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

ADHS

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	
	Yes	No
I. Nursing Services	20	5
II. Resident Rights	23	2
III. Administration	24	1
IV. Environment and Infection Control	13	2
V. Food Services	9	1
TOTAL CRITERIA MET	89	11

QUALITY PERFORMANCE SCALE	
"A" Excellent	
"B"	X
"C"	
"D"	
"A" 90-100 Points "B" 89-80 Points "C" 70-79 Points "D" 69 or fewer Points	

License Effective

From: March 11, 2021

Issued: April 1, 2021

Number: NCI-2643

Recommended By: Diane Eckles

Issued By

Assistant Director

TO BE FRAMED AND DISPLAYED IN A CONSPICUOUS PLACE

PIMA COUNTY
HEALTH DEPARTMENT

FOOD SAFETY INSPECTION REPORT

Page 1/4

As Governed by Pima County Code 8.08 3950 S. Country Club Rd, Ste 2301 Tucson AZ 85714 Phone 520-724-7908, Fax 520-724-9597	Number of Priority/Priority Foundation Violations	4	Date 01/24/2020 Time in 10:29 AM Time out 12:55 PM
	Number of Core Violations	1	

Establishment	Address	Rating	Purpose of Inspection	Est. Type and Risk Category
SAPPHIRE OF TUCSON NURSING & REHAB	2900 E MILBER ST TUCSON AZ 85714	Educational	Standard Frequency Inspection - Educational	Class 4 Institutional Food Operations Less than 2500sqft (4000C)
Permit# 3180926	Permit Holder SAPPHIRE OF TUCSON PROPERTIES LLC			

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

IN = in compliance OUT = not in compliance N/O = not observed N/A = not applicable COS = corrected on-site during inspection R = repeat violation

Risk factors are food preparation practices and employees behaviors most commonly reported to the Centers for Disease Control and Prevention as contributing factors in foodborne illness outbreaks.

Public health interventions are control measures to prevent foodborne illness or injury

Compliance Status		COS	R
Supervision			
01. In	PIC present, demonstrates knowledge, and performs duties	☐	☐
02. In	Certified Food Protection Manager	☐	☐
Employee Health			
03. In	Management and food employee knowledge, and conditional employee; Knowledge, responsibility and reporting	☐	☐
04. In	Proper use of restrictions and exclusions	☐	☐
05. In	Clean-up of Vomiting and Diarrheal Events	☐	☐
Good Hygienic Practices			
06. N/O	Proper eating, tasting, drinking, or tobacco use	☐	☐
07. In	No discharge from eyes, nose, and mouth	☐	☐
Preventing Contamination by Hands			
08. In	Hands clean and properly washed	☐	☐
09. In	No bare hand contact with RTE foods or a pre-approved alternative procedure properly followed	☐	☐
10. Out	Adequate handwashing sinks, properly supplied and accessible	☑	☐
Approved Source			
11. In	Food obtained from approved source	☐	☐
12. N/O	Food received at proper temperature	☐	☐
13. In	Food in good condition, safe, and unadulterated	☐	☐
14. N/A	Required records available: shellstock tags, parasite destruction	☐	☐
Protection from Contamination			
15. In	Food separated and protected	☐	☐
16. Out	Food-contact surfaces: cleaned and sanitized	☑	☐
17. In	Proper disposition of returned, previously served, reconditioned, and unsafe food	☐	☐
Time Temperature Control for Safety Food (TCS Food)			
18. N/O	Proper cooking time and temperatures	☐	☐
19. N/O	Proper reheating procedures for hot holding	☐	☐
20. N/O	Proper cooling time and temperatures	☐	☐
21. Out	Proper hot holding temperatures	☑	☐
22. In	Proper cold holding temperatures	☐	☐
23. In	Proper date marking and disposition	☐	☐
24. N/A	Time as a Public Health Control: procedures and records	☐	☐
Consumer Advisory			
25. N/A	Consumer advisory provided for raw or undercooked foods	☐	☐
Highly Susceptible Populations			
26. In	Pasteurized foods used; prohibited foods not offered	☐	☐
Food/Color Additives and Toxic Substances			
27. N/A	Food additives: approved and properly used	☐	☐
28. In	Toxic substances properly identified, stored, and used; held for retail sale, properly stored	☐	☐
Conformance with Approved Procedures			
29. N/A	Compliance with variance, specialized process, reduced oxygen packaging criteria or HACCP plan	☐	☐

PIMA COUNTY
HEALTH DEPARTMENT

FOOD SAFETY INSPECTION REPORT

As Governed by Pima County Code 8.08 3950 S. Country Club Rd, Ste 2301 Tucson AZ 85714 Phone 520-724-7908, Fax 520-724-9597	Permit# 3180926	Date 01/24/2020

Establishment	Address
SAPPHIRE OF TUCSON NURSING & REHAB	2900 E MILBER STTUCSON AZ 85714

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the introduction of pathogens, chemicals, and physical objects into foods.

IN = in compliance OUT = not in compliance N/O = not observed N/A = not applicable COS = corrected on-site during inspection R = repeat violation

Compliance Status			COS	R
Safe Food and Water				
30. In	Pasteurized eggs used used where required		☐	☐
31. In	Water and ice from approved source		☐	☐
32. N/A	Variance obtained for specialized processing methods		☐	☐
Food Temperature Control				
33. In	Proper cooling methods used; adequate equipment for temperature control		☐	☐
34. N/O	Plant food properly cooked for hot holding		☐	☐
35. N/O	Approved thawing methods used		☐	☐
36. In	Thermometers provided and accurate		☐	☐
Food Identification				
37. In	Food properly labeled; original container		☐	☐
Prevention of Food Contamination				
38. In	Insects, rodents, and animals not present		☐	☐
39. In	Contamination prevented during food preparation, storage, and display		☐	☐
40. In	Personal cleanliness		☐	☐
41. In	Wiping cloths; properly used and stored		☐	☐
42. N/O	Washing fruits & vegetables		☐	☐
Proper Use of Utensils				
43. In	In-use utensils; properly stored		☐	☐
44. In	Utensils, equipment & linens; properly stored, dried, & handled		☐	☐
45. In	Single-use/single-service articles; properly stored, used		☐	☐
46. In	Gloves used properly		☐	☐
Utensils, Equipment and Vending				
47. In	Food and non-food-contact surfaces cleanable, properly designed, constructed and used		☐	☐
48. In	Warewashing facilities, installed, maintained, used, test strips		☐	☐
49. In	Non-food-contact surfaces clean		☐	☐
Physical Facilities				
50. In	Hot and cold water available; adequate pressure		☐	☐
51. In	Plumbing installed; proper backflow devices		☐	☐
52. In	Sewage and waste water properly disposed		☐	☐
53. In	Toilet facilities: properly constructed, supplied, clean		☐	☐
54. In	Garbage/refuse properly disposed; facilities maintained		☐	☐
55. Out	Physical facilities installed, maintained, and clean		☐	☐
56. In	Adequate ventilation and lighting; designated areas used		☐	☐
Smoke Free				
57. In	Complies with Smoke Free Arizona 36-601.01		☐	☐
Pima County Code for Mobile Food Establishments ONLY				
58. N/A	A1. Exterior		☐	☐
59. N/A	A2. Interior		☐	☐
60. N/A	B. Additional operating permit requirements		☐	☐
61. N/A	C. Operations		☐	☐
62. N/A	D. Commissary		☐	☐

PIMA COUNTY
HEALTH DEPARTMENT

FOOD SAFETY INSPECTION REPORT

As Governed by Pima County Code 8.08 3950 S. Country Club Rd, Ste 2301 Tucson AZ 85714 Phone 520-724-7908, Fax 520-724-9597	Permit# 3180926	Date 01/24/2020

Establishment	Address
SAPPHIRE OF TUCSON NURSING & REHAB	2900 E MILBER STTUCSON AZ 85714

TEMPERATURE OBSERVATIONS

Item/Location	Temperature in Fahrenheit	Item/Location	Temperature in Fahrenheit
RI salad	40	RI cheese	40
Iced cut tomatoes	40	Iced lettuce cut	40
HH soup	157	HH hamburger	147
HH quesadilla	158	WI milk	40
WI salad mix	37	WI cheese	37
WI ham	32	WI lettuce	37
RI lettuce cut	40		

OBSERVATIONS AND CORRECTIVE ACTIONS

Item P /Pf/ C — Violations cited in this report must be corrected in the frames below as indicated. — Correction Date

10 Priority Foundation

Observations: Hand washing sink by the ware washing area had no supply of paper towels for employees use.

6-301.12 Each HANDWASHING SINK or group of adjacent HANDWASHING SINKS shall be provided with: (A) Individual, disposable towels;

Corrective Actions: PIC provided a roll of disposable paper towels. PIC mentioned that paper towel dispenser will be installed soon.

16 Priority Foundation

Observations: Observed a rusted shelving unit inside the WI refrigerator. Observed some food debris on the the shelving unit inside the WI.

4-601.11 (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch.

Corrective Actions: PIC had shelving unit replaced during the inspections. PIC had employee start cleaning the shelving units inside the WI.

16 Priority

Observations: Hot temperature sanitizer had to be cycled 3 times in order to reach a utensil surface temperature of 160F; first attempt 146, second attempt 154, third attempt 16.60F.

4-703.11 After being cleaned, EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be SANITIZED in: (B) Hot water mechanical operations by being cycled through EQUIPMENT that is set up as specified under §§ 4-501.15, 4-501.112, and 4-501.113 and achieving a UTENSIL surface temperature of 71°C (160°F) as measured by an irreversible registering temperature indicator;

Corrective Actions: PIC called Ecolab technician, technician arrived during the inspection. Ensure that high temperature sanitize machine meets and maintains a utensil surface temperature of 160F before sanitizing utensils and equipment. Utensils and equipment may also be sanitized in the 3-compartment sink using a chemical sanitizer.

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 §3-501.19, and except as specified under ¶ (B) and in ¶ (C) of this section,

PIMA COUNTY
HEALTH DEPARTMENT

FOOD SAFETY INSPECTION REPORT

As Governed by Pima County Code 8.08 3950 S. Country Club Rd, Ste 2301 Tucson AZ 85714 Phone 520-724-7908, Fax 520-724-9597	Permit# 3180926	Date 01/24/2020

Establishment	Address
SAPPHIRE OF TUCSON NURSING & REHAB	2900 E MILBER STTUCSON AZ 85714

TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57°C (135°F) or above, except that roasts cooked to a temperature and for a time specified in ¶ 3-401.11(B) or reheated as specified in ¶ 3-403.11(E) may be held at a temperature of 54°C (130°F) or above;

Corrective Actions: PIC reheated bean burritos to 165F.

55 Core

Observations: Observed missing or damaged floor tiles in particularly in the ware washing area. Observed damaged wall panels by the coffee station.

6-201.11 Except as specified under § 6-201.14 and except for antislip floor coverings or applications that may be used for safety reasons, floors, floor coverings, walls, wall coverings, and ceilings shall be designed, constructed, and installed so they are SMOOTH and EASILY CLEANABLE.

Corrective Actions: Correct by resurfacing damaged/missing floor tiles and damaged wall panel within 30 days so that they are smooth and easily cleanable.

ACTIONS TAKEN

Photos Taken for File

First Routine Inspection packet provided

CLOSING COMMENTS

This is a scheduled inspection, and will be assigned a rating of EDUCATIONAL INSPECTION, the violations noted must still be corrected by the next routine inspection.

Person In Charge (Print Name):	Richard Mariscal		
Person In Charge (Signature):		**Date**	01/24/2020
Inspector (Print Name):	Shelsie Dabdoub		
Inspector (Signature):		**Date**	01/24/2020

INSPECTION ADDITIONAL DETAILS

Notice of Inspection Rights Provided?	Yes
Does this Inspection Require a Foodborne Illness Investigation Response?	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.

300 S. FIRE CENTRAL PL.• TUCSON, AZ 85701-1640
(520) 791-4502 • FAX (520) 791-5346 TTY (520) 791-2639
www.tucsonaz.gov

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
CITY OF TUCSON

FIRE DEPARTMENT

Permit Activity Number: T19FO00647

Structure Address: 2900 E MILBER ST TUC

Project Description: 240 BEDS

Permit Type: State Llc Facls Annual Inspectio

Occupancy Group: I-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

Fire is Everyone's Fight.

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

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

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NCI-2643	A. BUILDING: _____ B. WING _____	R 04/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{Y 000}	Initial Comments An offsite follow-up survey was conducted on April 28, 2021. No deficiencies were cited.	{Y 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 04/12/21

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
NCI-2643 Y1	A. Building B. Wing Y2	4/28/2021 Y3

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

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Y0339	Correction	ID Prefix Y0342	Correction	ID Prefix Y1045	Correction
Reg. # R9-10-403.C.2.b.	Completed	Reg. # R9-10-403.C.2.e.	Completed	Reg. # R9-10-410.B.4.c.	Completed
LSC	04/20/2021	LSC	04/20/2021	LSC	04/20/2021
ID Prefix Y1147	Correction	ID Prefix Y1235	Correction	ID Prefix Y1477	Correction
Reg. # R9-10-411.C.9.	Completed	Reg. # R9-10-412.B.7.	Completed	Reg. # R9-10-414.B.3.b.	Completed
LSC	04/20/2021	LSC	04/20/2021	LSC	04/20/2021
ID Prefix Y1911	Correction	ID Prefix Y2159	Correction	ID Prefix Y2301	Correction
Reg. # R9-10-419.2.e.	Completed	Reg. # R9-10-421.D.3.a.	Completed	Reg. # R9-10-423.A.1.	Completed
LSC	04/20/2021	LSC	04/20/2021	LSC	04/20/2021
ID Prefix Y2349	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # R9-10-423.B.6.	Completed	Reg. #	Completed	Reg. #	Completed
LSC	04/20/2021	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	WC	4/28/21	[signature]	4/28/21
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
3/11/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

Gmail

Matt Connolly <matthew.connolly@azdhs.gov>

Sapphire of Tucson Plan of Correction (POC)

1 message

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

Hey Brian,

I got your POC and there are some things I need to have you fix/change before I can accept it.

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

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	(X3) DATE SURVEY COMPLETED
	NCI-2643	A. BUILDING: _____ B. WING _____	03/11/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	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:	Y 000	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.	
Y 339	R9-10-403.C.2.b. Administration 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: R9-10-403.C.2.b. Cover the provision of physical health services and behavioral health services; 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: 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	Y 339	<u>Y339</u> **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice, on both a temporary and permanent basis, including the date the correction will be accomplished?** Resident #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?** 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.	4/20/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brian Ballet — TITLE: ADMINISTRATOR — (X6) DATE: 4/10/2021

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NCI-2643	A. BUILDING: _____ B. WING _____	03/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAPPHIRE OF TUCSON NURSING AND REHAB, LLC	2800 EAST MILBER STREET TUCSON, AZ 85714

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 339	Continued From page 1 dementia without behavioral disturbance. Review of the Morse Fall Scale dated February 8, 2021 revealed the resident was at high risk for falling with a score of 80 (45 and above equals high risk). The assessment included the resident had fallen before; used crutches, a cane, or a walker; had a weak gait; and overestimates or forgets limits. A second Morse Fall scale was completed on February 9, 2021 and included the resident continued to be at high risk for falling. Review the care plan dated February 9, 2021 revealed the resident was at risk for falls related to confusion, weakness, and unaware of safety needs. Resident chooses to lay on the floor beside her bed and stated that she is more comfortable on the floor. The provider is aware of the preference. Resident does have the bed in low position and can self-adjust the height of the bed. The goal was that the resident would be free 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	Y 339	**What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** DON and/or Designee conducted an in-service to nursing staff related to safety devices completed on 4/3/2021. DON and/or designee conducted an in service to licensed staff on fall documentation, notification and monitoring of resident post fall. **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 DON and/or Designee will audit all new orders for safety devices daily for 21 days. The DON and/or Designee will audit all fall for proper documentation, notification, and monitoring post fall. 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. The DON and/or Designee will report any patterns or trends to our monthly QA&A committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NCI-2643	A. BUILDING: _____ B. WING _____	03/11/2021

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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

ADHS LICENSING SERVICES

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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.

ADHS LICENSING SERVICES

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Y 339	Continued From page 4 The resident was coded as having a fall in the last month, and the last 2-6 months prior to admission to the facility and a fall with an injury since admission to the facility. Review of an IDT note dated February 18, 2021 revealed: IDT follow up, change in elevation February 9, 2021. Resident has had no further changes in elevation. The resident continues to received therapies to maximize function. All interventions remain in place. An observation was conducted of resident #131 on March 11, 2021 at 10:34 a.m. The resident was observed to be in a room with a roommate, her bed was located nearest the room door and was not placed against the wall. There were no floor mats observed by the sides of the bed and no floor mats were found in the room. A walker was observed in the room against the wall opposite the foot of the resident's bed. Another observation was conducted of resident #131 on March 11, 2021 at 10:38 a.m. The resident was observed to transfer out of the bed and ambulate to the sink in the room. The resident did not call for assist verbally or by using the call light and did not use the walker. An interview was conducted on March 11, 2021 at 12:59 p.m. with a Certified Nursing Assistant (CNA/staff #125), who stated that she would know that a resident was at risk for falls from the report given by the nurse. Staff #125 stated that, as far as she knew, resident #131 had not had a fall. The CNA stated that resident #131 gets around pretty well, was pretty steady, and sometimes did not remember to use the call light. The CNA stated that she did not remember fall mats being used for this resident and that she	Y 339		

ADHS LICENSING SERVICES

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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 yet. The LPN stated that the resident should have floor mats in place if they were ordered by the physician and in the care plan.	Y 339		

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Y 339	Continued From page 6 An interview was conducted on March 11, 2021 at 1:16 p.m. with the LPN/Assistant Director of Nursing (ADON/staff #143). She stated that an order listing report was run each day and that the Interdisciplinary Team (IDT) would make sure all changes for a resident were reflected on the care plan. The ADON stated that staff were expected to follow the physician's orders as written and the information in the care plan was supposed to be accurate and followed by the staff. She stated that if clinical staff felt that an order needed to be changed the physician would be contacted. She stated that the staff would notify the physician about what was going on and why it was felt that a change was needed. The ADON stated that resident #131 had an order for bilateral floor mats and was care planned to have floor mats, therefore, the mats should be in place. She stated that staff had not followed the order and the care plan, which put the resident at risk for injury. Staff #143 conducted an observation of the resident's (#131) room and confirmed that there were no fall mats present by the resident's bed or in the room. In an interview conducted on March 11, 2021 at 3:22 p.m. with the DON (staff #51), the DON stated that she expected residents falls to be reviewed and staff to assess for interventions and to put intervention in place and assess their effectiveness. She stated that if it is determined that an intervention(s) was needed, she expected that intervention(s) would be implemented as per physician's orders and/or the care plan. She stated that she expects staff to follow physician's orders as written. She stated that if an intervention was determined to no longer be appropriate, the staff should re-assess the resident and update the care plan and orders as appropriate. She stated that resident #131 should	Y 339		

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Y 339	Continued From page 7 have had floor mats as ordered and care planned, and that her expectations were not met. She stated that the resident would be at risk for more falls if the interventions for fall prevention were not followed. Review of the facility's policy for assessing falls and their causes revealed: The purpose of this procedure is to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. General Guidelines included: Falls are a leading cause of morbidity and mortality among the elderly in nursing homes; falling may be related to underlying clinical or medical conditions, overall functional decline, medication side effects, and/or environmental risk factors; residents must be assessed regularly for potential risk of falls and relevant risk factors must be addressed properly. After an observed or probable fall, clarify the details of the fall, such as when the fall occurred and what the individual was trying to do at the time the fall occurred. Within 24 hours of a fall, begin to try to identify possible or likely causes of the incident. When a resident fall, the following information should be recorded in the resident's medical record: The condition in which the resident was found; Assessment data, including vital signs and any obvious injuries; Interventions, first aid, or treatment administered; Notification of the physician and family, as indicated; Completion of a falls risk assessment; Appropriate interventions taken to prevent future falls; The signature and title of the person recording the data.	Y 339		
Y 342	R9-10-403.C.2.e. Administration R9-10-403.C. An administrator shall ensure that:	Y 342		

ADHS LICENSING SERVICES

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Y 342	Continued From page 8 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: R9-10-403.C.2.e. Cover infection control; This RULE is not met as evidenced by: Based on observations, staff interviews, facility documentation, policies and procedures, and the Centers for Disease Control (CDC) guidelines, the facility failed to implement their policies to ensure that infection control measures were implemented during communal dining, staff screening for COVID-19 was complete, and that staff appropriately donned and doffed personal protective equipment (PPE), performed hand hygiene, and cleaned eye protection. Findings include: -Regarding Communal Dining: During the entrance conference for the recertification survey on March 1, 2021 at 10:53 a.m. with the Administrator (staff #216), Assistant Administrator (staff #217), and the Director of Nursing (DON/staff #51), they stated that the most recent positive case of COVID-19 had occurred over the weekend (February 27, 2021), indicating that the facility was currently in outbreak status. On March 1, 2021 at 12:07 p.m., an observation	Y 342	**Y342** **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?** No Residents found to be affected. **How will you identify other residents having the potential to be affected by the 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 or what systemic changes will you make to ensure that the deficient practice does not recur?** All staff will be in-serviced on screening process by ICP for COVID-19 regarding temperatures, proper donning and doffing of PPE, and hand hygiene. Reception screeners in-service by ICP on conducting screening and reviewing documentation for completeness. ICP to in-service all staff on "Keep COVID-19 OUT!", "Use PPE Correctly for COVID-19", and "Clean Hands: Combat COVID-19!"	4/20/2021

ADHS LICENSING SERVICES

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Y 342	Continued From page 9 was conducted on the B-100 hall/secure dementia unit. Upon entering the unit, to the left of the doorway, the resident dining room was observed. It was noted that the dining room held 7 square tables, 1 small round table, and 1 larger round table. 19 residents and 4 staff members were observed in the dining room, including: -4 square tables with 3 residents seated at each table. -3 square tables with 2 residents seated at each table. -1 small round table with 1 resident seated at the table. -1 large round table with no residents seated there. One of the residents on the far side of the room was observed as he ate his meal. A female resident who was seated to his right began touching his table-top and attempting to grab at his food. The first resident swatted at her and she moved away. 17 out of the 19 residents in the room were noted to be eating independently, and most were within approximately 2-3 feet from each other, including 3 new residents (Persons Under Investigation/PUI) who were on droplet precautions. To the immediate left of the entrance to the dining room, one staff member was observed to be serving food into Styrofoam food containers from a heating table. The food was delivered to the residents by two of the other staff members. The fourth staff member was pouring drinks and providing them to the residents. After all of the meals and drinks had been served, the staff member that had been serving the food moved the heating table off of the unit. One member of staff began to wipe down the counters, and instructed the other two to help the residents that required assistance with their	Y 342	All Staff will have training on CDC "Preparing for COVID-19 in Nursing Homes", Hand Hygiene Recommendations and Hand hygiene Guidance. IDT team conducted a root cause analysis on reasons for non-compliance. **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?** ICP and/or designee will conduct observations daily to ensure proper PPE donning and doffing, screening for COVID-19 and hand hygiene for 3 months. If expectations met, this will be reduced to monthly observations until 3 consecutive rounds of monthly monitoring have sustained compliance approved by QA committee and medical director. Any staff members found to be out of compliance will be reported to the ICP and/or Designee for immediate correction and re-education to licensed staff. The ICP and/or Designee will report any patterns or trends to our monthly QA&A committee.	

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Y 342	Continued From page 10 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 ½ 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	Y 342		

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Y 342	Continued From page 11 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. The facility's policy titled Social Distancing Policy, effective March 1, 2020, stated that in the event of an outbreak of a highly infectious and/or deadly disease, including a pandemic, the facility will enact its Social Distancing Policy in an attempt to limit the spread of disease through human to human contact. Actions to minimize contact between infected and healthy individuals will range from the use of sick time, and limitation or cancellation of the following, including activities involving groups and group meals. Social distancing is a public health practice designed to limit the spread of infection by ensuring sufficient physical distance between individuals. Taking measures to ensure social distancing decreases opportunities for close contact among persons, thereby decreasing the potential for disease transmission among people and slowing the spread of disease. Social distancing measures may include a recommended minimum distance	Y 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Y 342	Continued From page 12 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	Y 342		

ADHS LICENSING SERVICES

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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 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 staff's 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	Y 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NCI-2643	A. BUILDING: _____ B. WING _____	03/11/2021

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Y 342	Continued From page 14	Y 342		

temperatures on the screening did not meet her expectation.

The facility's policy titled Coronavirus Disease (COVID-19) stated the facility will conduct education, surveillance, and infection control and prevention strategies to reduce the risk of transmission of COVID-19. The facility will follow and implement recommendations and guidelines in accordance with the CDC, the State Department of Public Health, and County Department of Health. The policy stated that everyone entering the facility will be screened including, all visitors, residents returning from trips out, and employees before they enter the facility, including obtaining a temperature.

The CDC guidelines titled Preparing for COVID-19 in Nursing Homes, updated November 20, 2020, included core practices which should remain in place even as nursing homes resume normal activities, including evaluating and managing healthcare personnel. The guidance stated that all HCP should be screened at the beginning of their shift for fever and symptoms of COVID-19, that temperatures should be actively taken, and the absence of symptoms consistent with COVID-19 documented.

Regarding PPE and hand hygiene:

-Review of the facility census dated March 1, 2021 revealed there were 34 residents residing on the B-100 hall/secure dementia unit. Further review revealed 5 out of 34 of the residents were new admissions and were on 14-day observation/droplet precautions for signs and symptoms of COVID-19.

On March 1, 2021 at 12:25 p.m., an observation

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NCI-2643	A. BUILDING: _____ B. WING _____	03/11/2021

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Y 342	Continued From page 15 was conducted of the B-100 hall. PPE carts were observed outside of the rooms where the residents that were new admissions resided. In addition, posted on the doorframe of each of their rooms was a green sign. The sign stated to stop and please see a nurse before entering, and to turn the sign over for PPE requirements to enter the room. The other side of the sign stated that the individual in the room was a Person Under Investigation (PUI). Instructions included that housekeeping staff must wear N95 or KN95 mask, surgical mask over the N95 or KN95 mask, gown, face shield or goggles, and gloves, that staff should wash hands with soap and water, or may use hand sanitizer, and that staff should clean face shield/goggles when they were done in the room. On March 1, 2021 at 12:28 p.m., a housekeeper (staff #196) was observed to clean a room of one of the resident's on observation/droplet precautions. The housekeeper was observed to don a N95/KN95 face mask with a surgical mask covering it, goggles, gloves, and a gown. However, the housekeeper's gown was observed to be tied at the waist and not at the neck. As the housekeeper mopped the floor, the gown was observed to slip off her shoulders, covering only the lower portion of her arms. The housekeeper's back, chest, and upper arms were completely exposed. At approximately 12:32 p.m., the housekeeper doffed her gown and walked to the nurses' station. The housekeeper was not observed to doff her gloves and surgical mask, and she did not clean her goggles. The housekeeper told the nurse the resident required assistance. The nurse followed the housekeeper back to the resident's room, and the nurse donned full PPE prior to entering the resident's room. The housekeeper doffed her gloves at the	Y 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Y 342	Continued From page 16	Y 342		

door to the resident's room, did not perform hand hygiene, did not doff the surgical mask, and did not clean her goggles. The housekeeper was then observed to don a clean pair of gloves and pull her cart into the doorway of a resident's room who was not on isolation precautions. She took a spray bottle and cloth into the resident's room and began to clean it.

At 12:49 p.m. on March 1, 2021, an interview was conducted with the housekeeper (staff #196). Staff #196 stated that she was not supposed to wear her gown untied at the neck and that she was taught to tie her gown at the neck and the waist when entering a PUI room. The housekeeper stated that when she exits the resident's room, she takes off her gown and gloves, and that is about it. She stated that she takes off her goggles to clean them with window cleaner before going into the next resident's room. Staff #196 stated that she was told to clean her goggles with window cleaner. She said she washes her hands when she is finished in one resident's room and will wash her hands again when she enters the next resident's room. The housekeeper stated that she still needed to wash her hands.

On March 4, 2021 at 10:44 a.m., an interview was conducted with the IP (staff #143). The IP stated all staff were educated about PPE in January 2021. She stated her expectation for staff entering a PUI room is to don the double masks, face shield or goggles, gown, and gloves. The IP stated that when staff leave the PUI room, her expectation is that staff doff the gown, gloves, and surgical mask before they exit. She stated staff may clean their face shield or goggles with alcohol swabs either in the room before they leave, or right as they exit. The IP stated that the

ADHS LICENSING SERVICES

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Y 342	Continued From page 17 risk for not following that process would be possible cross contamination. An interview was conducted on March 5, 2021 at 8:42 a.m. with the Director of Nursing (DON/staff #51). She stated that her expectation for staff entering a PUI room included to don a gown that was tied at the neck and waist, masks, face shield or goggles, and gloves if providing care. The facility policy's titled Handwashing/Hand Hygiene/Hand Hygiene Monitoring revised March 2020, stated that the facility considered hand hygiene the primary means to prevent the spread of infections. The policy stated that all personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors which included to use an alcohol-based hand rub containing at least 62% alcohol, or alternatively, soap and water in the following situations: after removing gloves and before and after entering isolation precaution settings. The policy stated that hand hygiene is the final step after removing and disposing of PPE. The facility's COVID-19 Reference Binder included the use of face shields for Persons Under Investigation (PUIs). The cleaning of face shields included wearing gloves and using alcohol wipes to disinfect the shield. Wipe the inside followed by the outside of the face shield, allow to fully dry, dispose of gloves, and perform hand hygiene. Also included was that the face shield must be cleaned after leaving each PUI room. The facility's COVID-19 Reference Binder	Y 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Y 342	Continued From page 18 included the CDC guidance titled Use of PPE When Caring for Patients with Confirmed or Suspected COVID-19. The guidance stated that PPE must be donned correctly before entering the patient area including tying all the ties on the gown; PPE must remain in place and be worn correctly for the duration of work in potentially contaminated areas; and PPE must be removed slowly and deliberately in a sequence that prevents self-contamination. The doffing instructions included that gloves should be removed prior to exiting the patient room. The CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic updated December 14, 2020 stated that the CDC recommended using additional infection prevention and control practices during the COVID-19 pandemic, along with standard practices, as a part of routine healthcare delivery to all patients. These practices are intended to apply to all patients, not just those with suspected or confirmed SARS-CoV-2 infection. The guidance stated that employers should select appropriate PPE and provide it to HCP. HCP must receive training on and demonstrate an understanding of when to use PPE, what PPE is necessary, how to properly don, use, and doff PPE in a manner to prevent self-contamination. Additionally, any reusable PPE must be properly cleaned, decontaminated, and maintained after and between uses. -An observation was conducted of the facility COVID testing process on March 4, 2021 at 7:10 a.m. The Certified Nursing Assistant (CNA/staff #95) conducting the testing, was observed to don a gown, but did not secure/tie the gown at the	Y 342		

ADHS LICENSING SERVICES

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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.	Y 342		

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Y1045	R9-10-410.B.4.c. Resident Rights R9-10-410.B. An administrator shall ensure that: R9-10-410.B.4. A resident or the resident's representative: R9-10-410.B.4.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 failed 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 Aripiprazole (antipsychotic) 5 milligram (mg) tablet give 0.5 tablet by mouth at bedtime for severe depression augmentation as evidenced by (AEB) suicidal ideation.	Y1045	**Y1045** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice, on both a temporary and permanent basis, including the date the correction will be accomplished?** Resident # 58, #74, and #106 found to be affected, all consents corrected and obtained for these residents. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** The DON and/or designee conducted a medical record review for all residents on psychotropics on 4/5/2021. No other residents were found to be affected **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** DON and/or Designee conducted an in-service on Psychotropic consents to licensed nurses. **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**	4/20/2021

ADHS LICENSING SERVICES

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Y1045	Continued From page 21 Review of the Medication Administration Record (MAR) dated December 2020 revealed the resident received the Aripiprazole as ordered on December 30 and 31, 2020. Review of a quarterly Minimum Data Set (MDS) assessment dated January 11, 2021 revealed the resident had a Brief Interview for Mental Status (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 the resident received the Aripiprazole as ordered from January 1 through 21, 2021. 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. 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.	Y1045	**for implementing/monitoring the corrective action?** The DON and/or Designee will audit all orders daily of psychotropics for completion and accuracy of consent for 21 days. Any consent found to be out of compliance will be reported to the DON and/or Designee for immediate correction and re-education to licensed staff.	

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Y1045	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 Abilify/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 constipation, seizure disorder, or edema is present. However, Aripiprazole/Abilify 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 Dyskinesia, seizure disorder, chronic constipation, glaucoma, diabetes, skin pigmentation, yellowing of the skin.	Y1045		

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Y1045	Continued From page 23 Review of the current care plan, last revised March 2, 2021, revealed the resident used psychotropic medications related to major depression AEB passive suicidal ideation. An interview was conducted on March 9, 2021 at 11:32 a.m. with a Licensed Practical Nurse (LPN/staff #180). She stated that staff must obtain consent from the resident or the resident representative to receive a psychotropic medication before the medication could be administered. She stated that the consent included the name of the medication, the dose ordered, why the medication was being used, the classification of the medication and potential side effects of the medication. She stated that the medication classification marked on the consent form should match the actual classification of the medication that was ordered, even if the medication is being used for a different reason. She stated that the unit manager would let the floor nurse know that the resident would be getting a psychotropic medication and would obtain the consent if she was able, if unable, the unit manager would assign a nurse to obtain the consent. An interview was conducted on March 11, 2021 at 4:15 p.m. with the Director of Nursing (DON/staff #51). She stated that she expects staff to obtain informed consent from the resident or the resident's representative when a psychotropic medication is ordered and before the medication is administered. She stated that the consent should contain the medication being given, what the medication is being used for, review of potential side effects, and the correct classification for the medication. For the Abilify/Aripiprazole for resident #58, she stated that the consent should have been obtained	Y1045		

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Y1045	Continued From page 24 before the medication was administered in December of 2020 and that it was not. She stated the consent was not obtained until January 26, 2021 and that her expectations were not met. She stated that the medication was an antipsychotic and should not have been marked on the consent form as an antidepressant and that the side effects reviewed with the resident would not have been correct for the medication ordered. -Resident #74 was admitted to the facility on February 8, 2020, with diagnoses that included alcohol abuse, acute pyelonephritis, and urinary tract infection. Regarding Fluoxetine A physician's order dated November 14, 2020 included for Fluoxetine HCL Tablet 20 mg give 1 tablet by mouth in the morning for anxiety as evidenced by restlessness related to Post Traumatic Stress Disorder, Unspecified. This order was discontinued on November 17, 2020. A physician's order dated November 18, 2020 included for Fluoxetine HCL Tablet 20 mg give 1 tablet by mouth in the morning for Depression as evidenced by lack of interest in activities related to Post Traumatic Stress Disorder, Unspecified. This order was discontinued on January, 6, 2021 A physician's order dated January 7, 2020 included for Fluoxetine HCL Tablet 20 mg give 2 tablets by mouth in the morning for Depression as evidenced by lack of interest in activities. A review of the MARs for November and December 2020, and January, February, and March 2021 revealed the resident was	Y1045		

ADHS LICENSING SERVICES

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Y1045	Continued From page 25 administered Fluoxetine as ordered. The Consultant Pharmacist's Medication Regimen Reviews for November 2020, December 2020, and January 2021 included resident #74 was recently started on Fluoxetine and that the pharmacist was unable to find a consent for the medication in the electronic charting system. Continued review of the clinical record revealed a consent for Fluoxetine was obtained on February 11, 2021. Regarding Quetiapine Fumarate A physician's order dated October 21, 2020 included for Quetiapine Fumarate (antipsychotic) 50 mg give 1 tablet by mouth at bedtime for psychosis related to Post Traumatic Stress Disorder as evidenced by delusions. This order was discontinued on November 18, 2020. A physician's order dated November 7, 2020 included for Quetiapine Fumarate give 50 mg tablet by mouth one time only for verbal and physical aggression for 1 day. A physician's order dated November 18, 2020 included for Quetiapine Fumarate 50 mg tablet 50, give 1.5 tablet by mouth at bedtime for psychosis related to Post Traumatic Stress Disorder as evidenced by delusions. This order was discontinued on November 22, 2020. A Physician's Order dated November 22, 2020 included Quetiapine Fumarate 50 mg tablet, give 1 tablet by mouth at bedtime for psychosis related to Post Traumatic Stress Disorder as evidenced by delusions.	Y1045		

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	NCI-2643	A. BUILDING: _____ B. WING _____	03/11/2021

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

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Y1045	Continued From page 26 Review of the MARs for November and December 2020, and January and February 2021 revealed the resident was administered Quetiapine Fumarate as ordered. The Consultant Pharmacist's Medication Regimen Reviews dated November and December 2020, and January 2021 included the consent form for resident #74 for Quetiapine indicated a specific dose of 25 mg, that the dose had changed, and that facility should consider obtaining an updated consent for the use of Quetiapine. However, no consents were found for the change in dosage to 50 mg in October or the change in dosage to 75 mg in November until February 11, 2021 An interview was conducted on March 11, 2021 at 10:55 A.M. with this resident's LPN (staff #171), who said the pharmacy medication reviews are conducted by the pharmacist and then sent to DON who then distributes to them to staff to review and send to the provider. The LPN stated the provider documents if they want to change the order. Staff #171 said that regarding consents, she would review the chart to locate the consent and that if there was not a consent, she would speak to the resident or the resident's family to obtain the consent. Staff #171 stated that she was not sure why this resident was missing consents. The LPN said that it could have been given it to the physician and not returned. An interview was conducted on March 11, 2021 at 3:22 p.m. with the DON (staff #51), who said the expectation is that when a new psychotropic	Y1045		

ADHS LICENSING SERVICES

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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

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Y1045	Continued From page 28 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 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 the medication. The DON stated the Mirtazapine should not have been 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 involved in the decision. A resident and/or representative has the right to be informed about	Y1045		

ADHS LICENSING SERVICES

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Y1045	Continued From page 29 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.	Y1045		
Y1147	R9-10-411.C.9. Medical Records R9-10-411.C. An administrator shall ensure that a resident's medical record contains: R9-10-411.C.9. Orders; 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	Y1147	Y1147 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice, on both a temporary and permanent basis, including the date the correction will be accomplished?** Resident #16 found to be affected. Order already updated previously. **How will you identify other residents having the potential to be affected by the 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 house on 3/30/2021. No other residents were found to be affected. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** Administrator and/or Designee conducted an in-service on hospice orders to IDT on 3/18/2021.	4/20/2021

ADHS LICENSING SERVICES

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Y1147	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 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 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	Y1147	**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 Social Service Director and/or Designee will audit all new Hospice admits for correct orders for 28 days. Any hospice residents found to be out of compliance will be reported to the DON and/or Designee for immediate correction and re-education to IDT.	

ADHS LICENSING SERVICES

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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.	Y1147		
Y1235	R9-10-412.B.7. Nursing Services R9-10-412.B. A director of nursing shall ensure that: R9-10-412.B.7. An unnecessary drug is not administered to a resident. 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 #78) were not administered unnecessary drugs by failing to consistently monitor for adverse side effects of use and targeted behaviors. 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 3, 2020 for Duloxetine hydrochloride (HCL) (antidepressant) 60 milligram (mg) capsule by mouth two times a day	Y1235	**Y1235** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice, on both a temporary and permanent basis, including the date the correction will be accomplished?** Resident #58, #74 and #78 found to be affected. Orders corrected 3/23/21. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** The DON and/or designee conducted a medical record review for all residents on psychotropics on 4/5/2021 no other residents found to be affected. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** DON and/or Designee conducted an in-service to licensed nurses on Psychotropic orders and proper monitoring of target behaviors and side effects.	4/20/2021

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	NCI-2843	A. BUILDING: _____ B. WING _____	03/11/2021

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Y1235	Continued From page 32 for depression as evidenced by passive suicidal ideations. -A second order dated December 30, 2020 for Aripiprazole (antipsychotic) 5 mg tablet give 0.5 tablet by mouth at bedtime for severe depression augmentation as evidenced by (AEB) suicidal ideation. 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 suicidal ideations every shift for passive suicidal ideations, depression. However, there was no documentation of the above monitoring on the "day" shift for December 15, and 20-22, 2020, no documentation on the "night" shift December 25 and 30, 2020, and no documentation for antipsychotic side effects. Review of a quarterly Minimum Data Set (MDS) assessment dated January 11, 2021 revealed the resident had a Brief Interview for Mental Status	Y1235	**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 DON and/or Designee will audit all psychotropics orders daily for 21 days for proper target behavior monitoring and side effects on EMAR. Any psychotropic found to be out of compliance will be reported to the DON and/or Designee for immediate correction and re-education to licensed staff. The DON and/or Designee will report any patterns or trends to our monthly QA&A committee.	

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Y1235	Continued From page 33 (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 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 suicidal ideations every shift for passive suicidal ideations, depression.	Y1235		

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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	Y1235		

ADHS LICENSING SERVICES

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Y1235	Continued From page 35 symptoms. An interview was conducted on March 9, 2021 at 11:32 a.m. with a Licensed Practical Nurse (LPN/staff #180). The LPN stated that a psychotropic medication 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 shift. Staff #180 stated that the documentation should be filled in and should not have blanks. She stated that if there were blanks on the monitors record staff would not be able to show that the monitoring was done. After review of the behavior and side effect monitoring for resident #58, she stated that staff did not follow facility expectation for documentation. The LPN stated that it is important to monitor the resident for side effects and behaviors to determine if the medication was effective for the resident's needs or to be able to see if the resident was having side effects. An interview was conducted on March 11, 2021 at 3:22 p.m. with the Director of Nursing (DON/staff #51). The DON stated that she expects all residents who are receiving psychotropic medications to be monitored every shift for side effects and target behaviors. The DON stated that the monitoring should be documented in one of the administration records (i.e. Monitors, MAR, Treatment Administration Record) and needs to completed by a licensed nurse, not a Certified Nursing Assistant (CNA). The DON reviewed the administration record for resident #58 and stated that staff did not meet expectations related to the missing documentation of side effect and target behavior monitoring.	Y1235		

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Y1235	Continued From page 36 -Resident #78 was readmitted to the facility on December 20, 2020 with diagnoses that included unspecified dementia without behavioral disturbance and major depressive disorder, recurrent. 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 December 2020 and January 2021 revealed the resident was administered citalopram hydrobromide. The significant change MDS assessment dated January 12, 2021 revealed a score of 00 on the BIMS, indicating the resident had severe cognitive impairment. The assessment included the resident received antidepressant medication for 7 out of the 7 days during the look-back period. However, a review of the Monitors documentation for January 2021 revealed no documentation to indicate whether or not the resident had exhibited antidepressant target behaviors, side-effects, and adverse reactions on 2 out of 31 day shifts and 5	Y1235		

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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 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.	Y1235		

ADHS LICENSING SERVICES

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	NCI-2643	A. BUILDING: _____ B. WING _____	03/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAPPHIRE OF TUCSON NURSING AND REHAB, LLC	2800 EAST MILBER STREET TUCSON, AZ 85714

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y1235	Continued From page 38 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 did not reveal the resident was being monitored for adverse side effects and the targeted behavior for 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 MAR/TAR in the monitoring section.	Y1235		

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Y1235	Continued From page 39 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	Y1235		

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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 documented in the resident's medical record.	Y1235		
			Y1477	4/20/2021
Y1477	R9-10-414.B.3.b. Comprehensive Assessment; Care Plan R9-10-414.B. An administrator shall ensure that a care plan for a resident: R9-10-414.B.3. Ensures that a resident is provided nursing care institution services that: R9-10-414.B.3.b. Assist the resident in maintaining the resident's highest practicable	Y1477	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice, on both a temporary and permanent basis, including the date the correction will be accomplished?** Resident #74, and #16 found to be affected. Care Plan updated 3/12/2021.	

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Y1477	Continued From page 41 well-being according to the resident's comprehensive assessment. This RULE is not met as evidenced by: Based on clinical record review, resident and staff interviews, and review of policy and procedures, the facility failed to ensure a care plan was developed to assist two residents (#74 and #16) in maintaining their highest practicable well-being by failing to address depression and the use of an antidepressant medication for resident #74 and religious dietary preferences for resident #16. Findings include: -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. Regarding depression Review of the admission Minimum Data Set (MDS) assessment dated February 15, 2020, included a Resident Mood Interview Patient Health Questionaire-9 (PHQ-9) total Severity Score was 11, which indicated the resident had moderate depression. The assessment also included the Mood State care area was triggered on the Care Area Assessment (CAA) Summary and that Mood State would be addressed in the care plan. However, review of the care plan initiated	Y1477	**How will you identify other residents having the potential to be affected by the 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 found to be affected. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** Administrator and/or Designee conducted an in-service on Comprehensive Care Plan for religion and depression to Social Services Department on 3/19/2021. **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 Social Service Director and/or Designee will audit all new admits for completion and accuracy of care plans related to depression and religion for 28 days. Any Care Plans found to be out of compliance will be reported to the Administrator and/or Designee for immediate correction and re-education to Social services department.	

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Y1477	Continued From page 42 February 27, 2020 did not include depression. An interview was conducted on March 10, 2021 at 2:10 P.M. with the MDS Registered Nurse (staff #87), who stated that when a resident is admitted, the admission MDS assessment period is from day 1 to day 8, and then they have 7 days after that to develop the comprehensive care plan. After reviewing resident #74's clinical record, staff #87 stated the mood care area was triggered due to depression. Staff #87 stated Social Services completes that area of the care plan. An interview was conducted on March 11, 2021 at 3:21 P.M. with the Director of Nursing (DON/staff #51), who said the care plan focuses are generated by the MDS assessment. The DON stated that she would review the resident's clinical record regarding the depression score. A follow up interview was conducted on March 11, 2021 at 4:50 P.M. with the DON (staff #51). The DON said that her expectation is that the staff should have develop a care plan for this resident as the score indicated moderate depression. Regarding an antidepressant medication Review of the clinical record revealed a physician order dated November 14, 2020 for Fluoxetine (antidepressant) 20 milligrams (mg) one tablet by mouth in the morning for anxiety as evidenced by (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.	Y1477		

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Y1477	Continued From page 43 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	Y1477		

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Y1477	Continued From page 44 associated with the medication. An interview was conducted on March 11, 2021 at 3:22 P.M. with DON (staff #51), who stated psychotropic medications and monitoring for side effects, adverse reactions and behaviors associated with those medications should be care planned. The DON stated it is her expectation that any psychotropics medications ordered for resident #74 be care planned. The DON acknowledged the antidepressant medication was not addressed in resident #74's care plan until March 1, 2021. -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 resident information face sheet revealed Jewish as the resident's religion. 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 was completed by the dietician (staff #124). 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. Review of the care plan revealed a care plan had not been developed to include the resident's Jewish preferences related to diet. An interview was conducted on March 4, 2021 at	Y1477		

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Y1477	Continued From page 45 2:02 P.M. with the dietician (staff #124), who stated a dietary assessment is conducted for new residents which includes discussing the resident's food preferences. Staff #124 stated that dietary preferences and religious beliefs are determined by visits to the resident. Staff #124 stated that the facility has not had many residents with religious preference requests in the past and is "not aware of any residents with religious preferences at this moment." Staff #124 stated she completes the nutrition component of the care plan. When asked if she was aware of resident #16 Jewish faith and his preference for a Jewish diet, staff #124 responded "I was not aware of that." Staff #124 stated she would update resident #16 care plan with his Jewish diet preferences. In an interview conducted with the resident on March 11, 2021 at 1:10 P.M., the resident stated that he is active in the Jewish faith. An interview was conducted on March 11, 2021 at 3:22 P.M. with the DON (staff #51), who stated it is her expectation that the diet portion of the care plan would include religious diet preferences. Staff #51 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's Comprehensive Care Plan policy revised December 2016 stated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a	Y1477		

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Y1477	Continued From page 46 comprehensive, person-centered care plan for each resident. The policy included the IDT includes a member of the food and nutrition services staff and other appropriate staff or professionals as determined by the resident's needs or as requested by the resident. The policy also included the care planning process will incorporate the resident's personal and cultural preferences in developing the goals of care. The care plan will incorporate identified problem areas and incorporate risk factors associated with identified problems; and will identify the professional services that are responsible for each element of care.	Y1477		
Y1911	R9-10-419.2.e. Respiratory Care Services R9-10-419. If respiratory care services are provided on a nursing care institution's premises, an administrator shall ensure that: R9-10-419.2. Respiratory care services are provided according to an order that includes: R9-10-419.2.e. The oxygen concentration or oxygen liter flow and method of administration; This RULE is not met as evidenced by: Based on observations, clinical record review, staff interviews, and policy review, the facility failed to ensure one resident (#358) had an order to provide oxygen to the resident. Findings include: Resident #358 was admitted to the facility on February 28, 2021, with diagnoses that included	Y1911	Y1911 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice, on both a temporary and permanent basis, including the date the correction will be accomplished?** Resident #358 found to be affected. Order obtained 3/12/2021 **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** The DON and/or designee conducted a full house audit for residents on oxygen and orders on 3/23/2021. No other residents found to be affected	4/20/2021

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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 was observed receiving oxygen 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 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 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 administer oxygen. An interview was conducted on March 10, 2021 at 11:51 A.M. with the LPN Unit Manager (staff	Y1911	**What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** DON and/or Designee conducted an in-service to Licensed nurse on oxygen orders completed on 4/3/2021 **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 DON and/or Designee will audit new admits for oxygen and orders 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..	

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Y1911	Continued From page 48 #126), who said the resident had orders for oxygen from the hospital and that the resident has been receiving oxygen since admission. Staff #126 stated they missed inputting the order for oxygen. In an interview conducted 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 resident was missed. The DON stated her expectation would be that if the resident has orders from the hospital, an order would be obtained and the care provided. The facility's policy titled Oxygen Administration revealed the purpose of the procedure is to provide guidelines for safe oxygen administration. This procedure included verifying that there is a physician's order for the procedure and reviewing the physician's orders or facility protocol for oxygen administration.	Y1911		
Y2159	R9-10-421.D.3.a. Medication Services R9-10-421.D. When medication is stored at a nursing care institution, an administrator shall ensure that: R9-10-421.D.3. Policies and procedures are established, documented, and implemented to protect the health and safety of a resident for: R9-10-421.D.3.a. Receiving, storing, inventorying, tracking, dispensing, and discarding medication including expired medication;	Y2159	**Y2159** **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?** No residents found to be affected. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No residents found to be affected.	4/20/2021

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Y2159	Continued From page 49 This RULE is not met as evidenced by: Based on observations, staff interviews, and policy review, the facility failed to implement their policy to ensure expired medications and glucose test strips were not available for use and failed to ensure medications were stored at the recommended temperature. Findings include: An observation was conducted of the medication cart on the C-1 hall with a Licensed Practical Nurse (LPN/staff #139) on March 3, 2020 at 9:19 a.m. An opened vial of Novolin 70/30 insulin was observed, dated opened on February 1, 2021 and an opened vial of Lispro 100 insulin was observed, dated opened on January 2, 2021. The box containing the Novolin 70/30 insulin and the box containing the Lispro 100 insulin both had a sticker on it that stated "store in refrigerator". Continued observations of the medication cart revealed an unopened box of Novolin 70/30 insulin that had a sticker on the box that stated "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	Y2159	**What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** DON and/or Designee conducted an in-service on Medication storage to licensed nurses on 3/3/21. **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 DON and/or Designee will audit all medication carts and storage areas weekly for expired or mis- stored items for 21 days. Any medications found to be out of compliance will be reported to the DON and/or Designee for immediate correction and re-education to licensed staff.	

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Y2159	Continued From page 50 Nursing (DON/staff #51) on March 3, 2021 at 11:09 a.m. The DON stated expired medications are not to be left in the medication carts. Staff #51 stated the nurses are responsible for ensuring all expired medications are removed from the medication cart and given to her for disposal. The DON stated that using expired insulin is a problem as it may lose its potency and not work properly. The DON also stated that once opened, insulin is good for 30 days. She said that all unopened insulin is to be stored in the refrigerator. The DON stated that there should not be any broken glucometers on any medication carts. Staff #51 stated the nurse is expected to advise the unit manager of the broken item so that it can be promptly replaced. Review of the facility's policy, Storage of Medications, revealed drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. Discontinued, outdated or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. Medications requiring refrigeration are stored in a refrigerator located in the drug room at the nurses' station or other secured location.	Y2159		
Y2301	R9-10-423.A.1. Food Services R9-10-423.A. An administrator shall ensure that: R9-10-423.A.1. The nursing care institution has a license or permit as a food establishment under 9 A.A.C. 8, Article 1;	Y2301	**Y2301** **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?** No Residents found to be affected.	4/20/2021

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NCI-2643	A. BUILDING: _____ B. WING _____	03/11/2021

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

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

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Y2301	Continued From page 52 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). A facility's policy and procedure manual titled	Y2301		

ADHS LICENSING SERVICES

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Y2301	Continued From page 53 Food Safety - Director of Food and Nutrition Services' Responsibilities revealed that the director of food and nutrition will be responsible for providing safe foods to all individuals. It included that sanitary conditions will be maintained in the food storage, preparation and serving areas, and that employees will follow proper cleaning and sanitizing instructions for all kitchen equipment.	Y2301		
Y2349	R9-10-423.B.6. Food Services R9-10-423.B. A registered dietitian or director of food services shall ensure that: R9-10-423.B.6. Recommendations and preferences are requested from a resident or the resident's representative for meal planning; This RULE is not met as evidenced by: Based on observations, resident and staff interviews, clinical record review and policy review, the facility failed to ensure food preferences requested from one resident (#16) was implemented for meal planning. 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 resident information face sheet revealed Jewish as the resident's religion.	Y2349	**Y2349** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice, on both a temporary and permanent basis, including the date the correction will be accomplished?** Resident #16 affected by practice. **How will you identify other residents having the potential to be affected by the 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 and allergies. No other residents identified. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?**	4/20/2021

ADHS LICENSING SERVICES

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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. 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	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. 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 Food Service Director and/or Designee will report any patterns or trends to our monthly QA&A committee.	

ADHS LICENSING SERVICES

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Y2349	Continued From page 55 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	Y2349		

ADHS LICENSING SERVICES

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Y2349	Continued From page 56	Y2349		

preferences and the dietician will conduct an assessment based on admitting notes and the kitchen manager's recommendations. Staff #124 stated she will visit the newly admitted resident if her assessment indicates a visit or if the kitchen manager recommends she visit. Staff #124 stated that dietary preferences and religious beliefs are obtained by visits to the resident. Staff #124 stated that the facility has not had many residents with religious preference requests in the past and that she is "not aware of any residents with religious preferences at this moment." Staff #124 stated that per resident #16 request, he is served cold cereal and a banana for breakfast, cottage cheese with fruit for lunch, and a chef salad for dinner. When asked if she was aware of resident #16 Jewish faith and his preference for a Jewish diet, staff #124 responded "I was not aware of that."

During an interview was conducted with the resident on March 11, 2021 at 1:10 P.M., the resident stated that he is active in his Jewish faith. Resident #16 stated he does not practice a Kosher diet but he does practice a Pareve diet. Resident #16 stated a Pareve diet does not allow dairy with meat. Resident #16 stated he will not eat his meal if there is meat and dairy together on the tray. Resident #16 stated he often receives milk and meat on his food tray and that is not his preference and is not allowed on the Jewish diet. Resident #16 stated he would prefer not to receive dairy products on the same tray as his meat entrée.

An interview was conducted with the Kitchen Manager (staff #173) on March 11, 2021 at 1:40 P.M. The Kitchen Manager stated he conducts the initial admission interview regarding diet with residents that are new admissions. Staff #173

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Y2349	Continued From page 57 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.	Y2349		

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

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.

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

Gmail

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

Sapphire of Tucson Nursing & Rehab POC(a)

1 message

Brian Balliet <bballiet@sapphireestatesrc.com> Sat, Apr 10, 2021 at 1:01 PM
To: LTC Licensing - ADHS <ltc.licensing@azdhs.gov>
Cc: Brian Balliet <bballiet@sapphireoftucson.com>

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

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U.S.News & WORLD REPORT
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	NCI-2643	A. BUILDING: _____ APR 10 2021 B. WING _____ LONG TERM CARE 150 N. 18TH AVE # 440 PHOENIX, AZ 85007	03/11/2021

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Y 000	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:	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.	
Y 339	R9-10-403.C.2.b. Administration 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: R9-10-403.C.2.b. Cover the provision of physical health services and behavioral health services; 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: 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	Y 339	<u>Y339</u> **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice, on both a temporary and permanent basis, including the date the correction will be accomplished?** Resident #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?** 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.	4/20/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn Balliet, LNHA — TITLE: ADMINISTRATOR — (X6) DATE: 4/10/2021

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Y 339	Continued From page 1 dementia without behavioral disturbance. Review of the Morse Fall Scale dated February 8, 2021 revealed the resident was at high risk for falling with a score of 80 (45 and above equals high risk). The assessment included the resident had fallen before; used crutches, a cane, or a walker; had a weak gait; and overestimates or forgets limits. A second Morse Fall scale was completed on February 9, 2021 and included the resident continued to be at high risk for falling. Review the care plan dated February 9, 2021 revealed the resident was at risk for falls related to confusion, weakness, and unaware of safety needs. Resident chooses to lay on the floor beside her bed and stated that she is more comfortable on the floor. The provider is aware of the preference. Resident does have the bed in low position and can self-adjust the height of the bed. The goal was that the resident would be free 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	Y 339	**What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** DON and/or Designee conducted an in-service to nursing staff related to safety devices completed on 4/3/2021. **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 DON and/or Designee will audit all new orders for safety devices daily 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.	

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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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NCI-2643	A. BUILDING: _____ B. WING _____	03/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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.

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	NCI-2643	A. BUILDING: _____ B. WING _____	03/11/2021

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Y 339	Continued From page 4 The resident was coded as having a fall in the last month, and the last 2-6 months prior to admission to the facility and a fall with an injury since admission to the facility. Review of an IDT note dated February 18, 2021 revealed: IDT follow up, change in elevation February 9, 2021. Resident has had no further changes in elevation. The resident continues to received therapies to maximize function. All interventions remain in place. An observation was conducted of resident #131 on March 11, 2021 at 10:34 a.m. The resident was observed to be in a room with a roommate, her bed was located nearest the room door and was not placed against the wall. There were no floor mats observed by the sides of the bed and no floor mats were found in the room. A walker was observed in the room against the wall opposite the foot of the resident's bed. Another observation was conducted of resident #131 on March 11, 2021 at 10:38 a.m. The resident was observed to transfer out of the bed and ambulate to the sink in the room. The resident did not call for assist verbally or by using the call light and did not use the walker. An interview was conducted on March 11, 2021 at 12:59 p.m. with a Certified Nursing Assistant (CNA/staff #125), who stated that she would know that a resident was at risk for falls from the report given by the nurse. Staff #125 stated that, as far as she knew, resident #131 had not had a fall. The CNA stated that resident #131 gets around pretty well, was pretty steady, and sometimes did not remember to use the call light. The CNA stated that she did not remember fall mats being used for this resident and that she	Y 339		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NCI-2643	A. BUILDING: _____ B. WING _____	03/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 yet. The LPN stated that the resident should have floor mats in place if they were ordered by the physician and in the care plan.	Y 339		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NCI-2643	A. BUILDING: _____ B. WING _____	03/11/2021

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

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Y 339	Continued From page 6 An interview was conducted on March 11, 2021 at 1:16 p.m. with the LPN/Assistant Director of Nursing (ADON/staff #143). She stated that an order listing report was run each day and that the Interdisciplinary Team (IDT) would make sure all changes for a resident were reflected on the care plan. The ADON stated that staff were expected to follow the physician's orders as written and the information in the care plan was supposed to be accurate and followed by the staff. She stated that if clinical staff felt that an order needed to be changed the physician would be contacted. She stated that the staff would notify the physician about what was going on and why it was felt that a change was needed. The ADON stated that resident #131 had an order for bilateral floor mats and was care planned to have floor mats, therefore, the mats should be in place. She stated that staff had not followed the order and the care plan, which put the resident at risk for injury. Staff #143 conducted an observation of the resident's (#131) room and confirmed that there were no fall mats present by the resident's bed or in the room. In an interview conducted on March 11, 2021 at 3:22 p.m. with the DON (staff #51), the DON stated that she expected residents falls to be reviewed and staff to assess for interventions and to put intervention in place and assess their effectiveness. She stated that if it is determined that an intervention(s) was needed, she expected that intervention(s) would be implemented as per physician's orders and/or the care plan. She stated that she expects staff to follow physician's orders as written. She stated that if an intervention was determined to no longer be appropriate, the staff should re-assess the resident and update the care plan and orders as appropriate. She stated that resident #131 should	Y 339		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NCI-2643	A. BUILDING: _____ B. WING _____	03/11/2021

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Y 339	Continued From page 7 have had floor mats as ordered and care planned, and that her expectations were not met. She stated that the resident would be at risk for more falls if the interventions for fall prevention were not followed. Review of the facility's policy for assessing falls and their causes revealed: The purpose of this procedure is to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. General Guidelines included: Falls are a leading cause of morbidity and mortality among the elderly in nursing homes; falling may be related to underlying clinical or medical conditions, overall functional decline, medication side effects, and/or environmental risk factors; residents must be assessed regularly for potential risk of falls and relevant risk factors must be addressed properly. After an observed or probable fall, clarify the details of the fall, such as when the fall occurred and what the individual was trying to do at the time the fall occurred. Within 24 hours of a fall, begin to try to identify possible or likely causes of the incident. When a resident fall, the following information should be recorded in the resident's medical record: The condition in which the resident was found; Assessment data, including vital signs and any obvious injuries; Interventions, first aid, or treatment administered; Notification of the physician and family, as indicated; Completion of a falls risk assessment; Appropriate interventions taken to prevent future falls; The signature and title of the person recording the data.	Y 339		
Y 342	R9-10-403.C.2.e. Administration R9-10-403.C. An administrator shall ensure that:	Y 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NCI-2643	A. BUILDING: _____ B. WING _____	03/11/2021

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Y 342	Continued From page 8 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: R9-10-403.C.2.e. Cover infection control; This RULE is not met as evidenced by: Based on observations, staff interviews, facility documentation, policies and procedures, and the Centers for Disease Control (CDC) guidelines, the facility failed to implement their policies to ensure that infection control measures were implemented during communal dining, staff screening for COVID-19 was complete, and that staff appropriately donned and doffed personal protective equipment (PPE), performed hand hygiene, and cleaned eye protection. Findings include: -Regarding Communal Dining: During the entrance conference for the recertification survey on March 1, 2021 at 10:53 a.m. with the Administrator (staff #216), Assistant Administrator (staff #217), and the Director of Nursing (DON/staff #51), they stated that the most recent positive case of COVID-19 had occurred over the weekend (February 27, 2021), indicating that the facility was currently in outbreak status. On March 1, 2021 at 12:07 p.m., an observation	Y 342	Y342 **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?** No Residents found to be affected. **How will you identify other residents having the potential to be affected by the 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 or what systemic changes will you make to ensure that the deficient practice does not recur?** All staff will be in-serviced on screening process by ICP for COVID-19 regarding temperatures, proper donning and doffing of PPE, and hand hygiene. Reception screeners in-service by ICP on conducting screening and reviewing documentation for completeness. ICP to in-service all staff on "Keep COVID-19 OUT!", "Use PPE Correctly for COVID-19", and "Clean Hands: Combat COVID-19!"	4/20/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Y 342	Continued From page 10 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 ½ 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	Y 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NCI-2643	A. BUILDING: _____ B. WING _____	03/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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.

The facility's policy titled Social Distancing Policy, effective March 1, 2020, stated that in the event of an outbreak of a highly infectious and/or deadly disease, including a pandemic, the facility will enact its Social Distancing Policy in an attempt to limit the spread of disease through human to human contact. Actions to minimize contact between infected and healthy individuals will range from the use of sick time, and limitation or cancellation of the following, including activities involving groups and group meals. Social distancing is a public health practice designed to limit the spread of infection by ensuring sufficient physical distance between individuals. Taking measures to ensure social distancing decreases opportunities for close contact among persons, thereby decreasing the potential for disease transmission among people and slowing the spread of disease. Social distancing measures may include a recommended minimum distance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NCI-2643	A. BUILDING: _____ B. WING _____	03/11/2021

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Y 342	Continued From page 12 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	Y 342		

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NCI-2643	A. BUILDING: _____ B. WING _____	03/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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 staff's 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 AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NCI-2643	A. BUILDING: _____ B. WING _____	03/11/2021

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

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Y 342	Continued From page 14 temperatures on the screening did not meet her expectation. The facility's policy titled Coronavirus Disease (COVID-19) stated the facility will conduct education, surveillance, and infection control and prevention strategies to reduce the risk of transmission of COVID-19. The facility will follow and implement recommendations and guidelines in accordance with the CDC, the State Department of Public Health, and County Department of Health. The policy stated that everyone entering the facility will be screened including, all visitors, residents returning from trips out, and employees before they enter the facility, including obtaining a temperature. The CDC guidelines titled Preparing for COVID-19 in Nursing Homes, updated November 20, 2020, included core practices which should remain in place even as nursing homes resume normal activities, including evaluating and managing healthcare personnel. The guidance stated that all HCP should be screened at the beginning of their shift for fever and symptoms of COVID-19, that temperatures should be actively taken, and the absence of symptoms consistent with COVID-19 documented. Regarding PPE and hand hygiene: -Review of the facility census dated March 1, 2021 revealed there were 34 residents residing on the B-100 hall/secure dementia unit. Further review revealed 5 out of 34 of the residents were new admissions and were on 14-day observation/droplet precautions for signs and symptoms of COVID-19. On March 1, 2021 at 12:25 p.m., an observation	Y 342		

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NCI-2643	A. BUILDING: _____ B. WING _____	03/11/2021

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

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Y 342	Continued From page 15 was conducted of the B-100 hall. PPE carts were observed outside of the rooms where the residents that were new admissions resided. In addition, posted on the doorframe of each of their rooms was a green sign. The sign stated to stop and please see a nurse before entering, and to turn the sign over for PPE requirements to enter the room. The other side of the sign stated that the individual in the room was a Person Under Investigation (PUI). Instructions included that housekeeping staff must wear N95 or KN95 mask, surgical mask over the N95 or KN95 mask, gown, face shield or goggles, and gloves, that staff should wash hands with soap and water, or may use hand sanitizer, and that staff should clean face shield/goggles when they were done in the room. On March 1, 2021 at 12:28 p.m., a housekeeper (staff #196) was observed to clean a room of one of the resident's on observation/droplet precautions. The housekeeper was observed to don a N95/KN95 face mask with a surgical mask covering it, goggles, gloves, and a gown. However, the housekeeper's gown was observed to be tied at the waist and not at the neck. As the housekeeper mopped the floor, the gown was observed to slip off her shoulders, covering only the lower portion of her arms. The housekeeper's back, chest, and upper arms were completely exposed. At approximately 12:32 p.m., the housekeeper doffed her gown and walked to the nurses' station. The housekeeper was not observed to doff her gloves and surgical mask, and she did not clean her goggles. The housekeeper told the nurse the resident required assistance. The nurse followed the housekeeper back to the resident's room, and the nurse donned full PPE prior to entering the resident's room. The housekeeper doffed her gloves at the	Y 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NCI-2643	A. BUILDING: _____ B. WING _____	03/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 342	Continued From page 16	Y 342		

door to the resident's room, did not perform hand hygiene, did not doff the surgical mask, and did not clean her goggles. The housekeeper was then observed to don a clean pair of gloves and pull her cart into the doorway of a resident's room who was not on isolation precautions. She took a spray bottle and cloth into the resident's room and began to clean it.

At 12:49 p.m. on March 1, 2021, an interview was conducted with the housekeeper (staff #196). Staff #196 stated that she was not supposed to wear her gown untied at the neck and that she was taught to tie her gown at the neck and the waist when entering a PUI room. The housekeeper stated that when she exits the resident's room, she takes off her gown and gloves, and that is about it. She stated that she takes off her goggles to clean them with window cleaner before going into the next resident's room. Staff #196 stated that she was told to clean her goggles with window cleaner. She said she washes her hands when she is finished in one resident's room and will wash her hands again when she enters the next resident's room. The housekeeper stated that she still needed to wash her hands.

On March 4, 2021 at 10:44 a.m., an interview was conducted with the IP (staff #143). The IP stated all staff were educated about PPE in January 2021. She stated her expectation for staff entering a PUI room is to don the double masks, face shield or goggles, gown, and gloves. The IP stated that when staff leave the PUI room, her expectation is that staff doff the gown, gloves, and surgical mask before they exit. She stated staff may clean their face shield or goggles with alcohol swabs either in the room before they leave, or right as they exit. The IP stated that the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NCI-2643	A. BUILDING: _____ B. WING _____	03/11/2021

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Y 342	Continued From page 17	Y 342		

risk for not following that process would be possible cross contamination.

An interview was conducted on March 5, 2021 at 8:42 a.m. with the Director of Nursing (DON/staff #51). She stated that her expectation for staff entering a PUI room included to don a gown that was tied at the neck and waist, masks, face shield or goggles, and gloves if providing care.

The facility policy's titled Handwashing/Hand Hygiene/Hand Hygiene Monitoring revised March 2020, stated that the facility considered hand hygiene the primary means to prevent the spread of infections. The policy stated that all personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors which included to use an alcohol-based hand rub containing at least 62% alcohol, or alternatively, soap and water in the following situations: after removing gloves and before and after entering isolation precaution settings. The policy stated that hand hygiene is the final step after removing and disposing of PPE.

The facility's COVID-19 Reference Binder included the use of face shields for Persons Under Investigation (PUIs). The cleaning of face shields included wearing gloves and using alcohol wipes to disinfect the shield. Wipe the inside followed by the outside of the face shield, allow to fully dry, dispose of gloves, and perform hand hygiene. Also included was that the face shield must be cleaned after leaving each PUI room.

The facility's COVID-19 Reference Binder

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NCI-2643	A. BUILDING: _____ B. WING _____	03/11/2021

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Y 342	Continued From page 18 included the CDC guidance titled Use of PPE When Caring for Patients with Confirmed or Suspected COVID-19. The guidance stated that PPE must be donned correctly before entering the patient area including tying all the ties on the gown; PPE must remain in place and be worn correctly for the duration of work in potentially contaminated areas; and PPE must be removed slowly and deliberately in a sequence that prevents self-contamination. The doffing instructions included that gloves should be removed prior to exiting the patient room. The CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic updated December 14, 2020 stated that the CDC recommended using additional infection prevention and control practices during the COVID-19 pandemic, along with standard practices, as a part of routine healthcare delivery to all patients. These practices are intended to apply to all patients, not just those with suspected or confirmed SARS-CoV-2 infection. The guidance stated that employers should select appropriate PPE and provide it to HCP. HCP must receive training on and demonstrate an understanding of when to use PPE, what PPE is necessary, how to properly don, use, and doff PPE in a manner to prevent self-contamination. Additionally, any reusable PPE must be properly cleaned, decontaminated, and maintained after and between uses. -An observation was conducted of the facility COVID testing process on March 4, 2021 at 7:10 a.m. The Certified Nursing Assistant (CNA/staff #95) conducting the testing, was observed to don a gown, but did not secure/tie the gown at the	Y 342		

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NCI-2643	A. BUILDING: _____ B. WING _____	03/11/2021

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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.	Y 342		

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NCI-2643	A. BUILDING: _____ B. WING _____	03/11/2021

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Y1045	R9-10-410.B.4.c. Resident Rights R9-10-410.B. An administrator shall ensure that: R9-10-410.B.4. A resident or the resident's representative: R9-10-410.B.4.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 failed 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 Aripiprazole (antipsychotic) 5 milligram (mg) tablet give 0.5 tablet by mouth at bedtime for severe depression augmentation as evidenced by (AEB) suicidal ideation.	Y1045	**Y1045** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice, on both a temporary and permanent basis, including the date the correction will be accomplished?** Resident # 58, #74, and #106 found to be affected, all consents corrected and obtained for these residents. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** The DON and/or designee conducted a medical record review for all residents on psychotropics on 4/5/2021. No other residents were found to be affected **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** DON and/or Designee conducted an in-service on Psychotropic consents to licensed nurses. **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**	4/20/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Y1045	Continued From page 21 Review of the Medication Administration Record (MAR) dated December 2020 revealed the resident received the Aripiprazole as ordered on December 30 and 31, 2020. Review of a quarterly Minimum Data Set (MDS) assessment dated January 11, 2021 revealed the resident had a Brief Interview for Mental Status (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 the resident received the Aripiprazole as ordered from January 1 through 21, 2021. 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. 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.	Y1045	**for implementing/monitoring the corrective action?** The DON and/or Designee will audit all orders daily of psychotropics for completion and accuracy of consent for 21 days. Any consent found to be out of compliance will be reported to the DON and/or Designee for immediate correction and re-education to licensed staff.	

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Y1045	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 Abilify/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 constipation, seizure disorder, or edema is present. However, Aripiprazole/Abilify 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 Dyskinesia, seizure disorder, chronic constipation, glaucoma, diabetes, skin pigmentation, yellowing of the skin.	Y1045		

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	NCI-2643	A. BUILDING: _____ B. WING _____	03/11/2021

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Y1045	Continued From page 23 Review of the current care plan, last revised March 2, 2021, revealed the resident used psychotropic medications related to major depression AEB passive suicidal ideation. An interview was conducted on March 9, 2021 at 11:32 a.m. with a Licensed Practical Nurse (LPN/staff #180). She stated that staff must obtain consent from the resident or the resident representative to receive a psychotropic medication before the medication could be administered. She stated that the consent included the name of the medication, the dose ordered, why the medication was being used, the classification of the medication and potential side effects of the medication. She stated that the medication classification marked on the consent form should match the actual classification of the medication that was ordered, even if the medication is being used for a different reason. She stated that the unit manager would let the floor nurse know that the resident would be getting a psychotropic medication and would obtain the consent if she was able, if unable, the unit manager would assign a nurse to obtain the consent. An interview was conducted on March 11, 2021 at 4:15 p.m. with the Director of Nursing (DON/staff #51). She stated that she expects staff to obtain informed consent from the resident or the resident's representative when a psychotropic medication is ordered and before the medication is administered. She stated that the consent should contain the medication being given, what the medication is being used for, review of potential side effects, and the correct classification for the medication. For the Abilify/Aripiprazole for resident #58, she stated that the consent should have been obtained	Y1045		

ADHS LICENSING SERVICES

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Y1045	Continued From page 24 before the medication was administered in December of 2020 and that it was not. She stated the consent was not obtained until January 26, 2021 and that her expectations were not met. She stated that the medication was an antipsychotic and should not have been marked on the consent form as an antidepressant and that the side effects reviewed with the resident would not have been correct for the medication ordered. -Resident #74 was admitted to the facility on February 8, 2020, with diagnoses that included alcohol abuse, acute pyelonephritis, and urinary tract infection. Regarding Fluoxetine A physician's order dated November 14, 2020 included for Fluoxetine HCL Tablet 20 mg give 1 tablet by mouth in the morning for anxiety as evidenced by restlessness related to Post Traumatic Stress Disorder, Unspecified. This order was discontinued on November 17, 2020. A physician's order dated November 18, 2020 included for Fluoxetine HCL Tablet 20 mg give 1 tablet by mouth in the morning for Depression as evidenced by lack of interest in activities related to Post Traumatic Stress Disorder, Unspecified. This order was discontinued on January, 6, 2021 A physician's order dated January 7, 2020 included for Fluoxetine HCL Tablet 20 mg give 2 tablets by mouth in the morning for Depression as evidenced by lack of interest in activities. A review of the MARs for November and December 2020, and January, February, and March 2021 revealed the resident was	Y1045		

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Y1045	Continued From page 25 administered Fluoxetine as ordered. The Consultant Pharmacist's Medication Regimen Reviews for November 2020, December 2020, and January 2021 included resident #74 was recently started on Fluoxetine and that the pharmacist was unable to find a consent for the medication in the electronic charting system. Continued review of the clinical record revealed a consent for Fluoxetine was obtained on February 11, 2021. Regarding Quetiapine Fumarate A physician's order dated October 21, 2020 included for Quetiapine Fumarate (antipsychotic) 50 mg give 1 tablet by mouth at bedtime for psychosis related to Post Traumatic Stress Disorder as evidenced by delusions. This order was discontinued on November 18, 2020. A physician's order dated November 7, 2020 included for Quetiapine Fumarate give 50 mg tablet by mouth one time only for verbal and physical aggression for 1 day. A physician's order dated November 18, 2020 included for Quetiapine Fumarate 50 mg tablet 50, give 1.5 tablet by mouth at bedtime for psychosis related to Post Traumatic Stress Disorder as evidenced by delusions. This order was discontinued on November 22, 2020. A Physician's Order dated November 22, 2020 included Quetiapine Fumarate 50 mg tablet, give 1 tablet by mouth at bedtime for psychosis related to Post Traumatic Stress Disorder as evidenced by delusions.	Y1045		

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Y1045	Continued From page 26 Review of the MARs for November and December 2020, and January and February 2021 revealed the resident was administered Quetiapine Fumarate as ordered. The Consultant Pharmacist's Medication Regimen Reviews dated November and December 2020, and January 2021 included the consent form for resident #74 for Quetiapine indicated a specific dose of 25 mg, that the dose had changed, and that facility should consider obtaining an updated consent for the use of Quetiapine. However, no consents were found for the change in dosage to 50 mg in October or the change in dosage to 75 mg in November until February 11, 2021 An interview was conducted on March 11, 2021 at 10:55 A.M. with this resident's LPN (staff #171), who said the pharmacy medication reviews are conducted by the pharmacist and then sent to DON who then distributes to them to staff to review and send to the provider. The LPN stated the provider documents if they want to change the order. Staff #171 said that regarding consents, she would review the chart to locate the consent and that if there was not a consent, she would speak to the resident or the resident's family to obtain the consent. Staff #171 stated that she was not sure why this resident was missing consents. The LPN said that it could have been given it to the physician and not returned. An interview was conducted on March 11, 2021 at 3:22 p.m. with the DON (staff #51), who said the expectation is that when a new psychotropic	Y1045		

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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 LICENSING SERVICES

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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Y1045	Continued From page 28	Y1045		

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 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 the medication. The DON stated the Mirtazapine should not have been 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 involved in the decision. A resident and/or representative has the right to be informed about

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NCI-2643	A. BUILDING: _____ B. WING _____	03/11/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y1045	Continued From page 29 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.	Y1045		
Y1147	R9-10-411.C.9. Medical Records R9-10-411.C. An administrator shall ensure that a resident's medical record contains: R9-10-411.C.9. Orders; 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	Y1147	**Y1147** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice, on both a temporary and permanent basis, including the date the correction will be accomplished?** Resident #16 found to be affected. Order already updated previously. **How will you identify other residents having the potential to be affected by the 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 house on 3/30/2021. No other residents were found to be affected. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** Administrator and/or Designee conducted an in-service on hospice orders to IDT on 3/18/2021.	4/20/2021

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	NCI-2643	A. BUILDING: _____ B. WING _____	03/11/2021

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Y1147	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 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 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	Y1147	**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 Social Service Director and/or Designee will audit all new Hospice admits for correct orders for 28 days. Any hospice residents found to be out of compliance will be reported to the DON and/or Designee for immediate correction and re-education to IDT.	

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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.	Y1147		
Y1235	R9-10-412.B.7. Nursing Services R9-10-412.B. A director of nursing shall ensure that: R9-10-412.B.7. An unnecessary drug is not administered to a resident. 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 #78) were not administered unnecessary drugs by failing to consistently monitor for adverse side effects of use and targeted behaviors. 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 3, 2020 for Duloxetine hydrochloride (HCL) (antidepressant) 60 milligram (mg) capsule by mouth two times a day	Y1235	**Y1235** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice, on both a temporary and permanent basis, including the date the correction will be accomplished?** Resident #58, #74 and #78 found to be affected. Orders corrected 2/11/21. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** The DON and/or designee conducted a medical record review for all residents on psychotropics on 4/5/2021 no other residents found to be affected. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** DON and/or Designee conducted an in-service on Psychotropic PRN orders to licensed nurses.	4/20/2021

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	NCI-2643	A. BUILDING: _____ B. WING _____	03/11/2021

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Y1235	Continued From page 32 for depression as evidenced by passive suicidal ideations. -A second order dated December 30, 2020 for Aripiprazole (antipsychotic) 5 mg tablet give 0.5 tablet by mouth at bedtime for severe depression augmentation as evidenced by (AEB) suicidal ideation. 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 suicidal ideations every shift for passive suicidal ideations, depression. However, there was no documentation of the above monitoring on the "day" shift for December 15, and 20-22, 2020, no documentation on the "night" shift December 25 and 30, 2020, and no documentation for antipsychotic side effects. Review of a quarterly Minimum Data Set (MDS) assessment dated January 11, 2021 revealed the resident had a Brief Interview for Mental Status	Y1235	**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 DON and/or Designee will audit all orders daily of psychotropics for PRN use for 21 days. Any psychotropic found to be out of compliance will be reported to the DON and/or Designee for immediate correction and re-education to licensed staff.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NCI-2643	A. BUILDING: _____ B. WING _____	03/11/2021

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

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Y1235	Continued From page 33 (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 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 suicidal ideations every shift for passive suicidal ideations, depression.	Y1235		

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NCI-2643	A. BUILDING: _____ B. WING _____	03/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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	Y1235		

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Y1235	Continued From page 35 symptoms. An interview was conducted on March 9, 2021 at 11:32 a.m. with a Licensed Practical Nurse (LPN/staff #180). The LPN stated that a psychotropic medication 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 shift. Staff #180 stated that the documentation should be filled in and should not have blanks. She stated that if there were blanks on the monitors record staff would not be able to show that the monitoring was done. After review of the behavior and side effect monitoring for resident #58, she stated that staff did not follow facility expectation for documentation. The LPN stated that it is important to monitor the resident for side effects and behaviors to determine if the medication was effective for the resident's needs or to be able to see if the resident was having side effects. An interview was conducted on March 11, 2021 at 3:22 p.m. with the Director of Nursing (DON/staff #51). The DON stated that she expects all residents who are receiving psychotropic medications to be monitored every shift for side effects and target behaviors. The DON stated that the monitoring should be documented in one of the administration records (i.e. Monitors, MAR, Treatment Administration Record) and needs to completed by a licensed nurse, not a Certified Nursing Assistant (CNA). The DON reviewed the administration record for resident #58 and stated that staff did not meet expectations related to the missing documentation of side effect and target behavior monitoring.	Y1235		

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Y1235	Continued From page 36 -Resident #78 was readmitted to the facility on December 20, 2020 with diagnoses that included unspecified dementia without behavioral disturbance and major depressive disorder, recurrent. 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 December 2020 and January 2021 revealed the resident was administered citalopram hydrobromide. The significant change MDS assessment dated January 12, 2021 revealed a score of 00 on the BIMS, indicating the resident had severe cognitive impairment. The assessment included the resident received antidepressant medication for 7 out of the 7 days during the look-back period. However, a review of the Monitors documentation for January 2021 revealed no documentation to indicate whether or not the resident had exhibited antidepressant target behaviors, side-effects, and adverse reactions on 2 out of 31 day shifts and 5	Y1235		

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	NCI-2643	A. BUILDING: _____ B. WING _____	03/11/2021

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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 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.	Y1235		

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	NCI-2643	A. BUILDING: _____ B. WING _____	03/11/2021

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Y1235	Continued From page 38 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 did not reveal the resident was being monitored for adverse side effects and the targeted behavior for 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 MAR/TAR in the monitoring section.	Y1235		

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Y1235	Continued From page 39 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	Y1235		

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 documented in the resident's medical record.	Y1235		
			Y1477	4/20/2021
Y1477	R9-10-414.B.3.b. Comprehensive Assessment; Care Plan R9-10-414.B. An administrator shall ensure that a care plan for a resident: R9-10-414.B.3. Ensures that a resident is provided nursing care institution services that: R9-10-414.B.3.b. Assist the resident in maintaining the resident's highest practicable	Y1477	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice, on both a temporary and permanent basis, including the date the correction will be accomplished?** Resident #74, and #16 found to be affected. Care Plan updated 3/12/2021.	

ADHS LICENSING SERVICES

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Y1477	Continued From page 41 well-being according to the resident's comprehensive assessment. This RULE is not met as evidenced by: Based on clinical record review, resident and staff interviews, and review of policy and procedures, the facility failed to ensure a care plan was developed to assist two residents (#74 and #16) in maintaining their highest practicable well-being by failing to address depression and the use of an antidepressant medication for resident #74 and religious dietary preferences for resident #16. Findings include: -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. Regarding depression Review of the admission Minimum Data Set (MDS) assessment dated February 15, 2020, included a Resident Mood Interview Patient Health Questionaire-9 (PHQ-9) total Severity Score was 11, which indicated the resident had moderate depression. The assessment also included the Mood State care area was triggered on the Care Area Assessment (CAA) Summary and that Mood State would be addressed in the care plan. However, review of the care plan initiated	Y1477	**How will you identify other residents having the potential to be affected by the 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 found to be affected. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** Administrator and/or Designee conducted an in-service on Comprehensive Care Plan for religion and depression to Social Services Department on 3/19/2021. **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 Social Service Director and/or Designee will audit all new admits for completion and accuracy of care plans related to depression and religion for 28 days. Any Care Plans found to be out of compliance will be reported to the Administrator and/or Designee for immediate correction and re-education to Social services department.	

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NCI-2643	A. BUILDING: _____ B. WING _____	03/11/2021

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

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Y1477	Continued From page 42 February 27, 2020 did not include depression. An interview was conducted on March 10, 2021 at 2:10 P.M. with the MDS Registered Nurse (staff #87), who stated that when a resident is admitted, the admission MDS assessment period is from day 1 to day 8, and then they have 7 days after that to develop the comprehensive care plan. After reviewing resident #74's clinical record, staff #87 stated the mood care area was triggered due to depression. Staff #87 stated Social Services completes that area of the care plan. An interview was conducted on March 11, 2021 at 3:21 P.M. with the Director of Nursing (DON/staff #51), who said the care plan focuses are generated by the MDS assessment. The DON stated that she would review the resident's clinical record regarding the depression score. A follow up interview was conducted on March 11, 2021 at 4:50 P.M. with the DON (staff #51). The DON said that her expectation is that the staff should have develop a care plan for this resident as the score indicated moderate depression. Regarding an antidepressant medication Review of the clinical record revealed a physician order dated November 14, 2020 for Fluoxetine (antidepressant) 20 milligrams (mg) one tablet by mouth in the morning for anxiety as evidenced by (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.	Y1477		

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	NCI-2643	A. BUILDING: _____ B. WING _____	03/11/2021

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Y1477	Continued From page 43 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	Y1477		

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	NCI-2643	A. BUILDING: _____ B. WING _____	03/11/2021

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Y1477	Continued From page 44 associated with the medication. An interview was conducted on March 11, 2021 at 3:22 P.M. with DON (staff #51), who stated psychotropic medications and monitoring for side effects, adverse reactions and behaviors associated with those medications should be care planned. The DON stated it is her expectation that any psychotropics medications ordered for resident #74 be care planned. The DON acknowledged the antidepressant medication was not addressed in resident #74's care plan until March 1, 2021. -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 resident information face sheet revealed Jewish as the resident's religion. 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 was completed by the dietician (staff #124). 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. Review of the care plan revealed a care plan had not been developed to include the resident's Jewish preferences related to diet. An interview was conducted on March 4, 2021 at	Y1477		

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	NCI-2643	A. BUILDING: _____ B. WING _____	03/11/2021

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Y1477	Continued From page 45	Y1477		

2:02 P.M. with the dietician (staff #124), who stated a dietary assessment is conducted for new residents which includes discussing the resident's food preferences. Staff #124 stated that dietary preferences and religious beliefs are determined by visits to the resident. Staff #124 stated that the facility has not had many residents with religious preference requests in the past and is "not aware of any residents with religious preferences at this moment." Staff #124 stated she completes the nutrition component of the care plan. When asked if she was aware of resident #16 Jewish faith and his preference for a Jewish diet, staff #124 responded "I was not aware of that." Staff #124 stated she would update resident #16 care plan with his Jewish diet preferences.

In an interview conducted with the resident on March 11, 2021 at 1:10 P.M., the resident stated that he is active in the Jewish faith.

An interview was conducted on March 11, 2021 at 3:22 P.M. with the DON (staff #51), who stated it is her expectation that the diet portion of the care plan would include religious diet preferences. Staff #51 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's Comprehensive Care Plan policy revised December 2016 stated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NCI-2643	A. BUILDING: _____ B. WING _____	03/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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Y1477	Continued From page 46 comprehensive, person-centered care plan for each resident. The policy included the IDT includes a member of the food and nutrition services staff and other appropriate staff or professionals as determined by the resident's needs or as requested by the resident. The policy also included the care planning process will incorporate the resident's personal and cultural preferences in developing the goals of care. The care plan will incorporate identified problem areas and incorporate risk factors associated with identified problems; and will identify the professional services that are responsible for each element of care.	Y1477		
Y1911	R9-10-419.2.e. Respiratory Care Services R9-10-419. If respiratory care services are provided on a nursing care institution's premises, an administrator shall ensure that: R9-10-419.2. Respiratory care services are provided according to an order that includes: R9-10-419.2.e. The oxygen concentration or oxygen liter flow and method of administration; This RULE is not met as evidenced by: Based on observations, clinical record review, staff interviews, and policy review, the facility failed to ensure one resident (#358) had an order to provide oxygen to the resident. Findings include: Resident #358 was admitted to the facility on February 28, 2021, with diagnoses that included	Y1911	<u>Y1911</u> **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice, on both a temporary and permanent basis, including the date the correction will be accomplished?** Resident #358 found to be affected. Order obtained 3/12/2021 **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** The DON and/or designee conducted a full house audit for residents on oxygen and orders on 3/23/2021. No other residents found to be affected	4/20/2021

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	NCI-2643	A. BUILDING: _____ B. WING _____	03/11/2021

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

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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 was observed receiving oxygen 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 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 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 administer oxygen. An interview was conducted on March 10, 2021 at 11:51 A.M. with the LPN Unit Manager (staff	Y1911	**What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** DON and/or Designee conducted an in-service to Licensed nurse on oxygen orders completed on 4/3/2021 **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 DON and/or Designee will audit new admits for oxygen and orders 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..	

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Y1911	Continued From page 48 #126), who said the resident had orders for oxygen from the hospital and that the resident has been receiving oxygen since admission. Staff #126 stated they missed inputting the order for oxygen. In an interview conducted 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 resident was missed. The DON stated her expectation would be that if the resident has orders from the hospital, an order would be obtained and the care provided. The facility's policy titled Oxygen Administration revealed the purpose of the procedure is to provide guidelines for safe oxygen administration. This procedure included verifying that there is a physician's order for the procedure and reviewing the physician's orders or facility protocol for oxygen administration.	Y1911		
Y2159	R9-10-421.D.3.a. Medication Services R9-10-421.D. When medication is stored at a nursing care institution, an administrator shall ensure that: R9-10-421.D.3. Policies and procedures are established, documented, and implemented to protect the health and safety of a resident for: R9-10-421.D.3.a. Receiving, storing, inventorying, tracking, dispensing, and discarding medication including expired medication;	Y2159	**Y2159** **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?** No residents found to be affected. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No residents found to be affected.	4/20/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NCI-2643	A. BUILDING: _____ B. WING _____	03/11/2021

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Y2159	Continued From page 49 This RULE is not met as evidenced by: Based on observations, staff interviews, and policy review, the facility failed to implement their policy to ensure expired medications and glucose test strips were not available for use and failed to ensure medications were stored at the recommended temperature. Findings include: An observation was conducted of the medication cart on the C-1 hall with a Licensed Practical Nurse (LPN/staff #139) on March 3, 2020 at 9:19 a.m. An opened vial of Novolin 70/30 insulin was observed, dated opened on February 1, 2021 and an opened vial of Lispro 100 insulin was observed, dated opened on January 2, 2021. The box containing the Novolin 70/30 insulin and the box containing the Lispro 100 insulin both had a sticker on it that stated "store in refrigerator". Continued observations of the medication cart revealed an unopened box of Novolin 70/30 insulin that had a sticker on the box that stated "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	Y2159	**What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** DON and/or Designee conducted an in-service on Medication storage to licensed nurses on 3/3/21. **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 DON and/or Designee will audit all medication carts and storage areas weekly for expired or mis- stored items for 21 days. Any medications found to be out of compliance will be reported to the DON and/or Designee for immediate correction and re-education to licensed staff.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NCI-2643	A. BUILDING: _____ B. WING _____	03/11/2021

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Y2159	Continued From page 50 Nursing (DON/staff #51) on March 3, 2021 at 11:09 a.m. The DON stated expired medications are not to be left in the medication carts. Staff #51 stated the nurses are responsible for ensuring all expired medications are removed from the medication cart and given to her for disposal. The DON stated that using expired insulin is a problem as it may lose its potency and not work properly. The DON also stated that once opened, insulin is good for 30 days. She said that all unopened insulin is to be stored in the refrigerator. The DON stated that there should not be any broken glucometers on any medication carts. Staff #51 stated the nurse is expected to advise the unit manager of the broken item so that it can be promptly replaced. Review of the facility's policy, Storage of Medications, revealed drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. Discontinued, outdated or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. Medications requiring refrigeration are stored in a refrigerator located in the drug room at the nurses' station or other secured location.	Y2159		
Y2301	R9-10-423.A.1. Food Services R9-10-423.A. An administrator shall ensure that: R9-10-423.A.1. The nursing care institution has a license or permit as a food establishment under 9 A.A.C. 8, Article 1;	Y2301	**Y2301** **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?** No Residents found to be affected.	4/20/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NCI-2643	A. BUILDING: _____ B. WING _____	03/11/2021

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

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Y2301	Continued From page 51 This RULE is not met as evidenced by: Based on observations, staff interviews, quaternary information sheet, and review of policy and procedures, the facility failed to ensure that food establishment requirements were followed by failing to ensure quaternary sanitizing solution was maintained at the required level. Findings include: During an observation conducted on March 1, 2021 at 11:06 A.M., the Kitchen Manager (staff #173) was observed to test the concentration level of a sanitation bucket that was on a coffee cart in the kitchen. The test results revealed the quaternary ammonium concentration level was below the minimum level of 200 parts per million (ppm). An interview was conducted immediately following this observation with staff #173 who said the bucket solution needed to be changed out now. He stated that the sanitation buckets solution was changed out every 4 hours. Another observation was conducted on March 3, 2021 at 10:37 A.M. The Kitchen Manager (staff #173) was observed to test the sanitizing solution in a sanitation bucket that was on a coffee cart in the kitchen. The result of the test was 100 ppm. 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.	Y2301	**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No Residents found to be affected. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** Administrator and/or Designee conducted an in-service to dietary staff on sanitization bucket completed on 3/31/2021. **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 Administrator and/or Designee will audit all sanitization buckets for proper levels daily for 21 days. Any buckets found to be out of compliance will be reported to the Administrator and/or Designee for immediate correction and re-education of staff.	

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Y2301	Continued From page 52 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). A facility's policy and procedure manual titled	Y2301		

ADHS LICENSING SERVICES

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Y2301	Continued From page 53 Food Safety - Director of Food and Nutrition Services' Responsibilities revealed that the director of food and nutrition will be responsible for providing safe foods to all individuals. It included that sanitary conditions will be maintained in the food storage, preparation and serving areas, and that employees will follow proper cleaning and sanitizing instructions for all kitchen equipment.	Y2301		
Y2349	R9-10-423.B.6. Food Services R9-10-423.B. A registered dietitian or director of food services shall ensure that: R9-10-423.B.6. Recommendations and preferences are requested from a resident or the resident's representative for meal planning; This RULE is not met as evidenced by: Based on observations, resident and staff interviews, clinical record review and policy review, the facility failed to ensure food preferences requested from one resident (#16) was implemented for meal planning. 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 resident information face sheet revealed Jewish as the resident's religion.	Y2349	**Y2349** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice, on both a temporary and permanent basis, including the date the correction will be accomplished?** Resident #16 affected by practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** The DON and/or designee conducted a medical record review for all residents on psychotropics on 4/5/2021 no other residents found to be affected **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?**	4/20/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NCI-2643	A. BUILDING: _____ B. WING _____	03/11/2021

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

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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. 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	DON and/or Designee conducted an in-service on Psychotropic PRN orders to licensed nurses. **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 DON and/or Designee will audit all orders daily of psychotropics for PRN use for 21 days. Any psychotropic found to be out of compliance will be reported to the DON and/or Designee for immediate correction and re-education to licensed staff.	

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Y2349	Continued From page 55 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	Y2349		

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Y2349	Continued From page 56 preferences and the dietician will conduct an assessment based on admitting notes and the kitchen manager's recommendations. Staff #124 stated she will visit the newly admitted resident if her assessment indicates a visit or if the kitchen manager recommends she visit. Staff #124 stated that dietary preferences and religious beliefs are obtained by visits to the resident. Staff #124 stated that the facility has not had many residents with religious preference requests in the past and that she is "not aware of any residents with religious preferences at this moment." Staff #124 stated that per resident #16 request, he is served cold cereal and a banana for breakfast, cottage cheese with fruit for lunch, and a chef salad for dinner. When asked if she was aware of resident #16 Jewish faith and his preference for a Jewish diet, staff #124 responded "I was not aware of that." During an interview was conducted with the resident on March 11, 2021 at 1:10 P.M., the resident stated that he is active in his Jewish faith. Resident #16 stated he does not practice a Kosher diet but he does practice a Pareve diet. Resident #16 stated a Pareve diet does not allow dairy with meat. Resident #16 stated he will not eat his meal if there is meat and dairy together on the tray. Resident #16 stated he often receives milk and meat on his food tray and that is not his preference and is not allowed on the Jewish diet. Resident #16 stated he would prefer not to receive dairy products on the same tray as his meat entrée. An interview was conducted with the Kitchen Manager (staff #173) on March 11, 2021 at 1:40 P.M. The Kitchen Manager stated he conducts the initial admission interview regarding diet with residents that are new admissions. Staff #173	Y2349		

ADHS LICENSING SERVICES

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Y2349	Continued From page 57 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.	Y2349		

ADHS
LICENSING

Notice of Inspection Rights

Facility/Agency Name: Sapphire Of Tucson Nursing And Rehab, Llc			
Address: 2900 East Milber Street		City: Tucson	Zip: 85714
Facility I.D.#: LTC0053	License #: NCI-2643	Medicare #: 035099	Date of Inspection: March 1, 2021
Survey Event ID: Q5L611			
Inspector/Team Coordinator: Johnna High			
Accompanied By: Carey Sexton, Sallie Martinez, Lisa Andrin-Mazur, Michael Stanton, Lisa Bashford, Samantha Potter			

BUREAU OF LONG TERM CARE LICENSING

This inspection is conducted under the authority of:

1. Arizona Revised Statutes (A.R.S.) Title 36, Chapters 1 and 4, and Arizona Administrative Code (A.A.C.), Title 9, Chapter 10. Some of the activities during the inspection may include, but are not limited to, a facility premise inspection, review and/or copying of records, including personnel records, interviews with residents/patients/clients, family and staff, and review of services offered.
2. The purpose of this inspection is to:
   - X Determine compliance with health care institution requirements pursuant to the above A.R.S. and A.A.C.
   - ☐ Conduct a complaint investigation.
3. No fees are charged for this inspection.
4. An authorized representative of this facility may accompany the inspector(s) during the inspection conducted on these premises, except during any confidential interview.
5. You have the right to receive copies of any original documents taken by the inspector(s) during the inspection in those cases where the agency has authority to take original documents.
6. You and your staff have the opportunity to provide any information that would clarify an issue. Additionally, interviews with staff, family or residents/patients/clients may be conducted privately. Each person interviewed will be informed that statements made by the person may be included in the inspection report and each person whose conversations are tape or video recorded will be informed that the conversation is being tape or video recorded.
7. Upon completion of the inspection the inspector(s) will conduct an exit interview and informally disclose their findings. A Statement of Deficiencies (SOD) formally notifying you of the findings will be provided within 30 working days. You will be afforded an opportunity to submit a Plan of Correction (POC) unless the Department is considering enforcement against the license.
8. You have an opportunity to dispute any findings of non-compliance through an Informal Dispute Resolution (IDR). Details of the IDR process will be provided when the SOD is mailed to you.
9. If you have questions regarding this inspection, you may contact: Diane Eckles, Bureau Chief, at 150 N. 18th Ave., Suite 440, Phoenix, Arizona 85007-3242, Phone: (602) 364-2675, FAX: (602) 324-0993, E-Mail: Diane.Eckles@azdhs.gov. If you have an issue that you cannot resolve with the Bureau or the Division, you may contact the Office of Ombudsman-Citizens' Aide, 7878 N. 16th St., Suite 235 Phoenix AZ 85020 (602) 277-7292.
10. Your administrative hearing rights are found at A.R.S. § 41-1092 et seq., and rights relating to appeal of a final agency decision can be found in A.R.S. §12-901 et seq.

Upon entry to the premises for this inspection, the inspector(s) presented photo identification indicating that they are Arizona Department of Health Services (ADHS) employees and reviewed with me the above Notice of Inspection Rights. I have read the disclosures and am notified of my inspection and due process rights as listed. I understand that while I have the right to decline to sign this form, the ADHS representative(s) may proceed with the inspection.

Administrator/Director/Agency Representative Signature — Date: 3/1/2021

☐ Administrator/Director/Agency Representative refused to sign this form.
☐ Administrator/Director/Agency Representative or authorized on-site representative is not present.

Inspector/Team Coordinator Signature: — Date: 3/1/2021

☒ Copy left with Administrator/Director/Agency Representative

QUALITY RATING CERTIFICATE

Arizona Department of Health Services

ARIZONA DEPARTMENT OF HEALTH SERVICES
NURSING CARE INSTITUTION

Issued To: Sapphire of Tucson 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	1
IV. Environment and Infection Control	13	2
V. Food Services	9	1
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 Effective:

From: To:

Issued:

Number: NCI-

Recommended By

Issued By Assistant Director

Quality Rating Evaluation

Facility: Sapphire of Tucson Nrsg & Reh Phone:

Address:

Survey Date: Contact Person:

Nursing Services:

Criteria:	Pts.	Criteria Met? YES	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	0
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	0

Points Yes 20

Points No 5

Comments:

Resident Rights:

Criteria:	Pts.	Criteria Met? YES	NO
The nursing care institution is implementing a system that ensures a resident's privacy needs are met.	10	10	0
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	0
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 23

Points No 2

Comments:

Administration:

Criteria:	Pts.	Criteria Met? 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	Ø
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	Ø
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	Ø
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	1	Ø
The nursing care institution is implementing a system to ensure that a resident is free from unnecessary drugs.	2	1	1
The nursing care institution is implementing a system to ensure a personnel member attends in-service education according to policies and procedures.	1	1	Ø

Points Yes 24

Points No 1

Comments:

Environment and Infection Control:

Criteria:	Pts.	Criteria Met? YES	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	/	Ø
The nursing care institution develops a written disaster plan that includes procedures for protecting the health and safety of residents.	1	/	Ø
The nursing care institution ensures orientation to the disaster plan for each staff member is completed within the first scheduled week of employment.	1	/	Ø
The nursing care institution maintains a clean and sanitary environment.	1	/	Ø
The nursing care institution is implementing a system to prevent and control infection.	5	3	2
An employee washes hands after each direct resident contact or where hand washing is indicated to prevent the spread of infection.	1	/	Ø

Points Yes 13

Points No 2

Comments:

Food Services:

Criteria:	Pts.	Criteria Met? 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	ϕ
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	ϕ
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	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	ϕ
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	ϕ

Points Yes 9

Points No 1

Comments: