aware of that." Staff is not aware of that." Staff is not aware of that." Staff is not aware of that." Staff is not aware of that." Staff is not aware of that." Staff is not aware of that." Staff is not aware of that." Staff is not aware of that. "Staff is not aware of that." Staff is not aware of that." Staff is not aware of that." Staff is not aware of that. "Staff is not aware of that." Staff is not aware of that." Staff is not aware of that. "Staff is not aware of that." Staff is | Y1477 | | | |
| | | evelops and implements a | | | İ | |

| STATE | (EN | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | E CONSTRUCTION | (X3) DATE COMP | SURVEY |
|------------------------|-----|--|---|------------------------|---|-------------------|--------------------------|
| | | | NCI-2643 | B. WING | | 03 | /11/2021 |
| NAME (|)FP | ROVIDER OR SUPPLIER | | DRESS, CITY, ST | ATE, ZIP CODE | 03/ | 11/2021 |
| SAPPI | iiR | E OF TUCSON NURSING | AND REHAB, LLC 2900 EAST TUCSON, | MILBER STF AZ 85714 | REET | | |
| (X4) (I PREF TAG | X | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | BE | (X5) COMPLETE DATE |
| Y14 | | each resident. The poincludes a member of services staff and othe professionals as deterneeds or as requested also included the care incorporate the reside preferences in develop care plan will incorporate incorporate risk faidentified problems; ar professional services teach element of care. R9-10-419.2.e. Respir | on-centered care plan for dicy included the IDT the food and nutrition or appropriate staff or mined by the resident's diby the resident. The policy planning process will nut's personal and cultural ping the goals of care. The ate identified problem areas actors associated with and will identify the that are responsible for | Y1477 | <u>Y1911</u> | | 4/20/2021 |
| | | an administrator shall of R9-10-419.2. Respirat provided according to a R9-10-419.2.e. The or oxygen liter flow and multiple of the RULE is not met Based on observations staff interviews, and postalled to ensure one resto provide oxygen to the Findings include: Resident #358 was additionally according to the Residen | care institution's premises, ensure that: tory care services are an order that includes: exygen concentration or nethod of administration; as evidenced by: s, clinical record review, olicy review, the facility sident (#358) had an order the resident. | | What corrective action(s) will be accomplished for those residents four have been affected by the deficient practice, on both a temporary and permanent basis, including the date to correction will be accomplished? Resident #358 found to be affected. Order obtained 3/12/2021 How will you identify other residents having the potential to be affected by same deficient practice and what corrective action will be taken? The DON and/or designee conducted full house audit for residents on oxygand orders on 3/23/2021. No other residents found to be affected | the a | |

PRINTED: 04/01/2021 FORM APPROVED ADHS LICENSING SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING NCI-2643 03/11/2021 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** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY Y1911 Y1911 Continued From page 47 What measures will be put into place or Chronic Obstructive Pulmonary Disease (COPD), what systemic changes will you make to encounter for orthopedic aftercare, and heart ensure that the deficient practice does not failure. recur? Review of the care plan initiated March 1, 2021 DON and/or Designee conducted an inrevealed the resident required oxygen therapy service to Licensed nurse on oxygen related to COPD. The goal was that the resident orders completed on 4/3/2021 would have no signs or symptoms of poor oxygen absorption. Interventions included administering How will the corrective action(s) be oxygen as prescribed to maintain adequate monitored to ensure the deficient practice oxygen saturation. will not recur, i.e., what quality assurance program will be put into place; and the However, further review of the clinical record did title, or position, of the person responsible not reveal an order for the resident to be for implementing/monitoring the administered oxygen. corrective action? During an observation conducted on March 2, The DON and/or Designee will audit new 2021 at 12:02 P.M., the resident was observed admits for oxygen and orders for 21 days. receiving oxygen via nasal cannula. Any resident found to be out of Another observation was conducted of the compliance will be reported to the DON resident on March 9, 2021 at 12:59 P.M. The and/or Designee for immediate correction resident was observed receiving oxygen at 4.5 and re-education to nursing staff.. liters per minute via nasal cannula from an oxygen concentrator. An interview was conducted on March 9, 2021 at 1:06 P.M. with a Licensed Practical Nurse (LPN/staff #15). The LPN stated the resident has COPD and is confused and will frequently remove the oxygen nasal cannula. The LPN stated the resident has an order for oxygen and that if there was not an order, she would review the hospital orders and contact the physician for an order.

After reviewing the physician's orders, the LPN stated that she was unable to find an order to

An interview was conducted on March 10, 2021 at 11:51 A.M. with the LPN Unit Manager (staff

administer oxygen.

| STATEMEN | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|--------------------------|---|--|---|--|-------------------------------|
| | | NCI-2643 | B. WING | | 03/11/2021 |
| | ROVIDER OR SUPPLIER E OF TUCSON NURSING | 2900 EAST | RESS, CITY, ST. MILBER STR 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | BE COMPLETE |
| | #126), who said the re oxygen from the hosp has been receiving ox #126 stated they miss oxygen. In an interview conduct Nursing (DON/staff #5 3:21 P.M., the DON so resident was missed. expectation would be orders from the hospit obtained and the care. The facility's policy tith revealed the purpose provide guidelines for This procedure include physician's order for the physician's order for the physician's orders oxygen administration. R9-10-421.D.3.a. Med R9-10-421.D.3. Polici established, document protect the health and R9-10-421.D.3.a. Rec | esident had orders for ital and that the resident tygen since admission. Staff eed inputting the order for order in the inputting the order for order in the content of its in the content of its in the content of its in the content of its in the resident has all, an order would be provided. The DON stated her that if the resident has all, an order would be provided. The content of the procedure is to safe oxygen administration of the procedure is to safe oxygen administration. The content of the procedure and reviewing or facility protocol for its intention is stored at a in, an administrator shall the sand procedures are ted, and implemented to safety of a resident for: The content of the content of its intention of the procedure and reviewing or facility protocol for its intention is stored at a in, an administrator shall the sand procedures are ted, and implemented to safety of a resident for: The content of the content of the content of the procedure and implemented to safety of a resident for: | Y2159 | Y2159 What corrective action(s) will be accomplished for those residents four have been affected by the deficient practice, on both a temporary and permanent basis, including the date to correction will be accomplished? No residents found to be affected. How will you identify other residents having the potential to be affected by same deficient practice and what corrective action will be taken? No residents found to be affected. | he |

FORM APPROVED **ADHS LICENSING SERVICES** STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING NCI-2643 03/11/2021 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** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY Y2159 Y2159 Continued From page 49 What measures will be put into place or This RULE is not met as evidenced by: what systemic changes will you make to Based on observations, staff interviews, and ensure that the deficient practice does not policy review, the facility failed to implement their recur? policy to ensure expired medications and glucose test strips were not available for use and failed to DON and/or Designee conducted an inensure medications were stored at the service on Medication storage to licensed recommended temperature. nurses on 3/3/21. Findings include: How will the corrective action(s) be monitored to ensure the deficient practice An observation was conducted of the medication will not recur, i.e., what quality assurance cart on the C-1 hall with a Licensed Practical program will be put into place; and the Nurse (LPN/staff #139) on March 3, 2020 at 9:19 title, or position, of the person responsible a.m. An opened vial of Novolin 70/30 insulin was for implementing/monitoring the observed, dated opened on February 1, 2021 and corrective action? an opened vial of Lispro 100 insulin was observed, dated opened on January 2, 2021. The The DON and/or Designee will audit all box containing the Novolin 70/30 insulin and the medication carts and storage areas weekly box containing the Lispro 100 insulin both had a sticker on it that stated "store in refrigerator". for expired or mis- stored items for 21 days. Any medications found to be out of Continued observations of the medication cart compliance will be reported to the DON revealed an unopened box of Novolin 70/30 and/or Designee for immediate correction insulin that had a sticker on the box that stated and re-education to licensed staff. "store in refrigerator" and an unopened box of Lispro 100 insulin that had a sticker on the box that stated "store in refrigerator". Also observed in the medication cart was a box of Evencare glucose test strips that had an expiration date of January 2, 2021 on it. In an interview conducted with the LPN (staff #139) at March 3, 2021 9:40 a.m., the LPN stated insulin that is not stored properly will not maintain potency and may not work as well. The LPN stated that the glucometer on the medication cart

was not in use, that it was broken.

An interview was conducted with the Director of

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|--------------------------|--|--|------------------------------|---|-------------------------------|
| | | NCI-2643 | B. WNG | · | 03/11/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, ST | ATE, ZIP CODE | |
| SAPPHIR | E OF TUCSON NURSING | AND REHAB, LLC 2900 EAST TUCSON, A | MILBER STR NZ 85714 | REET | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | SE COMPLETE |
| Y2301 | are not to be left in the stated the nurses are expired medications a medication cart and gl DON stated that using problem as it may lose properly. The DON als insulin is good for 30 of unopened insulin is to refrigerator. The DON not be any broken glumedication carts. Staff expected to advise the broken item so that it of the facility's Medications, revealed in the facility are stored under proper temperate controls. Discontinued drugs or biologicals and dispensing pharmacy of requiring refrigeration is located in the drug roo other secured location. R9-10-423.A.1. Food SR9-10-423.A. An adm. | stated expired medications are medication carts. Staff #51 responsible for ensuring all are removed from the expired insulin is a set its potency and not work as stated that once opened, days. She said that all be stored in the stated that there should cometers on any fr#51 stated the nurse is a unit manager of the can be promptly replaced. policy, Storage of drugs and biologicals used a in locked compartments ture, light and humidity, outdated or deteriorated a returned to the or destroyed. Medications are stored in a refrigerator m at the nurses' station or | Y2159 | Y2301 What corrective action(s) will be accomplished for those residents four have been affected by the deficient practice, on both a temporary and permanent basis, including the date the correction will be accomplished? No Residents found to be affected. | |
| | | | | | |

FORM APPROVED ADHS LICENSING SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING NCI-2643 03/11/2021 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** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD RE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) Y2301 Continued From page 51 Y2301 How will you identify other residents having the potential to be affected by the same deficient practice and what This RULE is not met as evidenced by: corrective action will be taken? Based on observations, staff interviews, quaternary information sheet, and review of policy No Residents found to be affected. and procedures, the facility failed to ensure that food establishment requirements were followed What measures will be put into place or by failing to ensure quaternary sanitizing solution what systemic changes will you make to was maintained at the required level. ensure that the deficient practice does not recur? Findings include: Administrator and/or Designee conducted During an observation conducted on March 1. an in-service to dietary staff on 2021 at 11:06 A.M., the Kitchen Manager (staff sanitization bucket completed on #173) was observed to test the concentration 3/31/2021. level of a sanitation bucket that was on a coffee cart in the kitchen. The test results revealed the How will the corrective action(s) be quaternary ammonium concentration level was below the minimum level of 200 parts per million monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and the An interview was conducted immediately title, or position, of the person responsible following this observation with staff #173 who said for implementing/monitoring the the bucket solution needed to be changed out corrective action? now. He stated that the sanitation buckets solution was changed out every 4 hours. The Administrator and/or Designee will audit all sanitization buckets for proper Another observation was conducted on March 3. levels daily for 21 days. Any buckets 2021 at 10:37 A.M. The Kitchen Manager (staff found to be out of compliance will be #173) was observed to test the sanitizing solution reported to the Administrator and/or in a sanitation bucket that was on a coffee cart in Designee for immediate correction and the kitchen. The result of the test was 100 ppm. re-education of staff. Following this observation, an interview was conducted immediately with staff #173 who said the bucket solution needed to be changed out. He changed the solution in the bucket, then performed another test which was observed to be

200 ppm.

FORM APPROVED ADHS LICENSING SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING: _ B. WING NCI-2643 03/11/2021 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 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) COMPLETE DATE |
|--------------------------|--|---------------------|---|--------------------------|
| Y2301 | An interview was conducted on March 8, 2021 at 9:52 AM with the Kitchen Manager (staff #173), who said that for sanitation buckets, the policy is that the solution is changed every 4 hours. Staff #173 said that he felt that the sanitizing solution was dilute from cleaning the coffee cart, and that the sanitizing solution level of the other bucket was low because the active elements evaporate in warm water. Staff #173 stated that upon reviewing the instructions, he should have left the test strip in the sanitizing solution for two minutes and that he did not because the other tests results were quick. The Kitchen Manager stated that the facility uses the quaternary sanitizer and that the concentration level is supposed to be between 200 and 400 ppm. An interview was conducted on March 11, 2021 at 3:31 P.M. with the Administrator (staff #217), who said the kitchen staff have to make a subjective decision when to change the sanitizing solution. Staff #217 stated that he had worked in the kitchen and remembers having to change and test the sanitation bucket solution. Staff #217 said that the Kitchen Manager had told him the policy was to change the sanitizing solution every four hours. The Administrator stated that he was unaware that the sanitizing solution had to be maintained at a specific ppm. The information sheet titled Quaternary Ammonium revealed that the best way to use quaternary ammonium as a routine sanitizer is to really understand what is needed in terms of strength. It included that when used on food contact surfaces, that the quaternary solution should test to a minimum of 200 parts per million (ppm). | Y2301 | | |
| | A facility's policy and procedure manual titled | <u> </u> | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | (X2) MULTIPLE CONSTRUCTION A BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|--|--|--|---------------------|---|-------------------------|-------------------------------|--|
| NCI-2643 | | B. WING | B. WING | | 03/11/2021 | | |
| NAME OF P | PROVIDER OR SUPPLIER | | DRESS, CITY, STA | | | | |
| SAPPHIRE OF TUCSON NURSING 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 LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | BE | (X5) COMPLETE DATE | |
| Y2301 | Food Safety - Director Services' Responsibility director of food and not for providing safe food included that sanitary maintained in the food serving areas, and that | or of Food and Nutrition lities revealed that the utrition will be responsible ds to all individuals. It | Y2301 | | | | |
| Y2348 | food services shall ens | stered dietitian or director of sure that: mmendations and ested from a resident or the | Y2349 | Y2349 What corrective action(s) will be accomplished for those residents four have been affected by the deficient practice, on both a temporary and permanent basis, including the date to correction will be accomplished? | | 4/20/2021 | |
| | Findings include: Resident #16 was adm 15, 2020 and readmitte with diagnoses that inc palliative care and type hyperglycemia. | s, resident and staff ord review and policy ed to ensure food d from one resident (#16) meal planning. mitted to the facility on June ed on November 20, 2020 cluded encounter for e 2 diabetes mellitus with | | Resident #16 affected by practice. How will you identify other residents having the potential to be affected by same deficient practice and what corrective action will be taken? The Food Service Director and/or Designee conducted a full audit of all resident religious food preferences ar allergies. No other residents identified What measures will be put into place what systemic changes will you make ensure that the deficient practice does recur? | the l nd ed. or to | | |

| PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) Y2349 Continued From page 54 A review of the clinical record revealed an initial nutritional assessment dated June 16, 2020 that the resident's meal plan would be adjusted to respect Jewish preferences: no pork, no dairy with meats. The assessment included the resident food allergies were seafood (shellfish, fish) - hives and difficulty breathing, and strawberries - hives. The assessment was completed by the dietician (staff #124). A review of the baseline care plan dated June 16, 2020 revealed resident #16 had allergies to seafood (fish, shellfish) and strawberries but did not include the resident's Jewish diet preference of no pork or dairy with meat. The quarterly Minimum Data Set (MDS) assessment dated December 10, 2020 revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident had intact cognition. | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|---|---|--|---|---|--|---|--------------------------|--|
| NAME OF PROVIDER OR SUPPLIER SAPPHIRE OF TUCSON NURSING AND REHAB, LLC O(A) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) Y2349 Continued From page 54 A review of the clinical record revealed an initial nutritional assessment dated June 16, 2020 that the resident's meal plan would be adjusted to respect Jewish preferences: no pork, no dairy with meats. The assessment included the resident food allergies were seafood (shellfish, fish) - hives and difficulty breathing, and strawberries - hives. The assessment was completed by the dietican (staff #124). A review of the baseline care plan dated June 16, 2020 revealed resident #16 had allergies to seafood (fish, shellfish) and strawberries but did not include the resident's Jewish diet preference of no pork or dairy with meat. The quarterly Minimum Data Set (MDS) assessment dated Docember 10, 2020 revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident had intact cognition. | | | | | | | | |
| SAPPHIRE OF TUCSON NURSING AND REHAB, LLC (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG) (X5) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) ID PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X6) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X6) ID PREFIX (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X6) ID PREFIX (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X7) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X7) ID PREFIX (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X7) Administrator and/or Designee conducted an in-service on following patient religious food preferences and allergies. (X7) Administrator and/or Designee conducted an in-service on following patient religious food preferences and allergies. (X8) Administrator and/or Designee conducted an in-service on following patient religious food preferences and allergies. (X8) HOW Will the corrective action(s) be monitored to ensure the deficient practice will not recur, Le., what quality assurance program will be put intro place; and the title, or position, of the person responsible for Implementing/monitoring the corrective action? (X9) The Food Service Director and/or designee will audit 3 meal trays daily for following patient religious food preferences and allergies. Any food trays found to be out of compliance will be reported to the Food Service Director and/or Designee for immediate correction and re-education to dietary staff. The | NCI-2643 | | | B. WNG | | 03/11/2 | 03/11/2021 | |
| SAPPHIRE OF TUCSON NURSING AND REHAB, LLC TUCSON, AZ 85714 | NAME OF F | PROVIDER OR SUPPLIER | STREET ADD | ORESS, CITY, 8T | ATE, ZIP CODE | | | |
| PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CONTINUED From page 54 A review of the clinical record revealed an initial nutritional assessment dated June 16, 2020 that the resident's meal plan would be adjusted to respect Jewish preferences: no pork, no dairy with meats. The assessment included the resident food allergies were seafood (shellfish, fish) - hives and difficulty breathing, and strawberries - hives. The assessment was completed by the dietician (staff #124). A review of the baseline care plan dated June 16, 2020 revealed resident #16 had allergies to seafood (fish, shellfish) and strawberries but did not include the resident's Jewish diet preference of no pork or dairy with meat. The quarterly Minimum Data Set (MDS) assessment dated December 10, 2020 revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident had intact cognition. | I SAPPHIRE OF TUCSON NURSING AND REHAB. LLC | | | | | | | |
| A review of the clinical record revealed an initial nutritional assessment dated June 16, 2020 that the resident's meal plan would be adjusted to respect Jewish preferences: no pork, no dairy with meats. The assessment included the resident food allergies were seafood (shellfish, fish) - hives and difficulty breathing, and strawberries - hives. The assessment was completed by the dietician (staff #124). A review of the baseline care plan dated June 16, 2020 revealed resident #16 had allergies to seafood (fish, shellfish) and strawberries but did not include the resident's Jewish diet preference of no pork or dairy with meat. The quarterly Minimum Data Set (MDS) assessment dated December 10, 2020 revealed a Brief Interview for Mental Status (BiMS) score of 13, indicating the resident had intact cognition. Administrator and/or Designee conducted an in-service on following patient religious food preferences and allergies. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and the title, or position, of the person responsible for implementing/monitoring the corrective action? The Food Service Director and/or designee will audit 3 meal trays daily for following patient religious food preferences and allergies. The quarterly Minimum Data Set (MDS) assessment dated December 10, 2020 revealed a Brief Interview for Mental Status (BiMS) score of 13, indicating the resident had intact cognition. | PREFIX | (EACH DEFICIENCY | Y MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR | BE | (X5) COMPLETE DATE | |
| An observation was conducted on March 2, 2021 at 8:30 A.M. Resident #16 was observed sitting on the side of the bed with the bedside table in front of him. The bedside table was observed to have a closed breakfast tray on it. An empty orange juice container and an unopened carton of milk were on the bedside table next to the unopened food container. A food preference card was observed on bedside table which read allergies PORK, FISH, STRAWBERRIES and below allergies was written NO PORK. A menorah was observed on the side table next to the resident's bed. During this observation an interview was conducted with resident #16, who stated the kitchen does not accommodate food allergies. Resident #16 stated he has pork and aspartame allergies. The resident stated that he is has been | Y2349 | A review of the clinical nutritional assessment the resident's meal planespect Jewish prefer with meats. The assert resident food allergies fish) – hives and diffical strawberries – hives. To completed by the dietion of the baseling 2020 revealed resident seafood (fish, shellfish not include the resident of no pork or dairy with the quarterly Minimum assessment dated Dea Brief Interview for More 13, indicating the real and the side of the bed front of him. The beds have a closed breakfard orange juice container milk were on the beds unopened food contain was observed on beds allergies PORK, FISH, below allergies was with menoral was observed the resident's bed. During this observation conducted with resider kitchen does not according the stated her stated her sident #16 stated her | il record revealed an initial it dated June 16, 2020 that an would be adjusted to ences: no pork, no dalry sement included the is were seafood (shellfish, alty breathing, and The assessment was clain (staff #124). The care plan dated June 16, at #16 had allergies to an example of the preference in meat. In Data Set (MDS) comber 10, 2020 revealed ental Status (BIMS) score sident had intact cognition. In Data Set was observed sitting with the bedside table in ide table was observed to st tray on it. An empty and an unopened carton of ide table which read is STRAWBERRIES and inten NO PORK. A d on the side table next to the men an interview was an #16, who stated the immodate food allergies. | Y2349 | an in-service on following patient religious food preferences and allers. How will the corrective action(s) be monitored to ensure the deficient provide will not recur, i.e., what quality assurprogram will be put into place; and to title, or position, of the person respot for implementing/monitoring the corrective action? The Food Service Director and/or designee will audit 3 meal trays daily following patient religious food preferences and allergies. Any food found to be out of compliance will be reported to the Food Service Directo and/or Designee for immediate correand re-education to dietary staff. The Food Service Director and/or Designe will report any patterns or trends to consider the staff of the food Service Director and/or Designe will report any patterns or trends to consider the staff of the food Service Director and/or Designe will report any patterns or trends to consider the staff of the food Service Director and/or Designe will report any patterns or trends to consider the staff of the food Service Director and/or Designe will report any patterns or trends to consider the staff of the food Service Director and/or Designe will report any patterns or trends to consider the staff of the food Service Director and/or Designe will report any patterns or trends to consider the staff of the food Service Director and/or Designe will report any patterns or trends to consider the staff of the food Service Director and | gies. ractice rance he ensible y for trays en crection le nee | | |

Q5L611

FORM APPROVED **ADHS LICENSING SERVICES** STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING NCI-2643 03/11/2021 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** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) Y2349 Continued From page 55 Y2349 served meals that have pork and diet drinks on the meal tray. Another meal observation was conducted of resident #16 on March 4, 2021 at 12:42 P.M. The resident's lunch tray consisted of a carton of milk, a hamburger, a container of cottage cheese, salad, Italian green beans, and mashed yams. Resident #16 was observed opening the Styrofoam lunch container and closing it and pushing it aside. An interview was conducted on March 4, 2021 at 10:18 A.M. with resident #16, who that stated he does not eat pork because he is Jewish. The resident stated that he does not have an allergy to pork and shellfish. The resident stated that he says he is allergic because no one has paid attention to the fact that he is Jewish. He stated that he has been served pork and fish while in the facility. Resident #16 stated "I hate fish." Resident #16 stated that when he is served a tray with pork or fish, he will request another tray. The resident stated that he has to wait for the new tray and that often a new tray is not brought to him. In an interview conducted with a Licensed Practical Nurse (LPN/staff #81) on March 4, 2021 at 10:29 A.M., the LPN stated dietary honors residents' food preferences. Staff #81 stated that when a resident is admitted, dietary is notified and they will conduct a nutritional assessment which includes dietary preferences. An interview was conducted on March 4, 2021 at 2:02 P.M. with the dietician (staff #124). The dietician stated a dietary assessment is conducted for a resident that is a new admission. Staff #124 stated the kitchen manager will visit

the resident on admission to discuss food

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | K3) DATE SURVEY COMPLETED | |
|---|--|--|------------------------|---|-----|------------------------------|--|
| NCI-2643 | | B. WING | | 03/11/2021 | | | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, ST | ATE, ZIP CODE | to. | | |
| SAPPHIR | E OF TUCSON NURSING | AND REHAB, LLC 2900 EAST TUCSON, A | MILBER STR NZ 85714 | REET | | | |
| (X4) ID PREFIX TAG | 4) ID SUMMARY STATEMENT OF DEFICIENCIES EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | | |
| Y2349 | assessment based on kitchen manager's rec stated she will visit the her assessment indica manager recommends that dietary preference obtained by visits to the stated that the facility with religious preferences as tated that per resider cold cereal and a banacheese with fruit for ludinner. When asked if #16 Jewish faith and hidlet, staff #124 responsiblet." During an interview ware resident on March 11, resident stated that he faith. Resident #16 stated a dairy with meat. Resident #16 stated a dairy with meat. Resident #16 stated a dairy with meat on his foreference and is not a Resident #16 stated hereceive dairy products meat entrée. An interview was cond Manager (staff #173) of P.M. The Kitchen Man the initial admission interview was conditional manager (staff #173) of P.M. The Kitchen Man the initial admission interview was conditional manager (staff #173) of P.M. The Kitchen Man the initial admission interview was conditional manager (staff #173) of P.M. The Kitchen Man the initial admission interview was conditional manager (staff #173) of P.M. The Kitchen Man the initial admission interview was conditional manager (staff #173) of P.M. The Kitchen Man the initial admission interview was conditional manager (staff #173) of P.M. The Kitchen Man the initial admission interview was conditional manager (staff #173) of P.M. The Kitchen Man the initial admission interview was conditional manager (staff #173) of P.M. The Kitchen Man the initial admission interview was conditional manager (staff #173) of P.M. The Kitchen Man the initial admission interview was conditional manager (staff #173) of P.M. The Kitchen Man the initial admission interview was conditional manager (staff #173) of P.M. The Kitchen Man the initial admission interview was conditional manager (staff #173) of P.M. The Kitchen Man the initial admission interview was conditional manager (staff #173) of P.M. The Kitchen Man the initial admission interview was conditional manager (staff #173) of P.M. The Kitchen Man the initial admission interview | lietician will conduct an admitting notes and the commendations. Staff #124 a newly admitted resident if ates a visit or if the kitchen is she visit. Staff #124 stated as and religious beliefs are not resident. Staff #124 shas not had many residents are requests in the past and of any residents with at this moment." Staff #124 shat #16 request, he is served and for breakfast, cottage inch, and a chef salad for she was aware of resident ais preference for a Jewish ided "I was not aware of ses conducted with the 2021 at 1:10 P.M., the is active in his Jewish ited he does not practice a pareve diet. Pareve diet does not allow ent #16 stated he will not meat and dairy together on stated he often receives cod tray and that is not his allowed on the Jewish diet. It is would prefer not to on the same tray as his | Y2349 | | | | |

FORM APPROVED **ADHS LICENSING SERVICES** STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING NCI-2643 03/11/2021 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** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL). COMPLETE **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY Y2349 Continued From page 57 Y2349 stated that he always asks food preferences and food allergies at the time of the initial assessment. Staff #173 stated he will then design a diet plan based on the resident's preferences. The Kitchen Manager stated that he does accommodate some religious diets requests but that he does not have the capability to cover all religious diets or to have a kosher kitchen. Staff #173 stated resident #16 told him he had a no pork preference because he was Jewish. He also stated that resident #16 stated he was not observant of the Jewish faith. Staff #173 stated that milk or dairy served with meat is not allowed on the Jewish faith diet. The Kitchen Manager stated he was unaware of resident #16 no dairy with meat preference or his Jewish diet preference. During an interview conducted with the Director of Nursing (DON/staff #51) on March 11, 2021 at 3:22 P.M., the DON stated her expectations are that the dietician and Kitchen Manager would have been aware of resident #16 Jewish faith and preferences and honored those beliefs and preferences. The facility Meal Planning Policy stated that based on the facility's reasonable efforts, menus should reflect the religious, cultural, and ethnic needs of the population served, as well as input received from individuals and groups.



April 1, 2021

Receipt Of This Notice Is Presumed To Be 04/01/2021 Important Notice - Please Read Carefully

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

Dear Mr. Balliet:

Thank you for the courtesy and cooperation extended to our staff during the recent inspection **#Q5L611** of your facility.

Enclosed is a statement of **STATE** deficiencies noted during the inspection of your facility on March 11, 2021. A Plan of Correction (PoC) for the deficiencies must be submitted. This plan must be both specific to the problems noted and general to the overall process involved.

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 be advised that your plan of correction will be available as a public document for review by interested parties.

Please place your plan of correction in the space provided in the right column of the statement of deficiencies and return the original to this office no later than April 11, 2021. You must include all pages of the Statement of Deficiencies when submitting your PoC. Please ensure to retain a copy for your files. If the plan of correction is not received by this Office on or before this date, state enforcement action may be taken.

Sapphire Of Tucson Nursing And Rehab, Llc April 1, 2021 Page 2

rules enare

Informal Dispute Resolution - You have an opportunity to dispute any deficiencies or language listed on the SOD through an Informal Dispute Resolution (IDR). To dispute a deficiency or language listed on the SOD, send a written request on a separate document due 10 days from receipt of this letter. The written request must include documentation that shows the licensee was in compliance at the time of the inspection. The Department will review the written request and documentation provided to the Department and notify you of the Department's decision. If you have any questions, please call: Diane Eckles, Bureau Chief, Bureau of Long Term Care 150 North 18th Avenue, #440, Phoenix, Arizona 85007at (602) 364-2690.

Sincerely,

Diane Eckles Bureau Chief

DE:mm

Attachment



LTC Licensing - ADHS < ltc.licensing@azdhs.gov>

Sapphire of Tucson Nursing & Rehab POC(a) ARIZONA DEPARTMENT OF HEALTH DIVISION OF PUBLIC HEALTH

1 message

Brian Balliet <bballiet@sapphireestatesrc.com> To: LTC Licensing - ADHS < ltc.licensing@azdhs.gov> Cc: Brian Balliet <bballiet@sapphireoftucson.com>

APR 1 0 2021

Sat, Apr 10, 2021 at 1:01 PM

LONG TERM CARE 150 N. 18TH AVE # 440 PHOENIX, AZ 85007

Good Afternoon,

Due to the size of the files and email limitations, I have separated the Sapphire of Tucson Nursing & Rehab POC into four(4) distinct emails.

Thank You,

Brian Balliet, LNHA Administrator Sapphire Estates Rehab Centre 2040 N. Wilmot Rd Tucson, AZ 85712

Office: (520)300-6115, ext. 1272

Fax: (520)499-3167

bballiet@sapphireestatesrc.com



REHAB CENTRE



Q5L621 Ftag POC (a).zip 25255K

ARIZONA DEPARTMENT OF HEALTH DIVISION OF PUBLIC HEALTH LICENSING PRINTED: 04/01/2021 FORM APPROVED

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION
A. BUILDING: ____

APR 1 0 2021

(X3) DATE SURVEY COMPLETED

NCI-2643

B. WNG_

LONG TERM CARE

03/11/2021

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

PHOENIX, AZ 85007

SAPPHIRE OF TUCSON NURSING AND REHAB, LLC

2900 EAST MILBER STREET TUCSON, AZ 85714

| | TUCSUN | , AZ 85/14 | | |
|--------------------------|---|---------------------|--|--------------------------|
| (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) COMPLETE DATE |
| | Initial Comments The State compliance survey was conducted on March 1 through 5, 2021 and March 8 through 11, 2021. Resident census was 164. The following deficiencies were cited: R9-10-403.C.2.b. Administration R9-10-403.C.2. Policies and procedures for physical health services and behavioral health services are established, documented, and implemented to protect the health and safety of a resident that: | Y 000 | Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by provisions of 42 CFR 483, et seq., and Health and Safety Code Section 1280. In response to the Department's findings, we submit the following Plan of Correction which shall constitute Sapphire of Tucson Nursing & Rehabilitation's credible allegation of compliance. | |
| | R9-10-403.C.2.b. Cover the provision of physical health services and behavioral health services; | | Y339 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice, on both a temporary and | 4/20/2021 |
| | This RULE is not met as evidenced by: Based on observations, clinical record review, staff interviews, and policy review, the facility failed to implement their policy to ensure a fall for one resident (#131) was thoroughly addressed and acted upon and that interventions were implemented. Findings include: | | permanent basis, including the date the correction will be accomplished? Resident #131 found to be affected. Safety devices updated on 3/11/21. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? | |
| 1 | Resident #131 was admitted to the facility on February 8, 2021 with diagnoses that included pneumonia, dependence on supplemental oxygen, personal history of self-harm, schizophrenia, bipolar disorder, and unspecified | | The DON and/or designee conducted a full house audit for safety devices related to fall on 4/1/2021. No other residents found to be affected. | |

LABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE

in Dallet, LNHA

ADMINISTRATOR

A 10 707

STATE FORM

Q5L611

ADHS LICENSING SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ COMPLETED B. WING NCI-2643 03/11/2021 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 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) Y 339 Continued From page 1 Y 339 What measures will be put into place or dementia without behavioral disturbance. what systemic changes will you make to ensure that the deficient practice does not Review of the Morse Fall Scale dated February 8, recur? 2021 revealed the resident was at high risk for falling with a score of 80 (45 and above equals DON and/or Designee conducted an inhigh risk). The assessment included the resident service to nursing staff related to safety had fallen before; used crutches, a cane, or a devices completed on 4/3/2021. walker; had a weak gait; and overestimates or forgets limits. How will the corrective action(s) be monitored to ensure the deficient practice A second Morse Fall scale was completed on will not recur, i.e., what quality assurance February 9, 2021 and included the resident program will be put into place; and the continued to be at high risk for falling. title, or position, of the person responsible Review the care plan dated February 9, 2021 for implementing/monitoring the revealed the resident was at risk for falls related corrective action? to confusion, weakness, and unaware of safety needs. Resident chooses to lay on the floor The DON and/or Designee will audit all beside her bed and stated that she is more new orders for safety devices daily for 21 comfortable on the floor. The provider is aware of days. Any resident found to be out of the preference. Resident does have the bed in compliance will be reported to the DON low position and can self-adjust the height of the and/or Designee for immediate correction bed. The goal was that the resident would be free and re-education to nursing staff. of falls. Interventions included to anticipate the resident's needs; be sure the resident's call light was within reach and encourage the resident to use it for assistance as needed; the resident needs prompt response to all requests for assistance; ensure the resident is wearing appropriate footwear when ambulating or mobilizing in the wheelchair. Another care plan dated February 9, 2021 revealed the resident was at risk for falls related to weakness, confusion, potential side effects of medication. The goal stated the resident would be free from falls. The interventions included to anticipate and meet the needs of the resident; ensure the resident call light is within reach at all times and encourage/remind the resident to use

O5L611

FORM APPROVED ADHS LICENSING SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING NCI-2643 03/11/2021 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 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) Y 339 Continued From page 2 Y 339 the call light for assistance as needed; maintain bed in low position, resident can self-adjust height of the bed. Review of a nurse progress note dated February 9. 2021 at 9:38 a.m. revealed the resident was status post fall with no injuries, pain or discomfort related to the fall. "Patient chooses to lay on the floor by choice." The note did not include the time of the fall. Review of an Interdisciplinary team (IDT) note dated February 9, 2021 at 10:13 a.m. revealed the IDT met to discuss the resident and the recent incident. The noted stated that the resident was newly admitted, pending therapy evaluations. Staff to continue to orient to surroundings, encourage call light use, provide and encourage use of appropriate footwear. Care Plan reviewed and updated. The note did not include the time of the fall. However, no further documentation was found or provided about this fall regarding the condition in which the resident was found, or notification to the physician and family. Review of a nurse progress note dated February 9, 2021 at 11:02 p.m. revealed the resident rolled out of bed at approximately "1025" and the aide came to notify the nurse that the resident was on the floor. Upon entering the room, the resident was laying comfortably on the floor with her pillow under her head and bed at the lowest position. This nurse, along with another nurse, helped the resident back onto her bed. No injuries noted at the current time, vitals were taken by this nurse and were within normal levels, resident did not complain about pain. Provider and DON were

notified of the situation. Resident is currently on

Q5I 611

PRINTED: 04/01/2021 FORM APPROVED ADHS LICENSING SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: NCI-2643 B. WNG 03/11/2021 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** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC (DENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) Continued From page 3 Y 339 neurologic checks for a fall on February 8, 2021. Aide came to notify this nurse once again that she witnessed the resident roll herself off of her bed. This nurse and aide helped the resident back on to her bed. Bilateral floor mats order was approved by the provider and were placed. Review of the physician's orders revealed orders dated February 9, 2021 for bilateral floor mats for falls and for a progress note status post fall every shift. The interventions of the fall care plan were revised on February 10, 2021 to include bed in low position, patient can self-adjust height of the bed; bilateral floor mats as resident allows/tolerates; bed located on the left wall by the window per resident preference for safety and increased living space; change room configuration to reduce the risk of physical injury due to resident putting self on the floor. Review of a psychiatry note dated February 11, 2021 revealed the resident was admitted to the facility post emergency department visit for increased behavioral disturbance at assisted living home with patient throwing self on the flow multiple times. Per staff, patient with impulsivity and difficult to redirect, high fall risk with recent fall present. Review of the admission Minimum Data Set (MDS) assessment dated February 15, 2021

revealed a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident had severely impaired cognition. The assessment included the resident required extensive assist with bed mobility and limited assist with transfers and walking in the room. The resident was coded as steady at all times with transitions and walking.

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: | CONSTRUCTION | | ATE SURVEY OMPLETED |
|--------------------------|--|---|-------------------------------|---|---------------------------------|--------------------------|
| | | NCI-2643 | B. WNG | | | 02/44/2024 |
| NAME OF F | PROVIDER OR SUPPLIER | | | | | 03/11/2021 |
| TOTALL OF F | NOVIDER OR SUPPLIER | | ADDRESS, CITY, STA | | | |
| SAPPHIR | E OF TUCSON NURSING | AND REHAB, LLC | AST MILBER STR N, AZ 85714 | EET | | |
| (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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC' | ION SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE |
| Y 339 | The resident was cod last month, and the la admission to the facilisince admission to the revealed: IDT follow us February 9, 2021. Rechanges in elevation. received therapies to interventions remain in the received therapies to interventions remain in the received therapies to interventions remain in the received the admission was observed to be in the received the foot of the received the foot of the received the foot of the resident was observed in the received the foot of the call light and did not call for the call light and | ed as having a fall in the st 2-6 months prior to ty and a fall with an injury e facility. e dated February 18, 2021 up, change in elevation sident has had no further The resident continues to maximize function. All in place. In place. In place are the room door and st the wall. There were no y the sides of the bed and and in the room. A walker com against the wall e resident's bed. In a sconducted of resident 21 at 10:38 a.m. The do to transfer out of the bed ink in the room. The rassist verbally or by using out use the walker. I ducted on March 11, 2021 at ified Nursing Assistant a stated that she would was at risk for falls from the rise. Staff #125 stated that, sident #131 had not had a nat resident #131 gets | Y 339 | DEFICIENC | n | |
| | The CNA stated that s | nember to use the call light. he did not remember fall is resident and that she | | | | |

| | NT OF DEFICIENCIES I OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: | CONSTRUCTION | | E SURVEY PLETED |
|--------------------------|---------------------------------------|---|-------------------------------|--|--|--------------------------|
| | | NCI-2643 | B. WING | | 0. | 3/11/2021 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET | DDRESS, CITY, STAT | F 7/0 0005 | | 3/11/2021 |
| | | **** | | | | |
| SAPPHIR | RE OF TUCSON NURSING | G AND REHAB. LLC | ST MILBER STRE | ET | | |
| | T | | I, AZ 85714 | | | |
| (X4) (D PREFIX TAG | (EACH DEFICIENT | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE | ACTION SHOULD BE TO THE APPROPRIATE | (X5) COMPLETE DATE |
| Y 339 | Continued From pag | e 5 | Y 339 | | | |
| | thought the resident | came from another unit. Staff | | | | |
| | #125 stated that duri | ing her care for the resident, | | | | |
| | the resident had bee | n in the current bed, with the | | | | |
| | bed in the current po | sition. | | | | ļ |
| | | | 1 1 | | | |
| | An interview was cor | nducted on March 11, 2021 at | | | | ļ |
| | 1:03 p.m. with a Lice | nsed Practical Nurse | | | | |
| | (LPN/staff #81). The | LPN stated that after a | 1 . [| | | İ |
| | | all, the nurse would conduct a | | | | |
| | | ent, a neurologic check, try | | | | |
| | | resident fell, do vital signs, | | | | |
| | | all light was in reach and that | | | | |
| | | aring appropriate footwear. | | | | |
| | | urse would notify the | | | | |
| | | the Director of Nursing | | | | |
| | (DON), the case man | | | | | |
| | | tated that the facility would | | | | |
| | conduct a risk assess | | | | | |
| | determine if the resid | | | | | |
| | | mat, call light reminder sign, | | | | ļ |
| | | the nurse manager would | | | | İ |
| | | the care plan. She stated | 1 | | | |
| | | y find out that a resident was | | | | |
| | | port. The LPN further stated e aware because the staff | | | | |
| | | really well. Staff #81 stated | | | | |
| | | resident #131 as she had | | | | |
| 1 | | care for her. She stated that | | | | |
| | | sident #131 come into the | 1 | | | |
| | | pace and that she would | | | | |
| | | sident to slow down. She | | | | |
| | stated that she had lin | | | | | |
| | resident #131 and did | not know if the resident | | | | |
| | had fallen. Staff #81 s | stated that the resident | | | | |
| | | current hall and room from a | | | | |
| | private room in a diffe | erent section of the facility | | | | |
| | and that the care plan | | | | | |
| | • | I stated that the resident | | | | |
| | | ts in place if they were | | | | |
| | ordered by the physic | cian and in the care plan. | 1 | | | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE C | | 1 | E SURVEY APLETED | |
|--|--|--|---------------------|---|--------------------------------------|--------------------------|--|
| | | NCI-2643 | B. WING | | 0 | 03/11/2021 | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, STATE | , ZIP CODE | | | |
| CADDUID | E OF THEFON MURRING | 2900 EAS | ST MILBER STREE | T | | | |
| SAFFIIK | E OF TUCSON NURSING | AND REHAB, LLC | , AZ 85714 | | | | |
| (X4) (D PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE | CTION SHOULD BE O THE APPROPRIATE | (X5) COMPLETE DATE | |
| Y 339 | Continued From page | : 6 | Y 339 | | 7.47.7. | | |
| 1:16 p.m. with the Nursing (ADON/sta order listing report Interdisciplinary Te changes for a resic plan. The ADON st to follow the physic information in the caccurate and follow that if clinical staff in changed the physic stated that the staff | | ducted on March 11, 2021 at N/Assistant Director of #143). She stated that an srun each day and that the (IDT) would make sure all twere reflected on the care of that staff were expected it's orders as written and the e plan was supposed to be by the staff. She stated that an order needed to be a would be contacted. She build notify the physician on and why it was felt that | | | | | |
| | resident #131 had an and was care planned therefore, the mats sh that staff had not follow plan, which put the res #143 conducted an ob (#131) room and confi | order for bilateral floor mats | | | | | |
| | 3:22 p.m. with the DOI stated that she expect reviewed and staff to a to put intervention in p effectiveness. She stath that an intervention(s) that intervention(s) wo physician's orders and | ed residents falls to be assess for interventions and lace and assess their ted that if it is determined was needed, she expected uld be implemented as per lor the care plan. She is staff to follow physician's stated that if an inned to no longer be | | | | | |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|--------------------------|---|---|---------------------|---|-------------------------------|
| [| | | A. BUILDING: | | COMPLETED |
| | | NCI-2643 | B. WING | | 03/11/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET AL | DRESS, CITY, ST | ATE, ZIP CODE | - |
| SAPPHIR | E OF TUCSON NURSING | AND BELIAR ILC 2900 EAS | T MILBER ST | REET | |
| | | TUCSON, | AZ 85714 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE COMPLETE |
| | She stated that the remore falls if the interven | s ordered and care expectations were not met. sident would be at risk for entions for fall prevention | | | |
| | were not followed. Review of the facility's and their causes rever procedure is to provide resident after a fall and identifying causes of the included: Falls are a leand mortality among the homes; falling may be clinical or medical condecline, medication side environmental risk factors of the fall occurred. The fall occurred and what the individual time the fall occurred begin to try to identify the incident. When a reinformation should be medical record: The corresident was found; As vital signs and any obtifirst aid, or treatment at the physician and familia. | s policy for assessing falls aled: The purpose of this e guidelines for assessing a d to assist staff in he fall. General Guidelines eading cause of morbidity he elderly in nursing related to underlying ditions, overall functional de effects, and/or tors; residents must be potential risk of falls and ust be addressed properly. The probable fall, clarify the as when the fall occurred all was trying to do at the Within 24 hours of a fall, possible or likely causes of esident fall, the following recorded in the resident's condition in which the assessment data, including vious injuries; Interventions, administered; Notification of illy, as indicated; | | | |
| Y 342 | falls; The signature and recording the data. R9-10-403.C.2.e. Adm | · | Y 342 | | |
| | R9-10-403.C. An adm | inistrator shall ensure that: | | | |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|--------------------------|---|---|-----------------------------------|---|--------------------------------------|
| | | NCI-2643 | B. WNG | | |
| NAME OF F | ROVIDER OR SUPPLIER | | ! | | 03/11/2021 |
| | | 2000 = 0 | ODRESS, CITY, ST ST MILBER STI | | |
| SAPPHIR | E OF TUCSON NURSING | AND REHAB. LLC | N, AZ 85714 | NEE I | |
| (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 APPROPR DEFICIENCY) | BE COMPLETE |
| Y 342 | Continued From page | 8 | Y 342 | <u>Y342</u> | 4/20/2021 |
| | physical health service services are establish | t the health and safety of a | | What corrective action(s) will be accomplished for those residents for have been affected by the deficient practice, on both a temporary and permanent basis, including the date correction will be accomplished? No Residents found to be affected. | |
| | documentation, policie Centers for Disease C the facility failed to impensure that infection c implemented during conscreening for COVID-1 staff appropriately don protective equipment (hygiene, and cleaned Findings include: -Regarding Communation During the entrance confective equipment (a.m. with the Administrator (staff #2 Nursing (DON/staff #5 most recent positive concurred over the wee indicating that the facili outbreak status. | s, staff interviews, facility is and procedures, and the control (CDC) guidelines, oblement their policies to control measures were communal dining, staff 19 was complete, and that ned and doffed personal PPE), performed hand eye protection. I Dining: | | How will you identify other resident having the potential to be affected be same deficient practice and what corrective action will be taken? All residents have the potential to be affected. What measures will be put into place what systemic changes will you make ensure that the deficient practice do recur? All staff will be in-serviced on screet process by ICP for COVID-19 regar temperatures, proper donning and do of PPE, and hand hygiene. Reception screeners in-service by IC conducting screening and reviewing documentation for completeness. ICP to in-service all staff on "Keep COVID-19 OUT!", "Use PPE Correfor COVID-19", and "Clean Hands: Combat COVID-19!" | e or e to es not ening offing offing |

| | T OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPL | E CONSTRUCTION | (X3) DATE SI | URVEY |
|--------------------------|--|--|---------------------|---|--------------|--------------------------|
| ANDPLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMPLE | TED |
| | | | B. WING | | | |
| | | NCI-2643 | B. VVIIVG | | 03/1 | 1/2021 |
| NAME OF P | PROVIDER OR SUPPLIER | STREET A | ODRESS, CITY, ST | ATE, ZIP CODE | | |
| SAPPHIR | E OF TUCSON NURSING | AND REHAB. LLC 2900 EAS | ST MILBER STR | EET | | |
| - | , | 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETE DATE |
| Y 342 | Continued From page | 10 | Y 342 | | | |
| | meals. | | | | | |
| | meals. | | | | | |
| | On March 1, 2021 at | 12:49 p.m. an interview was | | | | |
| | conducted with a Lice | | Ì | | | |
| | (LPN/staff #144). She | stated that the residents | | | | |
| | | and then have activities | | | 1 | |
| | | idents wander. She stated | | | | |
| | | to socialize in the dining | ļ | | | |
| | room. | | 1 | | - | |
| | At 1:06 n m on Morel | 4 2024 interview | | | 1 | |
| | At 1:06 p.m. on March 1, 2021 an interview was conducted with the Director of Maintenance (staff | | | | İ | |
| | | suring tape, he stated that | | | | |
| | each of the 7 square t | | | | | |
| | | by 42 inches; the small | | | | : |
| | | 41 ½ inches in diameter, | | | | |
| | | and table measured 48 | ļ. | | | |
| | inches in diameter. | | | | | |
| | O- M 2 0004 -4 6 | 2.40 | | | | |
| | | 3:43 a.m., an observation of B-100 hall was conducted. | 1 | | | |
| | _ | tables in the dining room | | | | |
| | · | ated at each table. The 2 | | | | |
| | | ed to have been removed | | | - | |
| | | -the-bed tables were in the | | | | |
| | dining room with 1 res | ident seated at each table, | | | İ | |
| | for a total of 16 reside | - | | | İ | |
| | residents on droplet p | | | | | |
| | | f the residents with their | | | | |
| | meais. The other resid | dents ate independently. | | | | |
| | An interview was cond | ducted on March 4, 2021 | | | | j |
| | | ventionist (IP/staff #143). | | | | l |
| | She stated that dining | • | | | | |
| | - | unit housing wandering | | | - | |
| | | he stated that the maximum | | | | j |
| | | ne dining room would be 10 | | | | |
| | | 3 staff members, more or | | | | |
| 1 | less. She stated that it | | | | | |
| ! | expectations for 19 re | sidents to be eating in the | | | | |

| -, | FOF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | ' ' | (X3) DATE SURVEY COMPLETED | |
|---------------|--|--|-----------------|--|------|-------------------------------|--|
| ! | | NCI-2643 | B. WNG | | 03/1 | 11/2021 | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, STA | ATE. ZIP CODE | | <u> </u> | |
| | | 2900 EAST | MILBER STR | EET | | | |
| SAPPHIR | E OF TUCSON NURSING | AND REHAB, LLC TUCSON, A | AZ 85714 | | | | |
| (X4) (D | SUMMARY ST | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | N . | (X5) | |
| PREFIX TAG | | Y MUST BE PRECEDED BY FULL SC IDENTIFYING (NFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | | COMPLETE DATE | |
| Y 342 | Continued From page 11 | | Y 342 | | | | |
| | dining room at one time. She stated that the risks of having that many residents in the dining room would include cross-contamination and/or the possible spread of COVID-19. | | | | | | |
| | On March 5, 2021 at 8:42 a.m., an interview was conducted with the DON (staff #51). She stated that communal dining does not meet her expectations. She stated that residents are to remain 6 feet apart. | | | | | | |
| | However, an observation of the B-100 hall dining room conducted on March 10, 2021 at 12:25 p.m. revealed that 17 residents were observed in the B-1 hall dining room awaiting their meals. 12 out of the 17 were not wearing masks, and multiple residents were noted to be seated less than 6 feet apart from each other and included the PUI residents on droplet precautions. | | | | | | |
| | effective March 1, 202 of an outbreak of a high disease, including a penact its Social Distar limit the spread of dishuman contact. Action between infected and range from the use of cancellation of the foll involving groups and distancing is a public limit the spread of infephysical distance between the spread of infephysical distance between the spread of concept distance between the spread of concept distance between the spread of disease. So spread of disease. So | ed Social Distancing Policy, 20, stated that in the event ghly infectious and/or deadly andemic, the facility will acing Policy in an attempt to ease through human to ease through human to ease through human to ease through human to ease through human to ease through human to ease through human to ease through human to ease through human to ease through human to ease through human to ease through human to ease through human to ease through human to ease through human to ease through human to ease through human to ease through the ease through t | | | | | |

FORM APPROVED ADH'S LICENSING SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WNG NCI-2643 03/11/2021 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 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) Y 342 Continued From page 12 Y 342 of three to six feet. The CDC's Considerations for Memory Care Units in Long-term Care Facilities updated May 12, 2020 included limiting the number of residents or space residents at least 6 feet apart as much as feasible when in a common area, and gently redirect residents who are ambulatory and are in close proximity to other residents or personnel. Review of the CDC guidance titled Preparing for COVID-19 in Nursing Homes, updated November 20, 2020, included that given their congregate nature and resident population served, nursing home populations are at high risk of being affected by respiratory pathogens like COVID-19 and other pathogens. As demonstrated by the COVID-19 pandemic, a strong infection prevention and control (IPC) program is critical to protect both residents and HCP. The guidance included for implementation of aggressive social distancing measures that included remaining at least 6 feet apart from others, cancelling communal dining and group activities, such as internal and external activities, reminding residents to practice social distancing, wear a cloth face covering (if tolerated), and performing hand hygiene. Regarding staff screening for COVID-19: Review of the staff screening documentation dated February 1, 2021 through February 28, 2021 revealed missing names for more than 140 occasions and missing temperatures for more than 23 occasions. An interview was conducted with the receptionist (staff #16) on March 4, 2021 at 11:47 a.m. Staff

#16 stated the process for COVID-19 screening

ADHS LICENSING 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 NCI-2643 03/11/2021 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) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) Y 342 Continued From page 13 Y 342 included washing hands prior to entry at the portable handwashing station located outside the main entrance to the building then entering the lobby. Staff #16 stated the person would then enter their name, take their temperature, and complete the screening questions on the kiosk. Staff #16 stated that if anyone answered a screening question with a "yes" response, indicating they had either symptoms of COVID-19 or close contact outside the facility with an individual confirmed to have COVID-19, she believed the administrator, DON, or IP would be sent an alert or notification. An interview was conducted on March 4, 2021 at 12:38 p.m. with the IP (staff #143). The IP stated the staff enter and exit the facility through the front entrance and are expected to be screened for COVID-19. The IP stated that if someone marked "yes" on the screening questionnaire, the receptionist would call herself or the administrator and that she would conduct further screening. She stated staffs names and temperatures should be documented. Staff #143 stated the incomplete documentation did not meet her expectations. On March 5, 2021 at 8:36 a.m., a follow-up interview was conducted with the receptionist (staff #16). Staff #16 stated that if an individual did not enter their name or temperature when conducting the screening for COVID-19, she thought the administrator, DON, or IP would receive a text notification. In an interview conducted with the DON (staff #51) on March 5, 2021 at 8:42 a.m., the DON stated that she expected the screening for COVID-19 be accurate and complete. The DON stated that omission of names and/or

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIED/CLIA | | | | | | |
|---|------------------------------|--|------------------|---------------------------------|-----------|------------------|
| | OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPI | LE CONSTRUCTION | (X3) DATE | SURVEY |
| 1113.50 | or optateorion | IDENTIFICATION NUMBER: | A. BUILDING | | COMP | LETED |
| | | 1 | | | 1 | |
| | | | 8 14410 | | 1 | |
| | | NCI-2643 | B. WING | | 03/ | 11/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET | DDRESS, CITY, ST | TATE 7/0 CODE | | |
| | | | | | | |
| SAPPHIR | E OF TUCSON NURSING | AND REHAB, LLC | ST MILBER STI | REET | | |
| | | TUCSON | l, AZ 85714 | | | |
| (X4) (D | SUMMARY STA | ATEMENT OF DEFICIENCIES | (D | PROVIDER'S PLAN OF CORRECTION | N | (WE) |
| PREFIX | | Y MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD | | (X5) COMPLETE |
| TAG | REGULATORY OR L | .SC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPROPR | | DATE |
| | | | | DEFICIENCY) | | |
| Y 342 | Y 342 Continued From page 14 | | Y 342 | | | |
| .] | Continued I form page | ; 14 | 1 342 | | | |
| | temperatures on the s | creening did not meet her | | | | |
| | expectation. | | | | | |
| | , | | 1 | | | 1 |
| | The facility's policy titl | ed Coronavirus Disease | | | | |
| | (COVID-19) stated the | e facility will conduct | } | | | |
| | | e, and infection control and | ļ | | | |
| | prevention strategies | | | | | |
| | | | | | | |
| | | D-19. The facility will follow | | | | |
| | | mendations and guidelines | | | | |
| | in accordance with the | | | | | |
| | Department of Public | | | | | |
| | | The policy stated that | | | | |
| | everyone entering the | facility will be screened | | | | |
| | including, all visitors, r | esidents returning from | | | | |
| 1 | _ | es before they enter the | | | | |
| | facility, including obtai | | Ì | | | |
| İ | | g a tomporataro. | | | | |
| | The CDC guidelines ti | tled Preparing for | ļ | | | |
| | | Homes, updated November | | | | |
| | _ | • | 1 | | | |
| | | re practices which should | | | | |
| i | · · | as nursing homes resume | İ | | | |
| | normal activities, inclu | | | | | |
| | | personnel. The guidance | 1 | | | |
| 1 | | ould be screened at the | 1 | | | |
| | | for fever and symptoms of | Į. | | | |
| | | ratures should be actively | | | İ | |
| | taken, and the absenc | e of symptoms consistent | İ | | | |
| | with COVID-19 docum | ented. | | | | |
| | | | | | | |
| | Regarding PPE and ha | and hygiene: | | | | |
| | - • | | | Ì | | İ |
| | -Review of the facility | census dated March 1, | | | | |
| | _ | ere 34 residents residing | | | | |
| | | re dementia unit. Further | | | | |
| 1 1 | | of 34 of the residents were | | | İ | |
| | new admissions and w | | | | | |
| | | • | 1 | | | J |
| | | ecautions for signs and | | | | l |
| | symptoms of COVID-1 | 9 . | | | | J |
| 1 1 | 0 14 1 4 5554 : : | | | | | |
| | On March 1, 2021 at 1 | 2:25 p.m., an observation | | | | I |

| ADHS LICENSING SERVICES | | 1 | 20107711071211 | (X3) DATE SURVEY | |
|-------------------------|---|--------------------------------|-------------------|--|------------------|
| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | ı | CONSTRUCTION | COMPLETED |
| AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: _ | | |
| | | | | | |
| | | NCI-2643 | B. WNG | | 03/11/2021 |
| | | <u></u> | | | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET AL | DRESS. CITY, STAT | TE, ZIP CODE | |
| | | 2900 EAS | T MILBER STRE | EET | |
| SAPPHIR | E OF TUCSON NURSING | AND REHAB, LLC TUCSON, | AZ 85714 | | |
| | CHRIADVOT | TATEMENT OF DEFICIENCIES | I ID | PROVIDER'S PLAN OF CORRECTIO | |
| (X4) ID PREFIX | (EACH DEFICIENC | CY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD | BE COMPLETE DATE |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | |
| | | | | , | |
| V 842 | Y 342 Continued From page 15 | | | | |
| . 5-2 | | |] | | |
| | was conducted of the B-100 hall. PPE carts were | | | | |
| | observed outside of the rooms where the | | | | |
| | residents that were new admissions resided. In | | Į į | | |
| | addition, posted on the | he doorframe of each of their | 1 | | |
| | rooms was a green s | sign. The sign stated to stop | į į | | |
| | and please see a nui | rse before entering, and to | | | |
| | turn the sign over for | PPE requirements to enter | } | | |
| | the room. The other | side of the sign stated that | į | 1 | |
| | | room was a Person Under | | | |
| | Investigation (PUI). I | nstructions included that | 1 | | |
| | nousekeeping staff n | nust wear N95 or KN95 | | | |
| | mask, surgical mask | over the N95 or KN95 mask, | | | |
| | gown, race shield or | goggles, and gloves, that | | | |
| | | inds with soap and water, or | | | |
| | | zer, and that staff should | | 1 | |
| | 1 | ggles when they were done in | | | |
| | the room. | | | | |
| | On March 1 2021 of | t 12:28 p.m., a housekeeper | | | |
| | | erved to clean a room of one | | | |
| | of the resident's on o | | | | |
| | | usekeeper was observed to | | | |
| | | e mask with a surgical mask | | | |
| | covering it, goggles, | - | | | |
| | • • • • • • | keeper's gown was observed | 1 | | |
| | | at and not at the neck. As the | | | |
| | | ed the floor, the gown was | 1 | | |
| | | ner shoulders, covering only | | | |
| | Today is the time | her arms. The housekeeper's | | | |
| | • | per arms were completely | | | |
| | | mately 12:32 p.m., the | | | |
| | | her gown and walked to the | | | |
| | - | housekeeper was not | | | |
| | | gloves and surgical mask, | | | |
| | and she did not clear | | | | |
| | | e nurse the resident required | | | |
| | | se followed the housekeeper | | | |
| | 1 | s room, and the nurse | | | |
| | donned full PPE prio | or to entering the resident's | | 1 | |
| | | eper doffed her gloves at the | l | | |

| | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|---|---------------------|---|------|-------------------------------|--|
| | | NCI-2543 | B. WNG | | 03/1 | 11/2021 | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, STA | ATE ZIP CODE | | | |
| | | | T MILBER STR | | | | |
| SAPPHIR | E OF TUCSON NURSING | AND REHAB. LLC | AZ 85714 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETE DATE | |
| Y 342 | Continued From page | e 16 | Y 342 | | | | |
| | door to the resident's hygiene, did not doff not clean her goggles then observed to don pull her cart into the compart who was not on isolat spray bottle and cloth began to clean it. At 12:49 p.m. on Marconducted with the host of the first stated that wear her gown untied was taught to tie her gwaist when entering a housekeeper stated the resident's room, she to gloves, and that is ab takes off her goggles cleaner before going room. Staff #196 state her goggles with wind washes her hands when she enters the inhousekeeper stated to housekeeper | the surgical mask, and did the surgical mask, and did the surgical mask, and did to the housekeeper was a clean pair of gloves and doorway of a resident's room tion precautions. She took a linto the resident's room and the resident's room and the resident's room and the resident's room and the resident's room and the resident's the resident the resident the resident the resident the resident's room. The resident's resident's resident's resident's room. The resident's room and row cleaner. She said she resident's room. The resident's room. | | | | | |
| | all staff were educate | d (staff #143). The IP stated dahout PPE in January | | | | | |
| | 2021. She stated her | | | | | | |
| | | s to don the double masks, | | | | | |
| | | s, gown, and gloves. The IP | | | | | |
| | | fleave the PUI room, her | 1 | | | | |
| | | aff doff the gown, gloves, | | | | | |
| | • | fore they exit. She stated | 1 | | | | |
| | | face shield or goggles with | 1 | | | | |
| | | in the room before they exit. The IP stated that the | | | | | |

| CTATEMENT OF DESIGNATION | | | | | | |
|--------------------------|------------------------------------|---|---------------------|---|-------------------------------|---|
| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| | | NCI-2643 | B. WNG | | 03/11/2021 | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST. | ATE ZIR CODE | | |
| | | | | | | |
| SAPPHIR | E OF TUCSON NURSING | AND REHAB, LLC | ST MILBER STR | (EE I | | |
| | | | I, AZ 85714 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE COMPLETE | |
| Y 342 | Continued From page | 17 | Y 342 | | | |
| | risk for not following t | hat process would be | | | | |
| | possible cross contan | | | | | |
| | processio or occorrigati | | | } | | |
| | An interview was con- | ducted on March 5, 2021 at | į | | | |
| | | ector of Nursing (DON/staff | | | | |
| | | her expectation for staff | | | | |
| | - | ncluded to don a gown that | | | | |
| | _ | and waist, masks, face | | | | |
| | shield or goggles, and | d gloves if providing care. | | | | |
| | 775 - 6104 10 4 444 | l- 4.11 4 4.1 4.1 | | | | |
| | | led Handwashing/Hand | | | | |
| | | ne Monitoring revised March | · | | | ı |
| | | facility considered hand neans to prevent the spread | | | | |
| | | cy stated that all personnel | | | | |
| | | egularly in-serviced on the | } | | | |
| | | ygiene in preventing the | | | | |
| | | ncare-associated infections. | | | | |
| | | low the handwashing/hand | | | | ı |
| | • | help prevent the spread of | | | | |
| | | rsonnel, residents, and | | | | |
| | • | d to use an alcohol-based | | | | 1 |
| | hand rub containing a | t least 62% alcohol, or | | | | 1 |
| | _ | d water in the following | | | | |
| | situations: after remov | ving gloves and before and | | | | |
| | | n precaution settings. The | 1 | | | |
| | | d hygiene is the final step | | | | |
| | after removing and dis | sposing of PPE. | | | | |
| | The facility's COVID-1 | 19 Reference Binder | | | | |
| | • | ce shields for Persons | 1 | | | |
| | | PUIs). The cleaning of face | 1 | | | j |
| | | ing gloves and using alcohol | | | | |
| | | shield. Wipe the inside | | | | |
| | | e of the face shield, allow to | | | | |
| | | oves, and perform hand | | | | |
| | hygiene. Also included | d was that the face shield | | | | 1 |
| | must be cleaned after | leaving each PUI room. | | | | |
| | The facility's COVID-1 | 19 Reference Binder | | | | |

PRINTED: 04/01/2021 FORM APPROVED

| | ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|--|-------------------------|--|-----------------------------------|-------------------------------|--|
| | | NCI-2643 | B. WING | | 03/ | 11/2021 | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADD | ORESS, CITY, STA | TE, ZIP CODE | | | |
| SAPPHIRE | E OF TUCSON NURSING | AND REHAB, LLC 2900 EAST TUCSON, | MILBER STRE AZ 85714 | EET | | | |
| (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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENT | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETE DATE | |
| Y 342 | When Caring for Patis Suspected COVID-19 PPE must be donned the patient area included sown; PPE must rem correctly for the durat contaminated areas; slowly and deliberate prevents self-contaminstructions included removed prior to exition the CDC Interim Inferest Recommendations for During the Coronavin (COVID-19) Pandemi 2020 stated that the Control additional infection propractices during the Covid with standard practice healthcare delivery to practices are intended just those with suspensive SARS-CoV-2 infection employers should selforovide it to HCP. However, when the provide it to HCP, and demonstrate and use PPE, what PPE indon, use, and doff Preself-contamination. A PPE must be properly and maintained after -An observation was | dance titled Use of PPE ents with Confirmed or a. The guidance stated that correctly before entering ding tying all the ties on the ain in place and be worn ion of work in potentially and PPE must be removed by in a sequence that ination. The doffing that gloves should be ing the patient room. In the patient room. In the doffing that gloves should be ing the patient room. In the patient room. In the patient room. In the patient room and Control or Healthcare Personnel as Disease 2019 and prevention and control and control and control and control and control and patients. These and to apply to all patients, not all patients. These and to apply to all patients, not all patients and that and the propriate PPE and and and the property and and the property and and the property and and the property and and the property and and the property and and the property and and the property and and the property and and the facility and between uses. | Y 342 | | | | |
| | a.m. The Certified Nu #95) conducting the t | ss on March 4, 2021 at 7:10 ursing Assistant (CNA/staff testing, was observed to don ecure/tie the gown at the | | | | | |

ADHS LICENSING SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: __ 03/11/2021 B. WNG NCI-2643 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) SUMMARY STATEMENT OF DEFICIENCIES COMPLETE (X4) D (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 TAĠ DEFICIENCY Y 342 Continued From page 19 waist prior to starting the COVID-19 testing for 5 staff members. An interview was conducted with the CNA (staff #95) on March 4, 2021 at 7:40 a.m. The CNA stated that she has received training regarding donning and doffing of PPE. The CNA stated the proper procedure for placing on a gown would include tying the gown in the back at the waist. Staff #95 stated that for the last five tests she conducted, she did not tie the gowns at the waist. The CNA stated that when a gown is not tied in the back during COVID-19 testing, it could be an infection control issue. An interview was conducted on March 4, 2021 at 10:15 a.m. with the IP (staff #143). She stated that staff have been in-serviced on PPE donning and doffing. The IP stated her expectations for donning gowns would include tying the gown at the waist. She stated that it does not meet her expectations to perform COVID-19 testing without tying the gown at the waist, prior to starting the test. She stated that it would be an infection control risk for contamination. Review of the facility's policy titled. Policy and Procedure COVID 19, revealed that to put on an isolation gown, all the ties must be tied. The CDC Sequence for Putting on PPE included the gown must fully cover the torso from neck to knees, arms to end of wrists, and wrap around the back; fasten in the back at the neck and waist. A review of the CDC guidance titled, COVID-19 Using Personal Protective Equipment (PPE), updated August 19, 2020, revealed when donning an isolation gown, tie all the ties on the gown.

| NOTICE AND ALL STATES | i i | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--|-----------|---|---|-----------------|--|--|-----------|
| SAPPHIRE OF TUCSON NURSING AND REHAB, LLC 2900 EAST MILBER STREET TUCSON, AZ 85744 PROMDERS PLANOF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDEMTIFYING INFORMATION) PROFIX TAG R9-10-410.B.4.c. Resident Rights R9-10-410.B.4. A resident or the resident's representative: R9-10-410.B.4. A resident or the resident's representative: R9-10-410.B.4. Descript in an emergency, is informed of proposed alternatives to psychotropic medication or a surgical procedure and the associated risks and possible complications of the psychotropic medication spror to administration and failed to correctly identify the medication for increasidents (#58, #74, and #106) and/or their representatives were informed of the risks and possible complications of psychotropic medications pror to administration and failed to correctly identify the medication for increasidents (#58, #74, and #106) and/or their representatives were informed of the risks and possible complications of psychotropic medications pror to administration and failed to correctly identify the medication desistication for one resident (#58) when consent was obtained. Findings include: Review of the physician's orders revealed an order dated December 30, 2020 for Aripiprazole (antipsychotic) 5 miligram (mg) tablet give 0.5 tablet by mouth at bedtime for severe depression augmentation as evidenced by (kB) sucidial | - | | NCI-2643 | B. WING | | 03/1 | 11/2021 |
| CASE | NAME OF P | ROVIDER OR SUPPLIER | STREET ADD | DRESS, CITY, ST | ATE, ZIP CODE | | |
| PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) R9-10-410.B. A. Resident Rights R9-10-410.B. A. administrator shall ensure that: R9-10-410.B. A. a resident or the resident's representative: R9-10-410.B. A. c. Except in an emergency, is informed of proposed alternatives to psychotropic medication or a surgical procedure and the associated risks and possible complications of the psychotropic medication or a surgical procedure; This RULE is not met as evidenced by: Based on clinical record review, staff interviews, and policy review, the facility failed to ensure three residents (#58, #74, and #106) and/or their representatives were informed of the risks and possible complications of a psychotropic medications prior to administration and failed to correctly identify the medication classification for one resident (#58) when consent was obtained. Findings include: -Resident #58 was admitted to the facility on July 10, 2020 and re-admitted on July 31, 2020 with diagnoses that included dementia, major depressive disorder, and post-traumatic stress disorder (PTSD). Review of the physician's orders revealed an order dated December 30, 2020 for Aripiprazole (antipsychotic) 5 milligram (mg) tablet give 0.5 tablet by mouth at bectime for severe depression augmentation as evidenced by (LEB) suicidal | SAPPHIR | E OF TUCSON NURSING | AND REHAB, LLC | | REET | | |
| R9-10-410.B. An administrator shall ensure that: R9-10-410.B. A. A resident or the resident's representative: R9-10-410.B. A. C. Except in an emergency, is informed of proposed alternatives to psychotropic medication or a surgical procedure and the associated risks and possible complications of the psychotropic medication or surgical procedure; This RULE is not met as evidenced by: Based on clinical record review, staff interviews, and policy review, the facility falled to ensure three residents (#58, #74, and #106) and/or their representatives were informed of the risks and possible complications of psychotropic medications prior to administration and failed to correctly identify the medication classification for one resident (#58) when consent was obtained. Findings include: -Resident #58 was admitted to the facility on July 10, 2020 and re-admitted on July 31, 2020 with diagnoses that included dementia, major depressive disorder, anxiety disorder, and post-traumatic stress disorder (PTSD). Review of the physician's orders revealed an order dated December 30, 2020 for Anjpiprazole (antipsychotic) 5 milligram (mg) tablet give 0.5 tablet by mouth at bedtime for severe depression augmentation as evidenced by (AEB) suicidal | PREFIX | (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR | BE | COMPLETE |
| i i i | Y1045 | R9-10-410.B. An adm R9-10-410.B.4. A res representative: R9-10-410.B.4.c. Exc informed of proposed medication or a surgic associated risks and p the psychotropic medi procedure; This RULE is not med Based on clinical reco and policy review, the three residents (#58, a representatives were possible complications medications prior to a correctly identify the n one resident (#58) wh Findings include: -Resident #58 was ad 10, 2020 and re-admit diagnoses that include depressive disorder, a post-traumatic stress Review of the physicia order dated Decembe (antipsychotic) 5 millig tablet by mouth at bec augmentation as evide | ninistrator shall ensure that: ident or the resident's pept in an emergency, is alternatives to psychotropic sal procedure and the possible complications of ication or surgical as evidenced by: as evidenced by: ard review, staff interviews, facility failed to ensure #74, and #106) and/or their informed of the risks and so f psychotropic diministration and failed to nedication classification for en consent was obtained. mitted to the facility on July the don July 31, 2020 with ed dementia, major anxiety disorder, and disorder (PTSD). an's orders revealed an and 30, 2020 for Aripiprazole gram (mg) tablet give 0.5 attime for severe depression | Y1045 | What corrective action(s) will be accomplished for those residents for have been affected by the deficient practice, on both a temporary and permanent basis, including the date correction will be accomplished? Resident # 58, #74, and #106 found affected, all consents corrected and obtained for these residents. How will you identify other residents having the potential to be affected be same deficient practice and what corrective action will be taken? The DON and/or designee conducte medical record review for all resident psychotropics on 4/5/2021. No other residents were found to be affected What measures will be put into place what systemic changes will you make ensure that the deficient practice do recur? DON and/or Designee conducted an service on Psychotropic consents to licensed nurses. How will the corrective action(s) be monitored to ensure the deficient prwill not recur, i.e., what quality assurprogram will be put into place; and to the corrective action of the correction action of the correct | the to be s y the d a nts on r e or e to es not in- actice rance he | 4/20/2021 |

| | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | 1 ' ' | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|--|--------------------------|---|-------------------------------|--------------------------|
| | | NCI-2643 | B. WING | | 03/1 | 1/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, STA | ATE, ZIP CODE | | |
| SAPPHIR | E OF TUCSON NURSING | AND REHAB. LLC | T MILBER STR AZ 85714 | EET | | |
| (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 APPROPE DEFICIENCY) | BE | (X5) COMPLETE DATE |
| Y1045 | Review of the Medica (MAR) dated Decembresident received the December 30 and 31, Review of a quarterly assessment dated Jaresident had a Brief Ir (BIMS) score of 10, whad moderately impairassessment included Parkinson's disease, depression, and PTSI revealed the resident antipsychotic medicate. Review of the MAR dathe resident received from January 1 through However, further revien to reveal the resident representative was in benefits of Aripiprazol of the medication. | tion Administration Record er 2020 revealed the Aripiprazole as ordered on 2020. Minimum Data Set (MDS) nuary 11, 2021 revealed the aterview for Mental Status hich indicated the resident red cognition. The the diagnoses of dementia, anxiety disorder, D. The assessment received seven days of an ion. ated January 2021 revealed the Aripiprazole as ordered the Aripiprazole as ordered the 12, 2021. ew of the clinical record did t or the resident's formed of the risks and e prior to the administration an's orders revealed an 12, 2021 for Aripiprazole 5 15 bedtime for severe | Y1045 | for implementing/monitoring the corrective action? The DON and/or Designee will aud orders daily of psychotropics for completion and accuracy of consent 21 days. Any consent found to be compliance will be reported to the I and/or Designee for immediate corrand re-education to licensed staff. | t for out of OON | |
| | Review of the MAR da the resident received from January 22 throu However, review of the reveal that informed of was obtained from the | ated January 2021 revealed the Aripiprazole as ordered ugh 24, 2021. e clinical record did not consent for the medication e resident or the resident's of the administration of the | | | | |

| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|--------------------------|--|---|---------------------|---|-------------------------------|--------------------------|--|
| | | NCI-2643 | B. WING | | 03/11 | 1/2021 | |
| NAME OF PR | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, STA | ATE, ZIP CODE | | | |
| SAPPHIRE | SAPPHIRE OF TUCSON NURSING AND REHAB, LLC 2900 EAST MILBER STREET TUCSON, AZ 85714 | | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | 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 APPROPR DEFICIENCY) | BE | (X5) COMPLETE DATE | |
| Y1045 | Continued From page | 222 | Y1045 | | | | |
| | order dated January 2 mg tablet by mouth at depression augmenta. Review of the MAR dathe resident received on January 25, 2021. However, continued revealed the resident representative was no benefits of Aripiprazol Review of the facility of Medications, dated Jafebruary 26, 2021, reconsented to the use treat depression. The forms as an antidepremarked on the forms anti-depressant medicisted were sedation, of tremors, agitation, hear ash, and sensitivity to attention if heart diseaseizure disorder, or endication which, per effects of sedation, dronstipation, blurred vertapyramidal reaction. | ated January 2021 revealed the Aripiprazole as ordered eview of the clinical record or the resident's of informed of the risks and e until January 26, 2021. Forms titled Psychotropic anuary 26, 2021 and evealed the resident of Abilify/Aripiprazole to drug was classified on the assant and the side effects were those related to an action. The side effects drowsiness, fast heartbeat, adache, weight gain, skin of the sun. With special ase, chronic constipation, dema is present. E/Abilify is an anti-psychotic of the above forms, has side owsiness, dry mouth, vision, weight gain, edema, and the sun attention. Tardive isorder, chronic is diabetes, skin | | | | | |

| | T OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | 1 | (X2) MULTIPLE CONSTRUCTION A BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|---------------------|---|------|-------------------------------|--|
| | | NCI-2643 | B. WING | | 03/1 | 11/2021 | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, STA | NTE, ZIP CODE | | | |
| SADDÚIDI | E OE THECON MUDCING | AND BEHAR 116 2900 EAS | T MILBER STR | EET | | | |
| SAFFIIK | E OF TUCSON NURSING | 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETE DATE | |
| Y1045 | Continued From page | 23 | Y1045 | | | | |
| Y1045 | Review of the current March 2, 2021, reveal psychotropic medication depression AEB pass. An interview was conditional and interview was conditional and interview was conditional and interview was conditional and interview was conditional and interview administered. She stational and included the name of ordered, why the medication classification of the medication classification that was a medication that was a medication is being us she stated that the unfloor nurse know that getting a psychotropic obtain the consent if sunit manager would a consent. An interview was conditional and informed consent from resident's representational medication is ordered is administered. She is should contain the medication is being the medication is being the medication is being the should contain the medication is being the medication is being the should contain the medication is being the medication is being the should contain the medication is being the should contain the medication is being the should contain the medication is being the should contain the medication is being the should contain the medication is being the should contain the medication is being the should contain the medication is being the should contain the medication is being the should contain the medication is being the should contain the medication is being the should contain the medication is being the should contain the medication is being the should contain the medication is being the should contain the medication is being the should contain the medication is being the should contain the medication is being the should contain the medication is being the should contain the should contain the medication is being the should contain the should contain the medication is being the should contain the should contain the should contain the should contain the should contain the should contain the should contain the should contain the should contain the should contain the should contain the should contain the should contain the should contain the should conta | care plan, last revised led the resident used cons related to major live suicidal ideation. ducted on March 9, 2021 at insed Practical Nurse is stated that staff must the resident or the resident live a psychotropic is medication could be sted that the consent the medication, the dose lication was being used, the edication and potential side ion. She stated that the ion marked on the consent is actual classification of the ordered, even if the sed for a different reason, with manager would let the the resident would be in medication and would she was able, if unable, the ssign a nurse to obtain the ducted on March 11, 2021 at ector of Nursing (DON/staff she expects staff to obtain in the resident or the live when a psychotropic and before the medication stated that the consent edication being given, what ig used for, review of | Y1045 | | | | |
| | | | | | | | |

| ADHS LIC | ENSING SERVICES | | | | T | |
|---------------|---|--|-------------------|---|----------------------------|--|
| STATEMENT | ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| AND PLAN O | F CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: _ | | | |
| | | | Ì | | | |
| ! | | NCI-2643 | B. WING | | 03/11/2021 | |
| | | | DOTOG OUTY STAT | T 210 CODE | | |
| NAME OF PR | ROVIDER OR SUPPLIER | • | DRESS, CITY, STAT | | | |
| SAPPHIRE | OF TUCSON NURSING | AND REHABILIC | T MILBER STRE | :E1 | | |
| | | TUCSON, | AZ 85714 | | | |
| (X4) ID | | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD | | |
| PREFIX TAG | | Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | PREFIX TAG | CROSS-REFERENCED TO THE APPROPI | | |
| IAG | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | DEFICIENCY) | | |
| | | 0.4 | Y1045 | | | |
| Y1045 | Continued From page | 24 | 11045 | | | |
| ; | before the medication | was administered in | | | | |
| | December of 2020 ar | nd that it was not. She stated | | | | |
| | | obtained until January 26, | | | | |
| | | pectations were not met. | | 1 | | |
| | She stated that the m | | Ì | | | |
| | | ould not have been marked | | | | |
| | on the consent form | as an antidepressant and | | | | |
| | | eviewed with the resident | | | | |
| | | correct for the medication | | | | |
| | ordered. | | | | | |
| | Decident #74 was a | dmitted to the facility on | | | | |
| | | th diagnoses that included | İ | | i | |
| | | pyelonephritis, and urinary | i | | | |
| | tract infection. | pycioneprintis, and armary | | | | |
| | u act inicotion. | | | | | |
| | Regarding Fluoxetine | | | | ļ | |
| | | | | | | |
| | A physician's order d | ated November 14, 2020 | | | | |
| | | ne HCL Tablet 20 mg give 1 | | | | |
| | | e morning for anxiety as | | | | |
| | evidenced by restless | | | | | |
| | | order, Unspecified. This | | | | |
| | order was discontinue | ed on November 17, 2020. | 1 | | | |
| | A physician's arder d | ated Nevember 19, 2020 | | | | |
| | | ated November 18, 2020 ne HCL Tablet 20 mg give 1 | ı | | | |
| | 1 | e morning for Depression as | | | | |
| | 1 - | interest in activities related | | | | |
| | | ress Disorder, Unspecified. | | | | |
| | 1 | ntinued on January, 6, 2021 | | | | |
| | | ••• | | | į | |
| | A physician's order d | ated January 7, 2020 | | | | |
| | included for Fluoxetir | ne HCL Tablet 20 mg give 2 | | | | |
| | 1 | ne morning for Depression as | | | | |
| | evidenced by lack of | interest in activities. | | | | |
| | | | 1 | | | |
| | A review of the MAR | | | | | |
| | | January, February, and | | | | |
| | March 2021 revealed | I the resident was | | | | |

Q5L611

| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (V2) 10 0 772 | CONCERNATION | (X3) DATE SURVEY | | |
|---------------|---|---|------------------|--|------------------|--|--|
| | AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION | | | |
| | | | A. BUILDING: | | COMPLETED | | |
| [| | | | | | | |
| | · | NCI-2643 | B. WNG | | 03/11/2021 | | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | ATE 7/8 CODE | · | | |
| | | | | | | | |
| SAPPHIRI | E OF TUCSON NURSING | AND REHAB. LLC | ST MILBER STR | REET | | | |
| | | TUCSON | I, AZ 85714 | | | | |
| (X4) ID | | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | | | |
| PREFIX TAG | · | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR | | | |
| .,,0 | | in order | TAG | DEFICIENCY) | INIE UNIE | | |
| | | | | | | | |
| Y1045 | Continued From page | 25 | Y1045 | | | | |
| | administered Fluoxeti | ne as ordered | | | | | |
| | | 40 0,0000 | | | | | |
| | The Consultant Pharm | nacist's Medication | | | | | |
| i | Regimen Reviews for | November 2020. | | | | | |
| | | January 2021 included | 1 | | | | |
| | | ently started on Fluoxetine | | | | | |
| | | ist was unable to find a | | | | | |
| | consent for the medic | | İ | | | | |
| | charting system. | | | | | | |
| | 0 / | | 1 | | | | |
| | Continued review of the | he clinical record revealed a | | | | | |
| | | was obtained on February | | | | | |
| | 11, 2021. | | | | | | |
| | | | | | | | |
| | Regarding Quetiapine | Fumarate | | | | | |
| | | | į | | | | |
| | A physician's order da | ated October 21, 2020 | ı | | | | |
| | included for Quetiapin | e Fumarate (antipsychotic) | | | | | |
| | 50 mg give 1 tablet by | mouth at bedtime for | | | | | |
| | psychosis related to P | Post Traumatic Stress | ļ | | | | |
| | Disorder as evidenced | d by delusions. This order | | | | | |
| | was discontinued on I | | ŀ | | | | |
| | | | | | | | |
| | A physician's order da | ited November 7, 2020 | | | | | |
| | included for Quetiapin | e Fumarate give 50 mg | | | | | |
| | tablet by mouth one ti | me only for verbal and | | | | | |
| | physical aggression for | or 1 day. | ŀ | | | | |
| | | | | | | | |
| | | ited November 18, 2020 | | | | | |
| | | e Fumarate 50 mg tablet | | | | | |
| | 50, give 1.5 tablet by | | | | | | |
| | psychosis related to P | | | | | | |
| | | d by delusions. This order | | | | | |
| | was discontinued on I | November 22, 2020. | | | | | |
| | A Bloods to the Control of the Control | | | | | | |
| | | ated November 22, 2020 | | | | | |
| | | umarate 50 mg tablet, give | 1 | | | | |
| | <u>-</u> | edtime for psychosis related | | | | | |
| | | ess Disorder as evidenced | | | | | |
| | by delusions. | | 1 | | | | |

| | OLIVOINO OLIVVICES | | | | | |
|-----------|------------------------------------|---|------------------------------|--|-------------------------------|-----|
| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| | | | A BUILDING. | | | |
| | NCI-2643 | | B. WING | | 03/11/2021 | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | ATE, ZIP CODE | | |
| | | 2900 EA | ST MILBER STE | REET | | |
| SAPPHIKI | E OF TUCSON NURSING | AND REHAB, LLC | , AZ 85714 | | | |
| (X4) ID | SUMMARY ST | ATEMENT OF DEFICIENCIES | ιD | PROVIDER'S PLAN OF CORRECTION | N (X5) | _ |
| PREFIX | | Y MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD | (/ | |
| TAG | REGULATORY OR I | SC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | RIATE DATE | |
| | | | | DEFICIENCY | | _ |
| Y1045 | Continued From page | 26 | Y1045 | | | |
| | | | | | | |
| | Review of the MARs | for November and | | | | |
| | | January and February 2021 | ŀ | | | |
| | revealed the resident | | ł | | | |
| | Quetiapine Fumarate | | | | | |
| | Quedapine i amarate | as ordered. | | | | |
| | The Consultant Pharm | nacist's Medication | | <u> </u> | | |
| | Regimen Reviews dat | | | | | |
| | | January 2021 included the | | | | ı |
| | | lent #74 for Quetiapine | | | Ì | |
| | | ose of 25 mg, that the dose | ŀ | | | |
| | | t facility should consider | | | | |
| | | consent for the use of | | | | 1 |
| | Quetiapine. | | | | | |
| | Howavar no concentr | s were found for the change | 1 | | ļ | |
| | | October or the change in | | | | ı |
| | | ovember until February 11, | | | | ١ |
| | 2021 | overnoer until replacify 11, | | | | Į |
| | | | 1 | | | ۱ |
| | An interview was cond | ducted on March 11, 2021 at | | | | ı |
| | | esident's LPN (staff #171), | | | | ı |
| | | by medication reviews are | | | | ı |
| | | macist and then sent to | | | | 1 |
| | DON who then distribu | | | | İ | ı |
| | review and send to the | e provider. The LPN stated | | | | ı |
| | the provider documen | ts if they want to change | | | | |
| | the order. Staff #171 s | said that regarding | | | | |
| | | eview the chart to locate | | | | J |
| | | f there was not a consent, | | | | |
| | | e resident or the resident's | | | | |
| | | nsent. Staff #171 stated | 1 | | | 1 |
| | that she was not sure | | | | | ı |
| | | LPN said that it could | | | | I |
| | have been given it to t | ne physician and not | | | | I |
|] [| returned. | | | | | |
| | An interview was con- | lucted on March 11, 2021 at | | | | |
| | | N (staff #51), who said the | | | | ļ |
| | | en a new psychotropic | | | | l |
| | | om pojonodopio | ī | | l | - 1 |

FORM APPROVED ADHS LICENSING SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING NCI-2643 03/11/2021 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 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) Y1045 Continued From page 27 Y1045 medication is ordered, there should be a consent. The DON stated it is the nurses' responsibility to obtain consent for psychotropic medications. The DON stated her expectations is that nursing should have obtained informed consent at the time the new medication was ordered and before the medication was administered. The DON stated that this resident should have had an informed consent for both the Quetiapine and the Fluoxetine. -Resident #106 was admitted to the facility on September 21, 2019 with diagnosis that included dementia with Behavioral Disturbance, Alzheimer's Disease, and unspecified psychosis. Review of the physician's orders revealed an order dated January 11, 2021, for Mirtazapine (antidepressant) 7.5 mg to be given by mouth at bedtime. A review of the MAR for January 2021, revealed the resident was administered the medication Mirtazapine as ordered, starting on January 11, 2021. A review of the quarterly MDS assessment dated February 1, 2021, revealed the resident had a Brief Interview for Mental status (BIMS) Score of 01, which indicated the resident's cognition was severely impaired. The MDS assessment also included the resident was administered an antidepressant medication. Continued review of the clinical record revealed a psychotropic medication consent dated February 12, 2021 for Mirtazapine.

However, further review of the clinical record revealed no evidence that the resident or the

| ADHS LIC | ENSING SERVICES | | | 201000000000000000000000000000000000000 | (X3) DATE SURVEY |
|------------|--|--|--------------------|---|------------------|
| STATEMENT | TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE | CONSTRUCTION | COMPLETED |
| AND PLAN O | F CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: _ | | |
| | | | | | |
| | | | B. WING | | 03/11/2021 |
| | | NCI-2643 | | | 1 00/11/2021 |
| NAME OF DE | ROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, STAT | re. ZIP CODE | |
| NAME OF FE | (OAIDEIL OIL OOL LEICH | 2900 EA | ST MILBER STRE | FT | |
| SAPPHIRE | OF TUCSON NURSING | AND REHAR LLC | I, AZ 85714 | - | |
| | | TUCSOR | 1, AZ 03/14 | | |
| (X4) ID | | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD | |
| PREFIX | (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | CROSS-REFERENCED TO THE APPROPR | |
| TAG | NEODE HOW ON | , | | DEFICIENCY) | |
| | | | | | |
| Y1045 | Continued From page | e 28 | Y1045 | | |
| | rocidonto roprocento | tive were informed of the |] | | |
| | | | | | |
| | risks and benefits of t | | 1 | | |
| | antidepressant/psych | |] | | |
| | Mirtazapine prior to F | editidity 12, 2021. | | | |
| | An Intendession | dusted on March 0, 2021 of | [[| | |
| | | ducted on March 9, 2021 at | - 1 | | |
| | | N (staff #189). The LPN | [[| | |
| | | osychotropic medication | [| | |
| | | rior to administering the first | | | |
| | | on. The LPN stated resident | | | |
| | #106 was administered | · · · · · · · · · · · · · · · · | | | |
| | | ary 11, 2021 and that she | | | |
| | | a consent for Mirtazapine | - | | |
| | prior to the consent for | or Mirtazapine dated | | | |
| | February 12, 2021. | | | | |
| | | | | | |
| | | t 4:05 p.m., an interview was | | | |
| | | irector of Nursing (DON/staff | | | |
| | #51). The DON state | d the nursing staff are | [| | |
| | responsible for obtain | ning consents for | [| | |
| | psychotropic medicat | ions and that it is her | [| | |
| | expectation that once | the order is written for a |] | | |
| | psychotropic medicat | ion that the consent for the |] | | |
| | medication be obtained | ed. The DON acknowledged | 1 | | |
| | that the Mirtazapine f | or resident #106 was started | | | |
| | on January 11, 2021, | per a physician order, and | 1 | | |
| | - | obtained until February 12, | | | |
| | 2021. The DON state | d that it did not meet her | [| | |
| | expectations that the | Mirtazapine consent was | | | |
| | • | ident was administered the | [| | |
| | medication. The DON | I stated the Mirtazapine | | | |
| | should not have been | administered to the | | | |
| | | onsent being obtained. | | | |
| | | | | | |
| | A review of the facility | s policy titled, Medication | | | |
| | • | ed that the medical record | | | |
| | | e that the resident, family | | | |
| | member or represent | | | | |
| | | on. A resident and/or | | | |
| | | e right to be informed about | | | |

FORM APPROVED ADHS LICENSING SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING: COMPLETED NCI-2643 03/11/2021 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 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) Y1045 Continued From page 29 Y1045 the resident's condition; treatment options, relative risks and benefits of treatment, required monitoring, expected outcomes of the treatment; and has the right to refuse care and treatment. Y1147 R9-10-411.C.9. Medical Records Y1147 Y1147 4/20/2021 R9-10-411.C. An administrator shall ensure that What corrective action(s) will be a resident's medical record contains: accomplished for those residents found to have been affected by the deficient R9-10-411.C.9. Orders: practice, on both a temporary and permanent basis, including the date the correction will be accomplished? This RULE is not met as evidenced by: Resident #16 found to be affected. Order Based on clinical record review, staff interviews. already updated previously. and policy review, the facility failed to ensure one resident (#16) medical record contained an order How will you identify other residents for hospice care. having the potential to be affected by the same deficient practice and what Findings include: corrective action will be taken? Resident #16 was admitted to the facility on June 15, 2020 and readmitted on November 20, 2020 The Social Service Director and/or with diagnoses that included encounter for designee conducted a medical record palliative care and type 2 diabetes mellitus with review for all hospice residents in house hyperglycemia. on 3/30/2021. No other residents were found to be affected. Review of the care plan initiated June 17, 2020 revealed the resident was on hospice services. What measures will be put into place or The goal was that the resident would have all what systemic changes will you make to needs met related to end of life care with the ensure that the deficient practice does not intervention that staff will anticipate and meet the recur? needs of the resident and contact the hospice agency as needed. Administrator and/or Designee conducted an in-service on hospice orders to IDT on The quarterly Minimum Data Set (MDS) 3/18/2021. assessment dated December 10, 2020 revealed a Brief Interview for Mental Status (BIMS) score

ADHS LICENSING SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ NCI-2643 B. WING 03/11/2021 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) (D SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) How will the corrective action(s) be Y1147 Continued From page 30 Y1147 monitored to ensure the deficient practice of 13, indicating the resident had intact cognition. will not recur, i.e., what quality assurance The assessment included the resident received program will be put into place; and the hospice care. title, or position, of the person responsible for implementing/monitoring the However, further review of the clinical record did corrective action? not reveal a physician order for hospice care. The Social Service Director and/or Review of the resident's hospice plan of care Designee will audit all new Hospice revealed the start of care date was on June 15. admits for correct orders for 28 days. Any 2020. Further review of the hospice hospice residents found to be out of documentation did not reveal an initial evaluation compliance will be reported to the DON had been conducted. and/or Designee for immediate correction and re-education to IDT. An interview was conducted on March 4, 2021 at 10:29 A.M. with a Licensed Practical Nurse (LPN/staff #81), who stated that a physician order is needed to admit a resident to hospice. An interview was conducted on March 5, 2021 at 8:42 A.M. with the Social Service Coordinator (staff #207), who stated the process for placing a resident in hospice care included obtaining a physician order. Staff #207 stated the hospice agency per resident's or family's preference is contacted and will come and evaluate the resident. Staff #207 stated the hospice agency will then provide hospice plan of care and orders. Staff #207 stated each resident on hospice has a hospice book, which contains hospice provider notes, care plans, and hospice care orders. In an interview conducted with the Director of Nursing (DON/staff #51) on March 11, 2021 at 3:22 P.M., the DON stated that it is her expectation that hospice residents have a physician order to be admitted to hospice. Staff #51 acknowledged there was no physician order for the resident to be admitted to hospice. The facility's hospice policy revised January 2014

FORM APPROVED ADHS LICENSING SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: _ B. WING NCI-2643 03/11/2021 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** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY**) Y1147 Continued From page 31 Y1147 revealed that when a resident has been diagnosed as terminally ill, the DON will contact the hospice agency the facility contracts with and request that a visit/interview with the resident/family be conducted to determine the resident's wishes relative to participation in the hospice program. The policy did not include obtaining a physician order for hospice. Y1235 4/20/2021 What corrective action(s) will be Y1235 Y1235 R9-10-412.B.7. Nursing Services accomplished for those residents found to have been affected by the deficient R9-10-412.B. A director of nursing shall ensure practice, on both a temporary and that: permanent basis, including the date the correction will be accomplished? R9-10-412.B.7. An unnecessary drug is not administered to a resident. Resident #58, #74 and #78 found to be affected. Orders corrected 2/11/21. How will you identify other residents This RULE is not met as evidenced by: Based on clinical record review, staff interviews, having the potential to be affected by the and policy review, the facility failed to ensure same deficient practice and what three residents (#58, #74, and #78) were not corrective action will be taken? administered unnecessary drugs by failing to consistently monitor for adverse side effects of The DON and/or designee conducted a use and targeted behaviors. medical record review for all residents on psychotropics on 4/5/2021 no other Findings include: residents found to be affected. -Resident #58 was admitted to the facility on July What measures will be put into place or 10, 2020 and re-admitted on July 31, 2020 with what systemic changes will you make to diagnoses that included dementia, major ensure that the deficient practice does not depressive disorder, anxiety disorder, and post-traumatic stress disorder (PTSD). DON and/or Designee conducted an in-Review of the physician's orders revealed: service on Psychotropic PRN orders to -An order dated December 3, 2020 for Duloxetine licensed nurses. hydrochloride (HCL) (antidepressant) 60 milligram (mg) capsule by mouth two times a day

Q5L611

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | (X3) DATE S | |
|--|--|--|------------------------------|---|---|--------------------------|
| | NO. 22.22 | | B. WING | | | |
| | | NCI-2643 | B. WING | | 03/1 | 11/2021 |
| NAME OF PROVID | ER OR SUPPLIER | STREET AL | ODRESS, CITY, ST | ATE, ZIP CODE | | |
| SAPPHIRE OF | TUCSON NURSING | AND REHAB, LLC | ST MILBER STF , AZ 85714 | REET | | |
| (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 APPROPR DEFICIENCY) | BE | (X5) COMPLETE DATE |
| for condead for co | tions. econd order dated iprazole (antipsychet by mouth at bed mentation as evidention. iew of the Medical R) dated December received ember 4-31, 2020 or resident received ember 30 and 31, ew of the "Monitor Drevealed: Depressant targed odes of targeted bedication managementation for side effect by shift. Chotropic target bedication managementation for statement for passive suicide ever, there was not the monitoring on the monitoring on the monitoring on the mentation for antipew of a quarterly for a quarterly for a second control of the mentation for antipew of a quarterly for a second control of the mentation for antipew of a quarterly for a second control of the mentation for antipew of a quarterly for the mentation for antipew of a quarterly for the mentation for antipe mentation for a quarterly for the me | denced by passive suicidal defined December 30, 2020 for hotic) 5 mg tablet give 0.5 ditime for severe depression enced by (AEB) suicidal defined by | Y1235 | How will the corrective action(s) be monitored to ensure the deficient privile of the program will be put into place; and the title, or position, of the person responsor for implementing/monitoring the corrective action? The DON and/or Designee will audit orders daily of psychotropics for PR for 21 days. Any psychotropic founds to out of compliance will be reported the DON and/or Designee for immediate correction and re-education to licensistaff. | rance he nsible t all N use d to d to liate | |

PRINTED: 04/01/2021 FORM APPROVED ADHS LICENSING SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED B. WNG NCI-2643 03/11/2021 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 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) Y1235 Continued From page 33 Y1235 (BIMS) score of 10, which indicated that the resident had moderately impaired cognition. The assessment included the resident received seven days of antipsychotic and antidepressant medications. Continued review of the physician's orders revealed: -January 22, 2021, Aripiprazole 5 mg tablet by mouth at bedtime for severe depression augmentation AEB suicidal ideation. -January 25, 2021, Aripiprazole 5 mg tablet by mouth at bedtime for severe depression augmentation AEB suicidal ideation. -January 26, 2021, Antipsychotic use: Observe closely for significant side effects and report to medical doctor every shift -January 28, 2021, Aripiprazole 5 mg tablet, give 7.5 mg by mouth at bedtime for severe depression augmentation AEB suicidal ideation. Review of the MAR dated January 2021 revealed: -The resident received Duloxetine as ordered. -The resident received Aripiprazole as ordered. Review of the "Monitors" record for January 2021 -Anti-Depressant target behavior crying. Monitor episodes of targeted behavior every shift for medication management. -Anti-Depressant target behavior verbalization of sadness. Monitor episodes of targeted behavior every shift for medication management.

every shift.

medication management.

-Monitor for side effects of Anti-Depressants

-Psychotropic target behavior, monitor episodes of delusions targeted behavior every shift for

-Monitor for statements of suicidal ideations every shift for passive suicidal ideations, depression.

ADHS LICENSING SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: B. WNG 03/11/2021 NCI-2643 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) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) (D (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) Y1235 Y1235 Continued From page 34 However, there was no documentation of the above monitoring on the "day" shift on January 10, 16, and 18, 2021, no documentation on the "night" shift on January 8-10, 14, and 22, 2021, and no monitoring for antipsychotic side effects from January 1-25, 2021. Further review of the "Monitors" record for January 2021 revealed: -Antipsychotic use: Observe closely for significant side effects and report to medical doctor every shift starting January 26, 2021. Review of the current care plan revealed: -Revised February 6, 2021 (initiated August 3, 2020): The resident uses psychotropic medications related to major depression AEB passive suicidal ideation. Goal: The resident will be/remain free of psychotropic drug related complications through review date. The interventions included to administer psychotropic medications as ordered by physician and to monitor for side effects and effectiveness every shift and to monitor/document/report as needed any adverse reactions of psychotropic medications. -Revised March 2, 2021 (initiated July 11, 2020): The resident uses antidepressant medication related to depression AEB verbalization of sadness. Goal: The resident will be free from discomfort or adverse reactions related to antidepressant therapy through the review date. The Interventions included to administer antidepressant medications as ordered by the physician, to monitor/document side effects and effectiveness every shift, to monitor/document/report as needed adverse reactions to antidepressant therapy, and to monitor/record for occurrence of target behavior

| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE SURVEY | |
|---|---|-------------------------------|-----------------|--|------------------|----|
| AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMPLETED | |
| | | | | | | |
| ï | | NCI-2643 | B. WING | | 03/11/2021 | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, STA | NTE, ZIP CODE | | |
| | | 2900 EAST | MILBER STR | EET | | |
| SAPPHIRI | E OF TUCSON NURSING | AND REHAB, LLC TUCSON, A | XZ 85714 | | | |
| | CHAMACYCT | ATEMENT OF DEFICIENCIES | 1 | CONTROL OF AN OF CORRECTION | | - |
| (X4) ID PREFIX | • | Y MUST BE PRECEDED BY FULL | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD | | TE |
| TAG | | SC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPROPR | | - |
| | | | | DEFICIENCY) | | |
| V4005 | O | - 05 | V4005 | - | | |
| Y1235 | Continued From page | 35 | Y1235 | | | |
| | symptoms. | | | | | 1 |
| | 5)p.t | | | | | |
| | An interview was con- | ducted on March 9, 2021 at | | | | |
| | 11:32 a.m. with a Lice | • | | | | |
| | (LPN/staff #180). The | | 1 | | | |
| | | ion order needed to include | | | | |
| | | | | | | |
| | the targeted behavior for the medication. Staff #180 stated that staff would monitor for side | | | | | |
| effects and target behaviors, and would | | | | | | |
| document on the "monitors" record twice each | | | ĺ | | | |
| shift. Staff #180 stated that the documentation | | | | | | |
| | | I should not have blanks. | | | | |
| | She stated that if then | | | | | |
| | | would not be able to show | | | | |
| | | | | | | |
| | _ | as done. After review of the | } | | | |
| | | ect monitoring for resident | | | | |
| | | taff did not follow facility | | | | |
| | · · | nentation. The LPN stated | | | | |
| | • | monitor the resident for side | | | | |
| | effects and behaviors | | | | | |
| | | live for the resident's needs | | | | |
| | or to be able to see if | the resident was having | | | | |
| | side effects. | | | | | |
| | | | | | | |
| | | ducted on March 11, 2021 at | | | | |
| | | ector of Nursing (DON/staff | | | | |
| | #51). The DON stated | I that she expects all | | | | |
| | residents who are rec | eiving psychotropic | | | | |
| | | nitored every shift for side | | | | |
| | effects and target behaviors. The DON stated that the monitoring should be documented in one | | | | | |
| | | | | | | |
| | of the administration r | ecords (i.e. Monitors, MAR, | | | | |
| | | tion Record) and needs to | | | | |
| | completed by a licens | ed nurse, not a Certified | | | | |
| | • | IA). The DON reviewed the | | | | |
| | | for resident #58 and stated | | | | |
| | | expectations related to the | | | | |
| | | on of side effect and target | | | | |
| | behavior monitoring. | | | | | |
| | 3 . | | | | | |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | I ' ' | E CONSTRUCTION | (X3) DATE S | |
|--------------------------|---|---|---------------------|---|-------------|--------------------------|
| | | | | | | |
| | | NCI-2643 | B. WNG | | 03/ | 11/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, ST | ATE, ZIP CODE | | |
| SAPPHIR | E OF TUCSON NURSING | AND REHAB, LLC | MILBER STR | EET | | |
| 00 15 | SHMMADY ST | TUCSON, A | | 1 00011050000111105000000000 | | 1 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | 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 APPROPE DEFICIENCY) | BE | (X5) COMPLETE DATE |
| Y1235 | Continued From page | 36 | Y1235 | | | |
| | I . | | | | | |
| | A review of physician's orders revealed orders with a start date December 21, 2020 for citalopram hydrobromide (antidepressant) 40 mg one tablet by mouth in the morning for depression AEB negative statements; monitoring for antidepressant target behavior AEB negative statements; monitoring for side-effects of the antidepressant, including sedation, drowsiness, headache, decreased appetite, dry mouth, blurred vision, urinary retention, and pyramidal side-effects, and monitoring for adverse reactions | | | | | |
| | for use of the antidepressant medication including, dizziness, nausea, diarrhea, anxiety, nervousness, insomnia, somnolence, weight gain, and anorexia. | | | | | |
| | Review of the MARs for January 2021 revealed administered citalopra | | | | | |
| | January 12, 2021 reversibles, indicating the recognitive impairment. | The assessment included antidepressant medication | | | | |
| | for January 2021 reve indicate whether or no antidepressant target | the Monitors documentation aled no documentation to it the resident had exhibited behaviors, side-effects, and 2 out of 31 day shifts and 5 | | | | |

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NCI-2643

NCI-2643

NCI-2643

STREET ADDRESS, CITY, STATE, ZIP CODE

SAPPHIRE OF TUCSON NURSING AND REHAB, LLC

(X2) MULTIPLE CONSTRUCTION
A. BUILDING:

NCI-2643

STREET ADDRESS, CITY, STATE, ZIP CODE

2900 EAST MILBER STREET

TUCSON, AZ 85714

(X4) ID
SUMMARY STATEMENT OF DEFICIENCIES
ID
PREFIX
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
PREFIX
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
PREFIX
(EACH CORRECTIVE ACTION SHOULD BE

| X4) ID REFIX 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) COMPLETI DATE |
|------------------------|--|---------------------|--|--------------------------|
| Y1235 | Continued From page 37 | Y1235 | | |
| | out of the 31-night shifts. | | | |
| | An interview was conducted on March 11, 2021 at | | | |
| | 10:51 a.m. with an LPN (staff #47), who stated | 1 1 | | |
| | daily monitoring of psychotropic medications for | | | |
| | adverse side effects and behaviors are conducted | | | |
| | and documented by every nurse. The LPN stated | | | |
| | that monitoring ensures the medication is working | | | |
| | and rules out any complications. | | | |
| | On March 11, 2021 at 3:25 p.m., an interview was | | | |
| | conducted with the DON (staff #51). The DON | 1 | | |
| l | stated that her expectation is that monitoring for | | | |
| | behaviors and adverse side effects related to | | | |
| 1 | psychotropic medications be conducted and | | | |
| | documented every shift. Staff #51 stated that the | | | |
| İ | expectation is that monitoring is started when the medication is started. The DON reviewed the | | | |
| | January 2021 monitoring record for resident #78 | | | |
| | and stated that it did not meet her expectations. | | | |
| | -Resident #74 was admitted to the facility on | | | |
| | February 8, 2020 and readmitted on September | | | |
| | 28, 2020 with diagnoses that included unspecified | | | |
| | dementia with behavioral disturbance, | | | |
| | post-traumatic stress (PTSD) disorder, major | | | |
| | depressive disorder and anxiety disorder. | | | |
| | Review of the clinical record revealed a physician | | | |
| | order dated November 14, 2020 for Fluoxetine | | | |
| | (antidepressant) 20 mg one tablet by mouth in the | | | |
| | morning for anxiety AEB restlessness related to PTSD. | | | |
| | On November 18, 2020, the order for Fluoxetine | | | |
| | was changed to Fluoxetine 20 mg tablet by mouth | | | |
| | in the morning for depression AEB lack of interest | | | |
| | in activities related to PTSD. | | | 1 |

Q5L611

| NCI-2643 NCI-2643 B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SAPPHIRE OF TUCSON NURSING AND REHAB, LLC 2900 EAST MILBER STREET TUCSON, AZ 85714 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) | | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|--|-----------|---|--|----------------------------|--|--|------------------|--|
| MAME OF PROVIDER OR SUPPLIER SAPPHIRE OF TUCSON NURSING AND REHAB, LLC (Y4) ID PREFX TAG SIMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTEYING INFORMATION) TAG Y1235 Continued From page 38 Review of the MARs for November 2020 and December 2020 revealed the resident was being monitored for adverse side effects and the targeted behavior of Fluoxetine. The physician order dated January 7, 2021 included for Fluoxetine and Depreceding for Fluoxetine and The Teresident had severe cognitive impairment. The assessment included the resident had severe cognitive impairment. The assessment included the resident recived antipsychotic and antidepressant medications during the 7-day look-back period. A review of the MARs and the TARs for January 2021 and February 2021 revealed the resident was administered Fluoxetine. Further review of the MARs and the Tars for January 2021 and February 2021 revealed the resident was administered Fluoxetine. Further review of the MARs and the TARs for January 2021 and February 2021 revealed the resident was administered Fluoxetine. Further review of the MARs and the TARs for January 2021 and February 2021 revealed the resident was administered Fluoxetine. Further review of the MARs and the TARs for January 2021 and February 2021 revealed the resident was administered Fluoxetine. | ANDIDAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | СОМР | LETED | |
| SAPPHIRE OF TUCSON NURSING AND REHAB, LLC (X0.10) PREFEX TAG SUMMARY STATEMENT OF DEPOCIENCES (EACH DEFICIENCY MUST BE PRECEDED BY PULL RESULATORY OR LSC IDENTIFYING INFORMATION) PREFEX TAG Review of the MARs for November 2020 and December 2020 revealed the resident was administered Fluoxetine as ordered. However, further review of the MARs and the Treatment Administration Record (TARs) for November 2020 and December 2020 and December 2020 and December 2020, and not reveal the resident was being monitored for adverse side effects and the targeted behavior of Fluoxetine. The physician order dated January 7, 2021 included for Fluoxetine 20 mg two tablets by mouth in the morning for depression AEB lack of interest in activities. Review of the annual MDS assessment dated January 23, 2021 revealed a BIMS score of 7, indicating the resident had severe cognitive impairment. The assessment included the resident received antipsychotic and antidepressant medications during the 7-day look-back period. A review of the MARs for January 2021 and February 2021 revealed the resident was administered Fluoxetine. Further review of the MARs and the TARs for January 2021 and February 2021 rid not reveal the resident was definistered Fluoxetine. Further review of the MARs and the TARs for January 2021 and February 2021 rid not reveal the resident was administered Fluoxetine. | | | NCI-2643 | B. WING | B. WING | | 03/11/2021 | |
| (X4) ib SUMMARY STATEMENT OF DEFICIENCIES EACH OERFICIENCY WIST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) 71235 Continued From page 38 Review of the MARs for November 2020 and December 2020 revealed the resident was administered Fluoxetine. However, further review of the MARs and the Treatment Administration Record (TARs) for November 2020 and December 2020 and December 2020 and December 2020 and December 2020 revealed the resident was administered Fluoxetine as ordered. However, further review of the MARs and the Treatment Administration Record (TARs) for November 2020 and December 2020, idin not reveal the resident was being monitored for adverse side effects and the targeted behavior of Fluoxetine. The physician order dated January 7, 2021 included for Fluoxetine 20 mg two tablets by mouth in the morning for depression AEB lack of interest in activities. Review of the annual MDS assessment dated January 23, 2021 revealed a BIMS score of 7, indicating the resident had severe cognitive impairment. The assessment included the resident received antipsychotic and antidepressant medications during the 7-day look-back period. A review of the MARs for January 2021 and February 2021 revealed the resident was administered Fluoxetine. Further review of the MARs and the TARs for January 2021 and February 2021 did not reveal the resident was being monitored for adverse side effects and the targeted behavior for | NAME OF F | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, ST | ATE, ZIP CODE | | | |
| (A) ID PREFEX SIMMARY STATEMENT OF DEFICIENCES BY PULL PREFEX RESULATORY OR LSC IDENTIFYING INFORMATION) 1235 Continued From page 38 Review of the MARS for November 2020 and December 2020 and December 2020 and December 2020 and December 2020 and December 2020 and December 2020 and December 2020 and December 2020 and December 2020 included for Fluoxetine as ordered. However, further review of the MARS and the Treatment Administration Record (TARs) for November 2020 and December 2020 included for Fluoxetine as ordered. The physician order dated January 7, 2021 included for Fluoxetine 20 mg two tablets by mouth in the morning for depression AEB lack of interest in activities. Review of the annual MDS assessment dated January 23, 2021 revealed a BIMS score of 7, indicating the resident had severe cognitive impairment. The assessment included the resident received antipsychotic and antidepressant medications during the 7-day look-back period. A review of the MARs for January 2021 and February 2021 revealed the resident was administered Fluoxetine. Further review of the MARs and the TARs for January 2021 and February 2021 and February 2021 did not reveal the resident was being monitored for adverse side effects and the targeted behavior for | SAPPHIR | SAPPHIRE OF THESON NURSING AND BEHAR LLC 2900 E/ | | | EET | | | |
| PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Y1235 Continued From page 38 Review of the MARs for November 2020 and December 2020 revealed the resident was administered Fluoxetine. However, further review of the MARs and the Treatment Administration Record (TARs) for November 2020 and December 2020 and December 2020, did not reveal the resident was being monitored for adverse side effects and the targeted behavior of Fluoxetine. The physician order dated January 7, 2021 included for Fluoxetine 20 mg two tablets by mouth in the morning for depression AEB lack of interest in activities. Review of the annual MDS assessment dated January 23, 2021 revealed a BIMS score of 7, indicating the resident has severe cognitive impairment. The assessment included the resident received antipsychotic and antidepressant medications during the 7-day look-back period. A review of the MARs for January 2021 and February 2021 revealed the resident was administered Fluoxetine. Further review of the MARs and the TARs for January 2021 and February 2021 revealed the resident was administered Fluoxetine. Further review of the MARs and the TARs for January 2021 and February 2021 did not reveal the resident was being monitored for adverse side effects and the targeted behavior for | OA! TIIK | E OF TOCSON NORSING | TUCSON, | AZ 85714 | | | | |
| Review of the MARs for November 2020 and December 2020 revealed the resident was administered Fluoxetine as ordered. However, further review of the MARs and the Treatment Administration Record (TARs) for November 2020 and December 2020, did not reveal the resident was being monitored for adverse side effects and the targeted behavior of Fluoxetine. The physician order dated January 7, 2021 included for Fluoxetine 20 mg two tablets by mouth in the morning for depression AEB lack of interest in activities. Review of the annual MDS assessment dated January 23, 2021 revealed a BIMS score of 7, indicating the resident had severe cognitive impairment. The assessment included the resident received antipsychotic and antidepressant medications during the 7-day look-back period. A review of the MARs for January 2021 and February 2021 revealed the resident was administered Fluoxetine. Further review of the MARs and the TARs for January 2021 and February 2021 and February 2021 and February 2021 did not reveal the resident was being monitored for adverse side effects and the targeted behavior for | PREFIX | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE A CROSS-REFERENCED T | ACTION SHOULD BE TO THE APPROPRIATE | COMPLETE | |
| An interview was conducted on March 10, 2021 at 11:50 A.M. with the LPN Unit Manager (staff #126), who stated monitoring for side effects, adverse reactions and behaviors for psychotropic medications should be documented on the | Y1235 | Review of the MARs of December 2020 reveal administered Fluoxetine. However, further review Treatment Administration November 2020 and Consider the resident was adverse side effects at Fluoxetine. The physician order discluded for Fluoxetine mouth in the morning interest in activities. Review of the annual displaying an activities. Review of the annual displaying an activities. Review of the annual displaying an activities. A review of the MARs resident received antipantide pressant medical look-back period. A review of the MARs February 2021 revealed administered Fluoxetine. Further review of the Marks resident was being side effects and the tatal Fluoxetine. An interview was conducted the first of the Marks of the Marks resident was being side effects and the tatal Fluoxetine. An interview was conducted the more discovered and discovered and discovered and discovered and the tatal fluoxetine. | for November 2020 and aled the resident was ne as ordered. Ew of the MARs and the tion Record (TARs) for December 2020, did not as being monitored for and the targeted behavior of ated January 7, 2021 at 20 mg two tablets by for depression AEB lack of MDS assessment dated ealed a BIMS score of 7, and severe cognitive assment included the psychotic and ations during the 7-day for January 2021 and add the resident was ne. MARs and the TARs for pruary 2021 did not reveal a monitored for adverse regeted behavior for adverse regeted behavior for lucted on March 10, 2021 at 20 Unit Manager (staff initoring for side effects, behaviors for psychotropic | Y1235 | DEFICIE | :NCY) | | |

PRINTED: 04/01/2021 **FORM APPROVED** ADHS LICENSING SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: __ B. WNG NCI-2643 03/11/2021 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** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG **DEFICIENCY**) Y1235 Continued From page 39 Y1235 In an interview conducted with the LPN Unit Manager (staff #171) on March 11, 2021 at 10:55 A.M., staff #171 stated that monitoring for side effects, adverse reactions and targeted behaviors would be documented in the TAR. An interview was conducted on March 11, 2021 at 3:22 P.M. with Director of Nursing (DON, Staff #51), who stated that all residents receiving psychotropic medications should be monitored for target behaviors and side effects. Staff #51 stated that it is a nursing order to monitor for side effects and target behaviors. The DON stated that when a physician orders the psychotropic medication. nursing is to order the monitoring of targeted behaviors and side effects at that same time. The DON stated it is her expectation that all residents on psychotropics be monitored starting from the time the medication is ordered and that the monitoring is documented in the TAR. The DON acknowledged resident #74 was not being monitored for side effects and targeted behaviors from November 14, 2020 through March 1, 2021. The facility's policy titled Medication Monitoring Medication Management stated that each resident's drug regimen is reviewed to ensure it is free from unnecessary drugs. This includes any drug without adequate monitoring. In addition, the policy stated that the facility's medication management supports and promotes the monitoring of medications for efficacy and adverse consequences. The intent of this

requirement is that each resident's entire drug/medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial wellbeing. When monitoring a resident receiving psychotropic medications, the

ADHS LICENSING SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: 03/11/2021 B. WNG NCI-2643 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) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC (DENTIFYING INFORMATION) TAG TAG DEFICIENCY) Y1235 Y1235 Continued From page 40 facility must evaluate the effectiveness of the medications as well as look for potential adverse consequences. A review of the facility's policy on medication management stated residents receive psychotropic medications only if they are ordered by the prescriber. The necessity is documented in the resident's medical record and in the care planning process. The prescriber and care planning team reassess the continued need for the ordered medication. Effects of the medications are documented as a part of the care planning process. Non-pharmacological interventions such as behavior modification or social services and their effects are documented as a part of the care planning process. The facility's medication management supports and promotes monitoring of medications for efficacy and adverse consequences. For each resident receiving psychotropic medications, the resident's entire drug/medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial wellbeing. The need for and response to therapy are monitored and Y1477 4/20/2021 documented in the resident's medical record. What corrective action(s) will be Y1477 Y1477 R9-10-414.B.3.b. Comprehensive Assessment; accomplished for those residents found to Care Plan have been affected by the deficient practice, on both a temporary and R9-10-414.B. An administrator shall ensure that permanent basis, including the date the a care plan for a resident: correction will be accomplished? R9-10-414.B.3. Ensures that a resident is Resident #74, and #16 found to be provided nursing care institution services that: affected. Care Plan updated 3/12/2021. R9-10-414.B.3.b. Assist the resident in maintaining the resident's highest practicable

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|--|---|---|--|--|
| | | NCI-2643 | B. WNG | | 03/11/2021 | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, STA | ATE, ZIP CODE | | |
| SAPPHIR | E OF TUCSON NURSING | AND PEHAR LLC 2900 EAST | MILBER STR | EET | | |
| SAFFIIIK | - TOCSON NORSING | TUCSON, A | XZ 85714 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | 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 APPROPR DEFICIENCY) | BE COMPLETE IATE DATE | |
| Y1477 | well-being according to comprehensive assess the sased on clinical reconstruction interviews, and review the facility failed to endeveloped to assist two in maintaining their highly failing to address do antidepressant medical religious dietary preference in the same and the sa | to the resident's isment. It as evidenced by: ord review, resident and staff of policy and procedures, sure a care plan was to residents (#74 and #16) ghest practicable well-being epression and the use of an ation for resident #74 and rences for resident #16. In the facility on readmitted on September es that included unspecified oral disturbance, (PTSD) disorder, major and anxiety disorder. In the facility on readmitted on September es that included unspecified oral disturbance, (PTSD) disorder, major and anxiety disorder. In the facility on readmitted on September es that included unspecified oral disturbance, (PTSD) disorder, major and anxiety disorder. | Y1477 | How will you identify other residents having the potential to be affected be same deficient practice and what corrective action will be taken? The Social Service Director and/or designee conducted a medical record review for all residents in house on 3/30/2021. No other residents were to be affected. What measures will be put into place what systemic changes will you make ensure that the deficient practice docrecur? Administrator and/or Designee cond an in-service on Comprehensive Car Plan for religion and depression to Services Department on 3/19/2021. How will the corrective action(s) be monitored to ensure the deficient provided the put into place; and the title, or position, of the person responsary for implementing/monitoring the corrective action? The Social Service Director and/or Designee will audit all new admits for completion and accuracy of care plan related to depression and religion for days. Any Care Plans found to be or compliance will be reported to the Administrator and/or Designee for immediate correction and re-education and re-education. | found found e or e to es not lucted e locial actice rance he nsible or as 28 at of | |
| | | | | immediate correction and re-education Social services department. | on to | |

| STATEMENT OF DEFICIENCIES (V1) PROVIDED/SLIDBLED/CLIA | | | T | | | |
|---|---|---|----------------------------|--|-------------------------------|-----|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | A. BUILDING: | | |
| | | | İ | | | |
| | | NCI-2643 | B. WNG | | 03/44/2024 | |
| | | 1101-2043 | | · · · · · · · · · · · · · · · · · · · | 03/11/2021 | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET AC | DRESS, CITY, ST | ATE, ZIP CODE | | l |
| | | 2900 EAS | T MILBER STR | EET | | |
| SAPPHIR | E OF TUCSON NURSING | AND REHAB, LLC TUCSON. | AZ 85714 | | | |
| | CUMMADY CT | | | 220/4250/2 2/ 4/ 05 0025070 | | - |
| (X4) ID PREFIX | | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD | V / | |
| TAG | | SC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPROPR | | |
| | | | 1 | DEFICIENCY) | | 1 |
| | | | | | | |
| Y1477 | Continued From page | e 42 | Y1477 | | | |
| | February 27, 2020 die | d not include depression. | | | | |
| | 1 ebidary 21, 2020 die | a not include depression. | 1 | | | |
| ; | An intensiew was con- | ducted on March 10, 2021 at | | | | |
| | | DS Registered Nurse (staff | | | | |
| | | when a resident is admitted, | | | | 1 |
| | • • | • | | | | |
| | | ssessment period is from en they have 7 days after | | | ľ | ı |
| | | • | | | | |
| | that to develop the comprehensive care plan. | | | | | ı |
| | After reviewing resident #74's clinical record, staff | | | | i | ı |
| | #87 stated the mood care area was triggered due | | | | | |
| | to depression. Staff #87 stated Social Services | | | | İ | |
| | completes that area of the care plan. | | | | | |
| | | | | | | 1 |
| | An interview was cond | ducted on March 11, 2021 at | | | | |
| | 3:21 P.M. with the Dir | ector of Nursing (DON/staff | | | | |
| | #51), who said the car | re plan focuses are | | | | |
| | generated by the MDS | S assessment. The DON | | | | |
| | stated that she would | review the resident's clinical | | | | |
| i | record regarding the d | depression score. | | | | |
| | | • | | | | |
| | A follow up interview v | was conducted on March 11, | | | | |
| | • | h the DON (staff #51). The | 1 | | | |
| | | pectation is that the staff | | | | |
| | | a care plan for this resident | | | | |
| | • | I moderate depression. | | | | 1 |
| | as the soore maleated | moderate depression. | 1 | | | Į |
| | | | 1 | | | |
| | Regarding an antidepressant medication | | | | | I |
| | regarding an anddep | ressant medication | | | | I |
| Review of the clinical record revealed a physician | | | | | Ì | |
| | | | i | | | ļ |
| | | r 14, 2020 for Fluoxetine | 1 | | | - 1 |
| | | illigrams (mg) one tablet by | | | | |
| | | for anxiety as evidenced by | 1 | | | - [|
| | (AEB) restlessness re | lated to PTSD. | 1 | | | - 1 |
| | | | | | | |
| | | 20, the order for Fluoxetine | | | | |
| | _ | etine 20 mg tablet by mouth | 1 | | | |
| | in the morning for dep | ression AEB lack of interest | | | | l |
| | in activities related to | PTSD. | | | | I |
| | | | 1 | | | - 1 |

PRINTED: 04/01/2021 **FORM APPROVED ADHS LICENSING SERVICES** STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING NCI-2643 03/11/2021 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 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) Continued From page 43 Y1477 Y1477 Review of the Medication Administration Records (MARs) for November 2020 and December 2020 revealed the resident was administered Fluoxetine as ordered. The physician order dated January 7, 2021 included for Fluoxetine 20 mg two tablets by mouth in the morning for depression AEB lack of interest in activities. Review of the annual MDS assessment dated January 23, 2021 revealed a BIMS score of 7. indicating the resident had severe cognitive impairment. The assessment included the resident received antidepressant medications during the 7-day look-back period. A review of the MARs for January 2021 and February 2021 revealed the resident was administered Fluoxetine. A review of the care plan did not reveal a care plan was developed for the use of an antidepressant medication until March 1, 2021. The interventions included monitoring for adverse reactions and the target behavior symptoms. An interview was conducted on March 10, 2021 at 11:50 A.M. with the Licensed Practical Nurse (LPN) Unit Manager (staff #126), who stated monitoring for side effects, adverse reactions and behaviors for psychotropic medications should be specifically addressed in the care plan. In an interview conducted with the LPN Unit

Manager (staff #171) on March 11, 2021 at 10:55 A.M., staff #171 stated a new medication like an antidepressant would be care planned. Staff #171 stated the care plan would include monitoring for side effects, adverse reactions and behaviors

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE S | |
|--------------------------|--|--|---------------------|---|-------------|--------------------------|
| : ! | | NCI-2643 | B. WNG | | 03/1 | 1/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, STA | ATE, ZIP CODE | | |
| SAPPHIRI | SAPPHIRE OF TUCSON NURSING AND REHAB, LLC TUCSON | | | EET | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | 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 APPROPR DEFICIENCY) | BE | (XS) COMPLETE DATE |
| Y1477 | 3:22 P.M. with DON (spsychotropic medicatic effects, adverse react associated with those planned. The DON stathat any psychotropics resident #74 be care packnowledged the ant not addressed in reside March 1, 2021. Resident #16 was ad 15, 2020 and readmitt with diagnoses that impalliative care and typ hyperglycemia. Review of the resident revealed Jewish as the A review of the clinical nutritional assessment the resident's meal plarespect Jewish prefers with meats. The assess the dietician (staff #12). The quarterly Minimur assessment dated Dea Brief Interview for M of 13, indicating the research green revealed plays and the resident stated of the care plant been developed to Jewish preferences research. | ducted on March 11, 2021 at staff #51), who stated ons and monitoring for side ions and behaviors medications should be care ated it is her expectation is medications ordered for planned. The DON idepressant medication was lent #74's care plan until mitted to the facility on June led on November 20, 2020 cluded encounter for e 2 diabetes mellitus with at information face sheet e resident's religion. It record revealed an initial that dated June 16, 2020 that an would be adjusted to ences: no pork, no dairy is ment was completed by (4). In Data Set (MDS) comber 10, 2020 revealed ental Status (BIMS) score is ident had intact cognition. In revealed a care plan had include the resident's lated to diet. | Y1477 | | | |
| | An interview was cond | lucted on March 4, 2021 at | | | | |

Q5L611

| - / 101 TO LI | OLINOINO OLIVAIQUO | | | | | | |
|---------------|--|--|-----------------|---|-----------|------------------|--|
| | T OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLI | E CONSTRUCTION | (X3) DATE | SURVEY | |
| AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMP | .ETED | |
| | | l | | | Ì | | |
| | | | į | | | | |
| | | NCI-2643 | B. WNG | B. WING | | 11/2021 | |
| | | | | | , ,,, | | |
| NAME OF P | RÖVIDER OR SUPPLIER | STREET AL | DRESS, CITY, ST | ATE, ZIP CODE | | | |
| | | 2900 EAS | T MILBER STR | EET | | | |
| SAPPHIR | E OF TUCSON NURSING | AND REHAB, LLC | AZ 85714 | - | | | |
| | | | 72 007 14 | | ÷•• | , | |
| (X4) ID | | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORREC | | (X5) | |
| PREFIX | | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX | (EACH CORRECTIVE ACTION SHOW | | COMPLETE DATE | |
| TAG | REGOLATORI ORI | LOC IDENTIF TING HAPORMATION) | TAG | CROSS-REFERENCED TO THE APPR DEFICIENCY) | OPRIATE | J. J. | |
| - | | | | | | | |
| Y1477 | Continued From page | 2 45 | Y1477 | | | | |
| | | | | | | | |
| | | etician (staff #124), who | | | | | |
| | stated a dietary asses | ssment is conducted for new | | | | | |
| | residents which include | des discussing the resident's | | | | | |
| | | off #124 stated that dietary | | | | | |
| | | ious beliefs are determined | | | | | |
| | | nt. Staff #124 stated that the | | | | | |
| | | | 1 | | | | |
| į į | | any residents with religious | Ì | | | | |
| | • | n the past and is "not aware | | | | | |
| | of any residents with religious preferences at this | | | | | | |
| | moment." Staff #124 stated she completes the | | | | | | |
| | nutrition component of | of the care plan. When | | | | | |
| | asked if she was awa | re of resident #16 Jewish | | | | | |
| | faith and his preferen | ce for a Jewish diet, staff | | | | | |
| | · | as not aware of that." Staff | | | | | |
| | | d update resident #16 care | | | | | |
| | | | : | | | | |
| | plan with his Jewish d | liet preferences. | | | | | |
| | | cted with the resident on | | | | i | |
| | March 11, 2021 at 1:1 | 0 P.M., the resident stated | | | | | |
| | that he is active in the | Jewish faith. | | | | | |
| | An interview was cond | ducted on March 11, 2021 at | | | | | |
| | | N (staff #51), who stated it | | | | | |
| | | t the diet portion of the care | 1 | | | | |
| | | ligious diet preferences. | | | | | |
| | • | | 1 | | | | |
| | | xpectations are that the | | | | | |
| | | manager would have been | | | | | |
| | aware of resident #16 Jewish faith and preferences and honored those beliefs and | | | | | | |
| | | | | | | | |
| | preferences. | | | | | | |
| | The facilitée Compret | nensive Care Plan policy | | | | | |
| | | | | | | | |
| | | 16 stated a comprehensive, | | | | | |
| | person-centered care | | | | | | |
| | | s and timetables to meet the | | | | | |
| | | sychosocial and functional | | | | | |
| | | nd implemented for each | 1 | | | | |
| | resident. The Interdisc | ciplinary Team (IDT), in | | | | | |
| | conjunction with the re | esident and his/her family or | | | | | |
| | | levelone and implements a | 1 | 1 | | ! | |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | |
|---|--|---|---|--|-------------------|-------------------------------|--|
| | | NCI-2643 | B. WING | B. WING | | 03/11/2021 | |
| NAME OF P | ROVIDER OR SUPPLIER | | DRESS, CITY, ST. | · | | | |
| SAPPHIRE OF TUCSON NURSING AND REHAB, LLC TUCSON, | | | MILBER STR AZ 85714 | REET | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION) | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | BE | (X5) COMPLETE DATE | |
| Y1477 | comprehensive, person each resident. The polincludes a member of services staff and other professionals as determined or as requested also included the care incorporate the reside preferences in development of the professional incorporate risk faidentified problems; and | on-centered care plan for slicy included the IDT the food and nutrition er appropriate staff or mined by the resident's diby the resident. The policy planning process will nit's personal and cultural ping the goals of care. The atte identified problem areas actors associated with and will identify the that are responsible for | Y1477 Y1911 | <u>Y1911</u> | | 4/20/2021 | |
| | an administrator shall R9-10-419.2. Respirate provided according to R9-10-419.2.e. The of oxygen liter flow and multiple of the state o | care institution's premises, ensure that: tory care services are an order that includes: xygen concentration or nethod of administration; as evidenced by: s, clinical record review, olicy review, the facility sident (#358) had an order | | What corrective action(s) will be accomplished for those residents fou have been affected by the deficient practice, on both a temporary and permanent basis, including the date to correction will be accomplished? Resident #358 found to be affected. Order obtained 3/12/2021 How will you identify other residents having the potential to be affected by same deficient practice and what corrective action will be taken? The DON and/or designee conducted full house audit for residents on oxygand orders on 3/23/2021. No other residents found to be affected | the the the | | |

| NAME OF PROVIDER OR SUPPLIER SAPPHIRE OF TUCSON NURSING AND REHAB, LLC 200 EAST MILBER STREET TUCSON, AZ 58714 PROVIDERS AGAINANCY STRIBBART OF DEPTCENCISE GRAD-HOPERCINETY WIST OF PRECEDED BY PILL REGULATORY OR LSC IDENTIFYING REFORMATION. Y1911 Continued From page 47 Chronic Obstructive Pulmonary Disease (COPD), encounter for orthopedic aftercare, and heart failure. Review of the care plan initiated March 1, 2021 revealed the resident required coxygen therapy related to COPD. The goal was that the resident would have no signs or symptoms of poor oxygen absorption. Interventions included administering oxygen as prescribed to maintain adequate oxygen aspersor or supplied in the resident or to every an administered oxygen. During an observation conducted on March 2, 2021 at 12:02 P. M., the resident was observed receiving oxygen via nasal cannula. Another observation was conducted of the resident was observed receiving oxygen received receiving oxygen at 12:55 P. M. The resident was observed receiving oxygen and conders for 21 days. Any resident found to be out of compliance will be reported to the DON and/or Designee for immediate correction and re-education to nursing staff | | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | (X2) MULTIPLE CONSTRUCTION A BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|---|-----------|---|--|-----------------|--|---|-------------------------------|--|
| Another observation was conducted on March 2, 2021 at 1:00 P.M. with a Licensed Practical Nurse (LPNVslatf #15). The LPN stated the resident nas an oxygen concentrator. An interview was conducted on March 9, 2021 at 1:00 P.M. with a Licensed Practical Nurse (LPNVslatf #15). The LPN stated the resident nas an order, she would review the hospital orders and conducted or administered was not an order, she would review the hospital orders and conducted that she was unable to find an order to administer oxygen. | | | NCI-2643 | B. WING | B. WNG | | 1 | |
| O(4) D SUMMARY STATEMENT OF DEFICIENCIES PRESTX PROPERTY PROPETTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPETTY PROPERTY | NAME OF P | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, ST | ATE, ZIP CODE | | : | |
| PREFIX (FANCHEDICARY USETS ERECEDED BY PULL REGULATORY OR LSG IDENTIFYING INFORMATION) Y1911 Continued From page 47 Chronic Obstructive Pulmonary Disease (COPD), encounter for orthopedic aftercare, and heart failure. Review of the care plan initiated March 1, 2021 revealed the resident required oxygen therapy related to COPD. The goal was that the resident would have no signs or symptoms of poor oxygen absorption. Interventions included administering oxygen as prescribed to maintain adequate oxygen saturation. However, further review of the clinical record did not reveal an order for the resident to be administered oxygen. During an observation conducted on March 2, 2021 at 12.02 P.M., the resident twas observed receiving oxygen at a.5 liters per minute via nasal cannula. Another observation was conducted of the resident on March 9, 2021 at 12.59 P.M. The resident was observed receiving oxygen at a.5 liters per minute via nasal cannula from an oxygen concentrator. An interview was conducted on March 9, 2021 at 1.00 P.M. with a Licensed Practical Nurse (LPN/staff #15). The LPN stated the resident has COPD and is confused and will frequently remove the oxygen assal cannula. The LPN stated the resident to administeroxygen. | SAPPHIR | E OF TUCSON NURSING | AND REHAB, LLC | | REET | | | |
| PREFIX TAG TAG TAG TAG Continued From page 47 Chronic Obstructive Pulmonary Disease (COPD), encounter for orthopedic aftercare, and heart failure. Review of the care plan initiated March 1, 2021 revealed the resident required oxygen therapy related to COPD. The goal was that the resident would have no signs or symptoms of poor oxygen absorption. Interventions included administering oxygen saturation. However, further review of the clinical record did not reveal an order for the resident to be administered oxygen. During an observation conducted on March 2, 2021 at 12:02 P.M., the resident was observed receiving oxygen was observed receiving oxygen was observed receiving oxygen at 4.5 liters per minute via nasal cannula. Another observation was conducted on March 9, 2021 at 1:05 P.M. with a Licensed Practical Nurse (LPNNstaff #15). The LPN stated the resident has COPD and is confused and will frequently remove the oxygen and order for oxygen and that if there was not an order, she would review the hospital orders and contact the physician for an order. After reviewing the physician's orders, the LPN stated that she was unable to find an order to administer oxygen. | | CHANAGNOT | | 1 | | | | |
| Chronic Obstructive Pulmonary Disease (COPD), encounter for orthopedic aftercare, and heart failure. Review of the care plan initiated March 1, 2021 revealed the resident required oxygen therapy related to COPD. The goal was that the resident would have no signs or symptoms of poor oxygen absorption. Interventions included administering oxygen asturation. However, further review of the clinical record did not reveal an order for the resident to be administered oxygen. During an observation conducted on March 2, 2021 at 12:02 P.M., the resident was observed receiving oxygen via nasal cannula. Another observation was conducted of the resident may observed receiving oxygen at 4.5 liters per minute via nasal cannula from an oxygen concentrator. An interview was conducted on March 9, 2021 at 1:06 P.M. with a Licensed Practical Nurse (LPN/staff #15). The LPN stated the resident has an order for oxygen and that if there was not an order, she would review the hospital orders and contact the physician for an order. After reviewing the physician's orders, the LPN stated that she was unable to find an order to administer oxygen. | PREFIX | (EACH DEFICIENCY | Y MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR | BE COM | PLETE | |
| An interview was conducted on March 10, 2021 at 11:51 A.M. with the LPN Unit Manager (staff | Y1911 | Chronic Obstructive Pencounter for orthope failure. Review of the care plarevealed the resident related to COPD. The would have no signs of absorption. Intervention oxygen as prescribed oxygen saturation. However, further revien to reveal an order for administered oxygen. During an observation 2021 at 12:02 P.M., the receiving oxygen via reactiving oxygen via resident on March 9, 2 resident was observed liters per minute via na oxygen concentrator. An interview was concentrator. An interview was concentrator and interview was concentrator. COPD and is confused the oxygen nasal can resident has an order was not an order, she orders and contact the After reviewing the phystated that she was unadminister oxygen. An interview was concentrator oxygen. | culmonary Disease (COPD), dic aftercare, and heart an initiated March 1, 2021 required oxygen therapy goal was that the resident or symptoms of poor oxygen ons included administering to maintain adequate as which of the clinical record did resident to be a conducted on March 2, he resident was observed has all cannula. It was conducted of the 2021 at 12:59 P.M. The directiving oxygen at 4.5 as all cannula from an an activated on March 9, 2021 at 1958 P.M. Stated the resident has did and will frequently remove hula. The LPN stated the for oxygen and that if there would review the hospital physician for an order. Special of the conducted on March 10, 2021 at 1959 physician for an order to did to the formal order to the conducted on March 10, 2021 at 1959 physician for an order to did to the formal order to the conducted on March 10, 2021 at 1959 physician for an order to the conducted on March 10, 2021 at 1959 physician for an order to the conducted on March 10, 2021 at 1959 physician for an order to the conducted on March 10, 2021 at 1959 physician for an order to the conducted on March 10, 2021 at 1959 physician for an order to the conducted on March 10, 2021 at 1959 physician for an order to the conducted on March 10, 2021 at 1959 physician for an order to the conducted on March 10, 2021 at 1959 physician for an order to the conducted on March 10, 2021 at 1959 physician for an order to the conducted on March 10, 2021 at 1959 physician for an order to the conducted on March 10, 2021 at 1959 physician for an order to the conducted on March 10, 2021 at 1959 physician for an order to the conducted on March 10, 2021 at 1959 physician for an order to the conducted on March 10, 2021 at 1959 physician for an order to the conducted on March 10, 2021 at 1959 physician for an order to the conducted on March 10, 2021 at 1959 physician for an order to the conducted on March 10, 2021 at 1959 physician for an order to the conducted on March 10, 2021 at 1959 physician for an order to the conducted on March 10, 2021 at 1959 ph | Y1911 | What measures will be put into place what systemic changes will you maken ensure that the deficient practice do recur? DON and/or Designee conducted an service to Licensed nurse on oxyger orders completed on 4/3/2021 How will the corrective action(s) be monitored to ensure the deficient pre will not recur, i.e., what quality assure program will be put into place; and to title, or position, of the person responsion implementing/monitoring the corrective action? The DON and/or Designee will audit admits for oxygen and orders for 21 Any resident found to be out of compliance will be reported to the E and/or Designee for immediate corrective action? | e to es not in- actice rance he insible it new days. | | |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION (X A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | |
|---------------|--|---|--|--|-------|-------------------------------|--|
| | | | A. BUILDING: | | | | |
| | | NCI-2643 | B. WNG | | 03/1 | 1/2021 | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, ST | ATE, ZIP CODE | | | |
| SAPPHIR | E OF TUCSON NURSING | AND REHAB, LLC 2900 EAST TUCSON, A | MILBER STR | EET | | | |
| (X4) ID | SUMMARY ST | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | | | |
| PREFIX TAG | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETE DATE | |
| Y1911 | Continued From page | | Y1911 | | | | |
| | #126), who said the re | esident had orders for ital and that the resident | | | | | |
| | | sygen since admission. Staff | | | | | |
| | #126 stated they miss | sed inputting the order for | | | | | |
| | oxygen. | | | | | | |
| | In an interview condu | cted with the Director of | | | | | |
| | Nursing (DON/staff #51) on March 11, 2021 at 3:21 P.M., the DON said the oxygen order for this | | | | | | |
| | | on said the oxygen order for this sed. The DON stated her | | | | | |
| | expectation would be | that if the resident has | | | | | |
| | orders from the hospit | | | | | | |
| | obtained and the care | provided. | | | | | |
| | | ed Oxygen Administration | | | : | | |
| | revealed the purpose | of the procedure is to safe oxygen administration. | | | | | |
| | | ed verifying that there is a | | | İ | | |
| | physician's order for the | he procedure and reviewing | | | I | | |
| | the physician's orders oxygen administration | • • | | | | | |
| | Oxygen administration | • | | Y2159 | | 4/20/2021 | |
| Y2159 | R9-10-421.D.3.a. Med | lication Services | Y2159 | 1223 | | 4,20,2021 | |
| | D0 40 404 5 115 | , , , , , , | | What corrective action(s) will be | | | |
| | | medication is stored at a n, an administrator shall | | accomplished for those residents fou | nd to | | |
| | ensure that: | i, an administrator shan | | have been affected by the deficient practice, on both a temporary and | | | |
| | | | | permanent basis, including the date t | :he | | |
| | | ies and procedures are ted, and implemented to | | correction will be accomplished? | İ | | |
| | | safety of a resident for: | | No residents found to be affected. | | | |
| | D0 40 404 D 0 = 0= | | | 110 residents round to be affected. | | | |
| | R9-10-421.D.3.a. Recinventorving, tracking, | dispensing, and discarding | | How will you identify other residents | | | |
| | medication including e | | | having the potential to be affected by same deficient practice and what | / the | | |
| | | | | corrective action will be taken? | | | |
| | | | | | | | |
| | | | | No residents found to be affected. | | | |

| | T OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLI | E CONSTRUCTION | (X3) DATE SURVEY | |
|--------------------------|---|---|---------------------|---|---|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMPLETED | |
| | | NCI-2643 | B. WING | | 03/11/2021 | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, ST | ATE, ZIP CODE | <u> </u> | |
| | | 2900 EAST | MILBER STR | EET | | |
| SAPPHIR | E OF TUCSON NURSING | AND REHAB, LLC TUCSON, | AZ 85714 | | | |
| (X4) ID PREFIX TAG | PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE COMPLETE | |
| Y2159 | This RULE is not mer Based on observation policy review, the faci policy to ensure expinitest strips were not aversommended temper recommended temper. An observation was controlled in the C-1 hall with Nurse (LPN/staff #138 a.m. An opened vial of beserved, dated opened observed, dated opened observed, dated opened box containing the Nobox containing the Lissicker on it that stated. Continued observation revealed an unopened insulin that had a stick store in refrigerator at Lispro 100 insulin that that stated store in refrigerator at Lispro 100 insulin that that stated store in reservation date of January in the stated store in the reservation date of January in the stated store in the reservation date of January in the stated that the glucom was not in use, that it is store in use, that it is not store potency and may not stated that the glucom was not in use, that it | t as evidenced by: as, staff interviews, and lity failed to implement their ed medications and glucose vailable for use and failed to vere stored at the rature. onducted of the medication ith a Licensed Practical a) on March 3, 2020 at 9:19 of Novolin 70/30 insulin was aled on February 1, 2021 and oro 100 insulin was aled on January 2, 2021. The avolin 70/30 insulin and the appro 100 insulin both had a d "store in refrigerator". The sof the medication cart d box of Novolin 70/30 wer on the box that stated and an unopened box of thad a sticker on the box offrigerator". The medication cart was a box of the strips that had an uary 2, 2021 on it. Ceted with the LPN (staff 11 9:40 a.m., the LPN stated and properly will not maintain work as well. The LPN teter on the medication cart | Y2159 | What measures will be put into place what systemic changes will you make ensure that the deficient practice do recur? DON and/or Designee conducted an service on Medication storage to lice nurses on 3/3/21. How will the corrective action(s) be monitored to ensure the deficient proviil not recur, i.e., what quality assurprogram will be put into place; and title, or position, of the person respot for implementing/monitoring the corrective action? The DON and/or Designee will audi medication carts and storage areas we for expired or missure stored items for 2 days. Any medications found to be compliance will be reported to the D and/or Designee for immediate correand re-education to licensed staff. | e to es not in- ensed actice rance he nsible t all reekly 21 out of ON | |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | E CONSTRUCTION | (X3) DATE S COMPL | |
|--------------------------|---|--|------------------------|---|----------------------|--------------------------|
| | | NCI-2643 | B. WING | | 03/1 | 11/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, STA | ATE, ZIP CODE | | |
| SAPPHIRE | E OF TUCSON NURSING | AND REHAB, LLC 2900 EAST TUCSON, A | MILBER STR AZ 85714 | EET | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETE DATE |
| Y2159 | Nursing (DON/staff #5 11:09 a.m. The DON sare not to be left in the stated the nurses are expired medications a medication cart and gi DON stated that using problem as it may lose properly. The DON als insulin is good for 30 cunopened insulin is to refrigerator. The DON not be any broken glumedication carts. Staff expected to advise the broken item so that it of Review of the facility's Medications, revealed in the facility are store under proper temperation controls. Discontinued drugs or biologicals ar dispensing pharmacy requiring refrigeration | stated expired medications are medication carts. Staff #51 responsible for ensuring all are removed from the iven to her for disposal. The grexitation expired insulin is a series of the its potency and not work so stated that once opened, days. She said that all to be stored in the stated that there should cometers on any fruit #51 stated the nurse is a unit manager of the can be promptly replaced. So policy, Storage of a drugs and biologicals used do in locked compartments ture, light and humidity and the increase of the or destroyed. Medications are stored in a refrigerator or at the nurses' station or | Y2159 | | | |
| Y2301 | R9-10-423.A.1. Food S | Services | Y2301 | <u>Y2301</u> | | 4/20/2021 |
| | R9-10-423.A.1. The n | ninistrator shall ensure that: nursing care institution has a food establishment under | | What corrective action(s) will be accomplished for those residents fou have been affected by the deficient practice, on both a temporary and permanent basis, including the date t correction will be accomplished? No Residents found to be affected. | | |

| | OLIVOINO OLIVIOLO | | | | | |
|-------------------|---------------------------------|---|-----------------|--|-------------|---------------------------------------|
| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPL | E CONSTRUCTION | (X3) DATE S | |
| ANDPLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | A. BUILDING: | | ETED |
| | | | 1 | | | |
| | | NCI-2643 | B. WING | | | |
| | | NCI-2043 | | | 03/1 | 1/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, ST | ATE, ZIP CODE | | |
| | | 2900 FAS | T MILBER STR | PEET | | |
| SAPPHIR | E OF TUCSON NURSING | AND REHAB, LLC | AZ 85714 | | | |
| - | | | 72 007 14 | | | |
| (X4) ID PREFIX | | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL | ID | PROVIDER'S PLAN OF CORRECTION | • | (X5) |
| TAG | | SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR | | COMPLETE DATE |
| | | • | 1 ".0 | DEFICIENCY) | | |
| 340004 | | | | | | · · · · · · · · · · · · · · · · · · · |
| Y2301 | Continued From page | e 51 | Y2301 | How will you identify other resident | e e | |
| | | | 1 | having the potential to be affected by | | |
| | | | | 1 | y tile | |
| | This RULE is not me | t as ouideneed by: | | same deficient practice and what | | |
| | Based on observation | | 1 | corrective action will be taken? | | |
| | | n sheet, and review of policy | | | | |
| | | | | No Residents found to be affected. | | |
| | | acility failed to ensure that quirements were followed | | | | |
| | | | | What measures will be put into place | e or | |
| 1 1 | | uaternary sanitizing solution | | what systemic changes will you make | e to | |
| | was maintained at the | required level. | | ensure that the deficient practice do | es not | |
| | <u></u> | | | recur? | | |
| | Findings include: | | | 1 | | |
| | | | 1 | Administrator and/or Designee cond | lucted | |
| | | conducted on March 1, | | an in-service to dietary staff on | iucicu | |
| | | ne Kitchen Manager (staff | | | | |
| | | o test the concentration | | sanitization bucket completed on | | |
| | | ucket that was on a coffee | | 3/31/2021. | | |
| | | e test results revealed the | | | | |
| | | n concentration level was | | How will the corrective action(s) be | | į |
| | below the minimum le | vel of 200 parts per million | İ | monitored to ensure the deficient pr | actice | i |
| | (ppm). | | | will not recur, i.e., what quality assur | rance | |
| . | | | 1 | program will be put into place; and t | he | ŀ |
| | An interview was cond | | | title, or position, of the person respo | nsible | ļ |
| | following this observat | tion with staff #173 who said | 1 | for implementing/monitoring the | | l |
| | the bucket solution ne | eded to be changed out | 1 | corrective action? | 1 | l |
| | now. He stated that th | e sanitation buckets | 1 | | | l |
| | solution was changed | out every 4 hours. | 1 | The Administrator and/or Designee | will | l |
| | | | 1 | audit all sanitization buckets for pro | | ļ |
| | | vas conducted on March 3, | Į. | levels daily for 21 days. Any bucket | | ł |
| | 2021 at 10:37 A.M. Th | ne Kitchen Manager (staff | 1 | | | ł |
| | #173) was observed to | o test the sanitizing solution | | found to be out of compliance will b | | Ì |
| | in a sanitation bucket | that was on a coffee cart in | | reported to the Administrator and/or | | į |
| | the kitchen. The result | of the test was 100 ppm. | | Designee for immediate correction a | na | į |
| | | | | re-education of staff. | | ŀ |
| | Following this observa | ition, an interview was | | | | ŀ |
| | | y with staff #173 who said | | | | l |
| | | eded to be changed out. He | | | | l |
| | changed the solution i | | | | | l |
| | | t which was observed to be | | | | l |
| : | 200 ppm. | | | | | |
| | | | | | | l |

| | CENOING SERVICES | | | | | |
|---------------|------------------------------------|--|------------------|---|-------------|--------------|
| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | | | SURVEY |
| | or our content | IDEATH IONHOR ROBUST. | A BUILDING: | A. BUILDING: | | LETED |
| | | | | | | |
| | | NCI-2643 | B. WING | | 03/ | 11/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | ATE, ZIP CODE | | |
| ^ 4 3 5 111 5 | :: | 2900 EAS | ST MILBER STR | REET | | |
| SAPPHIK | E OF TUCSON NURSING | AND REHAB, LLC TUCSON | , AZ 85714 | | | |
| (X4) ID | SUMMARY ST | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTI | ON | (X5) |
| PREFIX | | Y MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOUL | D BE | COMPLETE |
| TAG | REGULATORY OR I | LSC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPROX DEFICIENCY) | PRIATE | DATE |
| | | | | DE TOLETO, | | |
| Y2301 | Continued From page | 52 | Y2301 | | | |
| | An interview was con- | ducted on March 8, 2021 at | | | | 1 |
| | | hen Manager (staff #173), | | | | |
| | | tation buckets, the policy is | 1 | | | |
| | | anged every 4 hours. Staff | | | | |
| i l | 1 | that the sanitizing solution | 1 | | | Í |
| | | ing the coffee cart, and that | ŀ | | | |
| | | level of the other bucket | | | | |
| : 1 | | active elements evaporate | | | | |
| | in warm water. Staff# | f173 stated that upon | | | | |
| | | ions, he should have left the | | | | |
| | test strip in the sanitiz | ring solution for two minutes | ł | | | |
| | and that he did not be | | | | | |
| | results were quick. Th | ne Kitchen Manager stated | | | | |
| | that the facility uses th | he quaternary sanitizer and | İ | | | |
| | | level is supposed to be | | | | |
| | between 200 and 400 | ppm. | | | | |
| | A - into-rious woo con- | | | | | |
| | | ducted on March 11, 2021 at | | | | |
| | | ministrator (staff #217), who | | | | |
| | | have to make a subjective | | | | |
| | Staff #217 stated that | nge the sanitizing solution. | | | | |
| | | rs having to change and | F | | | |
| | | ket solution. Staff #217 said | | | | |
| | | ger had told him the policy | | | | |
| | | nitizing solution every four | | | | |
| | | ator stated that he was | | | | |
| | | tizing solution had to be | | | | |
| | maintained at a specif | | | | | |
| | • | | | | | |
| | The information sheet | | | | | |
| | Ammonium revealed t | that the best way to use | | | | |
| | | n as a routine sanitizer is to | | | | |
| | really understand wha | at is needed in terms of | | | | |
| | | nat when used on food | | | | |
| | | the quaternary solution | | | | |
| | | um of 200 parts per million | İ | | | |
| | (ppm). | | | | | |
| | A 2 100 1 11 11 11 | | | | | |
| | A facility's policy and p | procedure manual titled | | | | |

| ADI IS LI | CENSING SERVICES | Y | , | | | |
|---|--|--|-----------------|--|------------------|--|
| | FOF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLI | E CONSTRUCTION | (X3) DATE SURVEY | |
| ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | IDENTIFICATION NOMBER. | A. BUILDING: | | COMPLETED | |
| | | | | | | |
| | | NCI-2643 | B. WING | | 03/11/2021 | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET AD | ORESS, CITY, ST | ATE ZIP CODE | | |
| | | | MILBER STR | | | |
| SAPPHIRI | E OF TUCSON NURSING | AND REHAB, LLC TUCSON, | | ACE I | | |
| | 0.44.54.54.65 | <u></u> | T | | | |
| (X4) ID PREFIX | | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD | | |
| TAG | • | SC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPROPR | | |
| _ | | | <u> </u> | DEFICIENCY) | | |
| Y2301 | Continued From page | ÷ 53 | Y2301 | | | |
| | | | | | | |
| | | r of Food and Nutrition | | | | |
| | Services' Responsibili | | | | | |
| | for providing safe food | utrition will be responsible | | | | |
| | included that sanitary | | | | | |
| | - | d storage, preparation and | | | | |
| | | at employees will follow | | | | |
| | | anitizing instructions for all | | | | |
| | kitchen equipment. | | | | | |
| | • • | | | | | |
| Y2349 | R9-10-423.B.6. Food | Services | Y2349 | | | |
| | NO-10-120.D.O. 1 000 | CCIVICCS | 12010 | | | |
| | R9-10-423.B. A regis | tered dietitian or director of | | <u>Y2349</u> | 4/20/2021 | |
| | food services shall en | | | | | |
| | | | | What corrective action(s) will be | | |
| | R9-10-423.B.6. Reco | mmendations and | | accomplished for those residents fou | nd to | |
| | preferences are reque | ested from a resident or the | | have been affected by the deficient | | |
| | resident's representat | ive for meal planning; | | practice, on both a temporary and | | |
| | | | | permanent basis, including the date t | :he | |
| | | | | correction will be accomplished? | | |
| | T | | | | | |
| | This RULE is not met | | | Resident #16 affected by practice. | | |
| | Based on observation interviews, clinical rec | | | | | |
| | review, the facility fails | | | How will you identify other residents | | |
| | | d from one resident (#16) | | having the potential to be affected by | / the | |
| | was implemented for i | • • | | same deficient practice and what | | |
| | was implemented for i | | | corrective action will be taken? | | |
| | Findings include: | | | | | |
| | • | | | The DON and/or designee conducted | | |
| | Resident #16 was adn | nitted to the facility on June |] | medical record review for all residen | its on | |
| | | ted on November 20, 2020 | | psychotropics on 4/5/2021 no other | | |
| | with diagnoses that in | | | residents found to be affected | | |
| | | e 2 diabetes mellitus with | | SAPL - A | | |
| | hyperglycemia. | | | What measures will be put into place | | |
| | Davien of the section | t information for a start | | what systemic changes will you make | | |
| | | t information face sheet | | ensure that the deficient practice do | s not | |
| | revealed Jewish as the | e residents religion. | | recur? | | |
| | | | | | I | |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | E CONSTRUCTION | (X3) DATE S | |
|--------------------------|---|---|---------------------|---|---|--------------------------|
| _ | | NCI-2643 | B. WNG | B. WNG 03/1 | | 11/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, ST | ATE ZIP CODE | | |
| | | 2900 FAS | T MILBER STE | | | |
| SAPPHIR | E OF TUCSON NURSING | AND REHAB, LLC | 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETE DATE |
| Y2349 | A review of the clinical nutritional assessment the resident's meal planespect Jewish prefer with meats. The asseresident food allergies fish) - hives and diffical strawberries - hives. The completed by the diet of the baseling 2020 revealed resident seafood (fish, shellfish not include the resident of no pork or dairy with the quarterly Minimum assessment dated Dea Brief Interview for More of 13, indicating the resident on the side of the bed front of him. The beds have a closed breakfalorange juice container milk were on the beds unopened food contain was observed on beds allergies PORK, FISH below allergies was worth mercial means the side of the resident's bed. | Il record revealed an initial of dated June 16, 2020 that an would be adjusted to ences: no pork, no dairy assment included the swere seafood (shellfish, alty breathing, and The assessment was ician (staff #124). The care plan dated June 16, at #16 had allergies to an and strawberries but did not's Jewish diet preference in meat. The Data Set (MDS) comber 10, 2020 revealed ental Status (BIMS) score asident had intact cognition. The was observed sitting with the bedside table in ide table was observed to st tray on it. An empty and an unopened carton of ide table next to the mer. A food preference card side table which read, STRAWBERRIES and ritten NO PORK. A d on the side table next to | Y2349 | DON and/or Designee conducted an service on Psychotropic PRN orders licensed nurses. How will the corrective action(s) be monitored to ensure the deficient provided in the program will be put into place; and the title, or position, of the person response of implementing/monitoring the corrective action? The DON and/or Designee will audit orders daily of psychotropics for PR for 21 days. Any psychotropic found be out of compliance will be reported the DON and/or Designee for immediate correction and re-education to licensistaff. | actice rance he nsible t all N use d to d to diate | |
| | Resident #16 stated h | | | | | |

| | CENSING SERVICES | | | | |
|----------------------|--------------------------|--|-------------------|--|---------------------------------------|
| | T OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE SURVEY |
| AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER: | A BUILDING: | | COMPLETED |
| | | 1 | | · · · · · · · · · · · · · · · · · · · | |
| | | NOI 2642 | B. WNG | | |
| | | NCI-2643 | | | 03/11/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, STA | TE. ZIP CODE | |
| | | 2900 FA | ST MILBER STR | | |
| SAPPHIR | E OF TUCSON NURSING | AND REHAB. LLC | I, AZ 85714 | | |
| 1 | | | | | · · · · · · · · · · · · · · · · · · · |
| (X4) ID PREFIX | | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL | ID. | PROVIDER'S PLAN OF CORRECTION | 1 (***) |
| TAG | I . | SC IDENTIFYING INFORMATION) | PREFIX | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR | |
| | | ŕ | | DEFICIENCY) | |
| \\\(\text{cos}\) (0) | | | | | |
| Y2349 | Continued From page | 55 | Y2349 | | |
| | served meals that have | ve pork and diet drinks on | | | |
| | the meal tray. | | | | |
| | and modification | | | | |
| | Another meal observa | ation was conducted of | | | |
| | | h 4, 2021 at 12:42 P.M. The | 1 | | |
| | | consisted of a carton of milk, | 1 | | |
| | | iner of cottage cheese, | | | |
| ! | | eans, and mashed yams. | | | |
| | Resident #16 was obs | | | | |
| 1 | | | | | |
| | | ainer and closing it and | | | |
| | pushing it aside. | | | | |
| | An intentiew was cond | ducted on March 4, 2021 at | | | |
| i | | ent #16, who that stated he | | | |
| İ | | ause he is Jewish. The | | | |
| | | e does not have an allergy | | | |
| | | | | | |
| | | The resident stated that he | | | |
| | says he is allergic bed | • | | | |
| | | at he is Jewish. He stated | | | ļ |
| | | ed pork and fish while in the | | | |
| | - | stated "I hate fish." Resident | | | |
| | | he is served a tray with pork | | |] |
| | | another tray. The resident | | | |
| | | vait for the new tray and | | | |
| | that often a new tray is | s not brought to him. |] | | |
| | In an interview conduc | stad with a Licensed | | | |
| | | | | | |
| | | staff #81) on March 4, 2021 | | | |
| | | N stated dietary honors | | | |
| | | ences. Staff #81 stated that | | | |
| | | mitted, dietary is notified | | | |
| | | a nutritional assessment | | | |
| | which includes dietary | preterences. | | | |
| | An intension was seen | funtad on March 4, 2024 of | | | |
| | | fucted on March 4, 2021 at | | | |
| | | tician (staff #124). The | | | |
| | dietician stated a dieta | | | | |
| : | | ent that is a new admission. | | | |
| | | kitchen manager will visit | | | |
| | the resident on admiss | sion to discuss tood | 1 1 | | i |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLI A. BUILDING: | E CONSTRUCTION | (X3) DATE S | |
|--------------------------|---|--|-------------------------------|--|-------------|--------------------------|
| | | NCI-2643 | B. WING | The state of the s | 03/ | 11/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, ST | ATE, ZIP CODE | | |
| CADDUID | E OF THOSON MIDRING | 2000 EAST | MILBER STR | | | |
| SAFFRIN | E OF TUCSON NURSING | 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETE DATE |
| Y2349 | assessment based on kitchen manager's rec stated she will visit the her assessment indicar manager recommends that dietary preference obtained by visits to the stated that the facility with religious preferences that she is "not aware religious preferences stated that per resider cold cereal and a banacheese with fruit for ludinner. When asked if #16 Jewish faith and hidiet, staff #124 respontat." During an interview waresident on March 11, resident stated that he faith. Resident #16 stated a dairy with meat. Resident his meal if there is | dietician will conduct an admitting notes and the commendations. Staff #124 e newly admitted resident if ates a visit or if the kitchen is she visit. Staff #124 stated es and religious beliefs are ne resident. Staff #124 has not had many residents not requests in the past and of any residents with at this moment." Staff #124 hat #16 request, he is served ana for breakfast, cottage inch, and a chef salad for she was aware of resident nis preference for a Jewish nided "I was not aware of | Y2349 | DEFICIENCI | | |
| | milk and meat on his fi preference and is not a Resident #16 stated h | ood tray and that is not his allowed on the Jewish diet. | | | | |
| | Manager (staff #173) of P.M. The Kitchen Man the initial admission in | ducted with the Kitchen on March 11, 2021 at 1:40 hager stated he conducts terview regarding diet with admissions. Staff #173 | | | | |

| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | CONSTRUCTION | (X3) DATE S COMPL | |
|--------------------------|--|---|---------------------|---|----------------------|--------------------------|
| | | NCI-2643 | B. WNG 03/11 | | 1/2021 | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, STA | TE, ZIP CODE | | |
| SAPPHIR | E OF TUCSON NURSING | AND REHAB, LLC 2900 EAST TUCSON, A | MILBER STR | EET | | |
| (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 APPROPR DEFICIENCY) | BE | (X5) COMPLETE DATE |
| Y2349 | food allergies at the tit assessment. Staff #1' a diet plan based on the Kitchen Manager accommodate some that he does not have religious diets or to have religious diets or to have religious diets or to have religious diets or to have religious diets or to have religious diets or to have religious diets or to have religious diets or to have religious diets or to have religious diets or to have religious diets or to have reference because that milk or dairy serv on the Jewish faith die stated he was unawar with meat preference preference. During an interview or Nursing (DON/staff #5 3:22 P.M., the DON sthat the dietician and have been aware of repreferences and honopreferences. The facility Meal Plan based on the facility's should reflect the religious religious plants. | asks food preferences and me of the initial 73 stated he will then design the resident's preferences. It stated that he does religious diets requests but the capability to cover all ave a kosher kitchen. Staff #16 told him he had a no use he was Jewish. He also 16 stated he was not sh faith. Staff #173 stated ed with meat is not allowed et. The Kitchen Manager re of resident #16 no dairy or his Jewish diet conducted with the Director of 51) on March 11, 2021 at tated her expectations are Kitchen Manager would esident #16 Jewish faith and ored those beliefs and thing Policy stated that reasonable efforts, menus gious, cultural, and ethnic on served, as well as input | Y2349 | | | |



Notice of Inspection Rights

| Facility/Agency Name: Sa | pphire Of Tucson Nursing A | | |
|--|---|--|---|
| Address: 2900 East Milbe | r Street | City: Tucson | Zip: 85714 |
| Facility I.D.#: LTC0053 | License #: NCI-2643 | Medicare #: 035099 | Date of Inspection: March 1, 2021 |
| Survey Event ID: Q5L61 | | | |
| Inspector/Team Coordinate | or: Johnna High | | |
| Accompanied By: Carey S | exton, Sallie Martinez, Lisa | Andrin-Mazur, Michael Stanton | n, Lisa Bashford, Samantha Potter |
| | | | |
| 20-11-12-12-12-12-12-12-12-12-12-12-12-12- | | LONG TERM CARE LIC | ENSING |
| This inspection is conducted | under the authority of: | | |
| activities during the insp personnel records, inter- | pection may include, but are no views with residents/patients/cl | and 4, and Arizona Administrative at limited to, a facility premise inspe- lients, family and staff, and review of | Code (A.A.C.), Title 9, Chapter 10. Some of the action, review and/or copying of records, including of services offered. |
| | nce with health care institution | requirements pursuant to the above | A.R.S. and A.A.C. |
| Conduct a complaiNo fees are charged for | | | |
| 4. An authorized represent | ative of this facility may accom | npany the inspector(s) during the ins | spection conducted on these premises, except during |
| any confidential intervie | · W | | uring the inspection in those cases where the |
| agency has authority to | take original documents. | | |
| residents/patients/client included in the inspection | s may be conducted privately. I on report and each person who | Each person interviewed will be inf | issue. Additionally, interviews with staff, family or ormed that statements made by the person may be ecorded will be informed that the conversation is |
| Deficiencies (SOD) for | e inspection the inspector(s) wi mally notifying you of the find | ings will be provided within 30 wor | ormally disclose their findings. A Statement of thing days. You will be afforded an opportunity to inst the license. |
| 8. You have an opportunit | y to dispute any findings of not he SOD is mailed to you. | n-compliance inrough an informal i | Dispute Resolution (IDR). Details of the IDR process |
| 9. If you have questions re Arizona 85007-3242, P resolve with the Bureau | egarding this inspection, you m Phone: (602) 364-2675, FAX: (1 or the Division, you may cont | (602) 324-0993, E-Mail: Diane.Eck | Chief, at 150 N. 18th Ave., Suite 440, Phoenix, les@azdhs.gov. If you have an issue that you cannot tens' Aide, 7878 N. 16th St., Suite 235 Phoenix AZ |
| 10. Your administrative head in A.R.S. §12-901 et se | aring rights are found at A.R.S. | § 41-1092 et seq., and rights relati | ng to appeal of a final agency decision can be found |
| Services (ADHS) employee inspection and due process proceed with the inspection. | rights as listed. I understand | above Notice of Inspection Rights that while I have the right to decli | indicating that they are Arizona Department of Health in I have read the disclosures and am notified of my ne to sign this form, the ADHS representative(s) may |
| Administrator/Director/Ager | ncy Representative Signature | Date |); t |
| □ Administrator/I | | e refused to sign this form. or authorized on-site representativ | e is not present. |
| Inspector/Team Coordinator | Signature: | Dat | će: |
| | ministrator/Director/Agency R | epresentative | |
| | | | |

QUALITY RATING CERTIFICATE



ARIZONA DEPARTMENT OF HEALTH SERVICES NURSING CARE INSTITUTION

Issued To: Sapphire of Tueson Nursing and Rehab

The above named facility has met licensure requirements, has been licensed for one year or more and, therefore, has received the following quality rating as required by R9-10-919.

| COMPONENTS | CRITERIA MET | |
|---------------------------------------|-----------------|----|
| | Yes | No |
| I. Nursing Services | 20 | 5 |
| II. Resident Rights | 23 | 2 |
| III. Administration | 24 | ./ |
| IV. Environment and Infection Control | 13 | 2 |
| V. Food Services | 9 | / |
| TOTAL CRITERIA MET | 89 | 11 |

| | QUALITY PERFORMANCE SCALE | |
|------|---------------------------|--|
| "A" | | |
| "B" | | |
| "C" | | |
| "D" | | |
| "A": | 90 to 100 points | |
| "B": | 80 to 89 points | |
| "C": | 70 to 79 points | |
| "D": | 69 or fewer points | |

| License Effec | ctive: | | |
|---------------|--------|-----|----------------|
| From: | | То: | |
| Issued: | | | Recommended By |
| Number: | NCI- | | |

Quality Rating Evaluation

| Facility: Sapphire of Tucson Nrsgothalphone: | | | |
|---|------|-----------------|------------|
| Address: | | | |
| Survey Date: Contact Person: | | | |
| Nursing Services: | | | |
| Criteria: | Pts. | Criteria YES | Met? NO |
| The nursing care institution is implementing a system that ensures residents are provided nursing services to maintain the resident's highest practicable physical, mental, and psychosocial well-being according to the resident's comprehensive assessment and care plan. | 15 | 10 | 5 |
| The nursing care institution ensures that each resident is free from medication errors that resulted in actual harm. | 5 | 5 | Ø |
| The nursing care institution ensures the resident's representative is notified and the resident's attending physician is consulted if a resident has a significant change in condition or if the resident is in an incident that requires medical services. | 5 | 5 | 8 |
| Points Yes 20 Points No 5 Comments: | | | |

Resident Rights:

Criteria Met?
Criteria:
Pts. YES NO

| The nursing care institution is implementing a system that ensures a resident's privacy needs are met. | 10 | 10 | Q |
|---|----|----|---|
| The nursing care institution ensures that a resident is free from physical and chemical restraints for purposes other than to treat the resident's medical condition. | 10 | 10 | Ø |
| The nursing care institution ensures that a resident or the resident's representative is allowed to participate in the planning of, or decisions concerning treatment including the right to refuse treatment and to formulate a health care directive. | 5 | 3 | 2 |

| Points | Yes | <u> 23</u> | _ |
|--------|-----|------------|---|
| | | | |

Points No ________

Comments:

Administration:

Criteria:

Criteria Met?
Pts. YES NO

| The nursing care institution has no repeat deficiencies that resulted in actual harm or immediate jeopardy to residents that were cited during the last survey or other survey or complaint investigation conducted between the last survey and the current survey. | 10 | 10 | ф |
|---|----|----|------------|
| The nursing care institution is implementing a system to prevent abuse of a resident and misappropriation of resident property, investigate each allegation of abuse of a resident and misappropriation of resident's property, and report each allegation of abuse of a resident and misappropriation of resident's property to the Office of Long Term Care Licensure and as required by A.R.S. § 46-454. | 5 | 5 | φ |
| The nursing care institution is implementing a quality management program that addresses nursing care institution services provided to residents, resident complaints, and resident concerns, and documents actions taken for response, resolution, or correction of issues about nursing care institution services provided to residents, resident complaints, and resident concerns. | 5 | 5 | Ф |
| The nursing care institution is implementing a system to provide social services and a program of ongoing recreational activities to meet the resident's needs based on the resident's comprehensive assessment. | 1 | 1 | Ø |
| The nursing care institution is implementing a system to ensure that records documenting freedom from infectious pulmonary tuberculosis are maintained for each personnel member, volunteer, and resident. | 1 | / | \Diamond |
| The nursing care institution is implementing a system to ensure that a resident is free from unnecessary drugs. | 2 | 1 | |
| The nursing care institution is implementing a system to ensure a personnel member attends in-service education according to policies and procedures. | 1 | / | \$ |

| Points Yes | 24 |
|------------|----|
| Points No | 1 |

Comments:

Environment and Infection Control:

| Criteria: | Pts. | Criteria YES | Met? NO |
|--|------|-----------------|------------|
| The nursing care institution environment is free from a condition or situation within the nursing care institution's control that may cause a resident injury. | 5 | 5 | Ø |
| The nursing care institution establishes and maintains a pest control program. | 1 | 1 | 4 |
| The nursing care institution develops a written disaster plan that includes procedures for protecting the health and safety of residents. | 1 | 1 | Ф |
| The nursing care institution ensures orientation to the disaster plan for each staff member is completed within the first scheduled week of employment. | 1 | 1 | \$ |
| The nursing care institution maintains a clean and sanitary environment. | 1 | 11 | Q |
| The nursing care institution is implementing a system to prevent and control | _ | 2 | 1 |

An employee washes hands after each direct resident contact or where hand

washing is indicated to prevent the spread of infection.

5

1

| Points Yes <u>/ ろ</u> | _ |
|-----------------------|---|
| Points No | _ |

Comments:

infection.

Food Services:

Criteria:

Criteria Met?
Pts. YES NO

| The nursing care institution complies with 9 A.A.C. 8, Article 1, for food preparation, storage and handling as evidenced by a current food establishment license | 1 | 1 | Ф |
|---|---|---|---|
| The nursing care institution provides each resident with food that meets the resident's needs as specified in the resident's comprehensive assessment and care plan. | 3 | 3 | ф |
| The nursing care institution obtains input from each resident or the resident's representative and implements recommendations for meal planning and food choices consistent with the resident's dietary needs | 2 | 1 | / |
| The nursing care institution provides assistance to a resident who needs help in eating so that the individual's nutritional, physical, and social needs are met. | 2 | 2 | Φ |
| The nursing care institution prepares menus at least one week in advance, conspicuously posts each menu, and adheres to each planned menu unless an uncontrollable situation such as food spoilage or non-delivery of a specified food requires substitution. | 1 | 1 | Ф |
| The nursing care institution provides food substitution of similar nutritive value for residents who refuse the food served or who request a substitution. | 1 | 1 | ф |

| Points Yes | 9 |
|------------|---|
| Points No | |

Comments: