LTC
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STATE DOCUMENTS ONLY

THESE ARE STATE DOCUMENTS FOR COMPLAINTS INVESTIGATION

VIC011

CONDUCTED ON

2.2.17

THESE ARE OUR STATE PUBLIC RECORDS

ARIZONA DEPARTMENT
OF HEALTH SERVICES
LICENSING

April 10, 2017

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

Dear Mr. Balliet:

Enclosed is the **State Form: Revisit Report** forms which indicate that the following deficiencies were found to be corrected on 03/27/2017 at the time of the follow-up investigation to Complaint #UICO12. A copy will be filed in your public file.

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

Sincerely,

B Hernandez

Belinda Hernandez
CSR4/Licensing Certification Specialist

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Enclosures

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
NCI-2643 Y1	A. Building B. Wing Y2	3/27/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON SOUTHWEST HEALTH & REHABILITATION	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 Reg. # R9-10-403.C.2.b. LSC	Correction Completed 02/24/2017	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☒	REVIEWED BY (INITIALS) DA	DATE 3/27/17	SIGNATURE OF SURVEYOR Dale Coleman	DATE 3/27/17
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
2/2/2017	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

Receipt of Notice Presumed 02/07/2017 via email

February 7, 2017

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

Dear Mr Balliet:

The purpose of this letter is to inform you that the Department of Health Services, Office of Long Term Care, has investigated complaint # UICO11 on February 2, 2017. As a result of this investigation, the Department has found the facility to be out of compliance with State licensing requirements. A statement of **State** deficiencies is attached to this letter

The statement of deficiencies must be addressed by submitting a Plan of Correction (PoC). 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.

Your POC should be specific and realistic since it will be a public document available to all 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 by **February 17, 2017**. You must include all pages of the Statement of Deficiencies when submitting your PoC. **Plans of Correction sent by fax will not be accepted.** Retain a copy for your files. If the PoC is not received by this Office on or before **February 17, 2017**, state enforcement actions may proceed.

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: Joel Bunis, Bureau Chief, Bureau of Long Term Care 150 North 18th Avenue, #440, Phoenix, Arizona 85007at (602) 364-2690.

Sincerely,

Diane Eckles

Diane Eckles
Bureau Chief

DE\bh

Attachments

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 _____	C 02/02/2017

RECEIVED FEB 17 2017 BY: _____

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON SOUTHWEST HEALTH & REHABILITA	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 A complaint (AZ133764, AZ134243, AZ134306, AZ134460, AZ134559, AZ134598, and AZ134600) investigation survey was conducted on January 30 through February 2, 2017. The following deficiencies were cited.	Y 000	"This Plan of Correction constitutes the facility's allegation of compliance for the deficiencies cited in the AZ Department of Health Service, Office of Long Term Care, Statement of Deficiencies. However, the submission of this plan is not an admission that a deficiency exists. The Plan of Correction is prepared solely because it is required by Federal and State law. This response and Plan of Correction does not constitute an admission or agreement by the provider of the facts alleged or the conclusions set forth in the Statement of Deficiencies. We have implemented the Plan of Correction as stated below to correct the deficiencies cited."	2/24/17
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 clinical record review, staff interview, and review of facility policies and procedures, the facility failed to implement their abuse policy regarding the reporting of an injury of unknown origin for one resident (#10). The sample size was five. Findings include: Resident #10 was admitted to the facility on November 10, 2015 with diagnoses that included Alzheimer's disease with late onset, unspecified dementia without behavioral disturbance, and	Y 339	**Y339** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice, on both a temporary and permanent basis, including the date the correction will be accomplished?** Resident #10, a Behavioral Health resident who was resistive to care, was subsequently assessed for bruising. Bruises were monitored until resolved. Inservices being conducted between 2/15/17 and 2/24/17, which target licensed nurses. These include investigating and reporting injuries of unknown origin.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brian D. Balliet — TITLE: ADMINISTRATOR — (X6) DATE: 2/15/2017

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 _____	C 02/02/2017

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Y 339	Continued From page 1 schizoaffective disorder. Review of the clinical record revealed a Nursing Note dated April 9, 2016 which documented "Resident (family member) in to visit, complaining of bruise on forehead and bruise on thigh. (Family member) taking pictures of bruises. States she is calling the police to press assault charges. This nurse tried to accommodate her questions about the origin of the bruise. I informed her it was documented and was being looked into by unit manager. (Family member) calling in more family to witness bruises. DON (director of nursing) notified. Unit manager notified. Resident and family have gone to the front of facility to await the arrival of Tucson police department." Further review of the Nursing Notes revealed no other documentation regarding how the resident obtained the bruising. A Physician Progress Note dated April 11, 2016 documented "...fall with contusion to head..." Review of the Nursing Notes revealed no documentation regarding the resident sustaining a fall. Facility documentation dated May 9, 2016 documented "In response to the allegations that the resident had an un-witnessed fall over the April 2, 2016 - April 3, 2016 weekend and on April 9, 2016 the resident was found with more extensive bruising than previously reported...Upon review of the CNA (certified nursing assistant) statements and observation of the resident, there was no reported fall. The resident has a tendency to either resist transfers, strike out or 'go limp' leaning to one side or another. This leads to the possibility of striking	Y 339	**How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** Residents with an injury of unknown origin have the potential to be affected. Weekly Skin Observations are conducted and documented. No other residents have been identified as affected. **What measures will be put in place or what systematic changes will be made to ensure the deficient practice does not recur?** Licensed nurses are being in-serviced by the Administrator/designee between 2/15/17 and 2/24/17 regarding investigating and reporting injuries of unknown origin, per facility policy. **How will the facility monitor corrective actions(s) to ensure the deficient practice does not recur?** The Director of Nursing/designee will audit the Risk Management Reports in PointClickCare 5x/week x 2 weeks and compare to the Weekly Skin Report weekly x 2 weeks, then monthly x 2 months. Audit findings will be reported to the QAPI Committee x 3 months or until a lesser frequency is deemed appropriate.	

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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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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Y 339	Continued From page 2 herself against the wall or any nearby object..." An interview was conducted with the administrator, staff #16 on January 31, 2017. The administrator provided documentation that the facility conducted an investigation regarding the resident's bruising. The administrator stated that the investigation could not be certain that the resident's bruising were caused by her combative behaviors. The administrator stated that the bruising was of unknown origin and should have been reported to the State survey and certification agency. A review of the facility's policy Abuse documented "...Types of abuse that must be reported:...Injuries of unknown origin: source of injury not observed, or explained by resident and injury includes bruising on the head,neck, or trunk, fingerprint bruises anywhere on the body, lacerations, sprains, or fractured bones...The administrator/designee will report allegations of abuse to the state and/or other agencies as appropriate/required..."	Y 339		

ADHS
LICENSING

Notice of Inspection Rights

Facility/Agency Name: Avalon Southwest Health & Rehab

Address: 2900 East Milber Street		City: Tucson	Zip: 85714
Facility I.D.#: LTC0053	License #: NCI-2643	Medicare #: 035099	Date of Inspection: January 30, 2017

Survey Event ID: UICO11

Inspector/Team Coordinator: Chris Benson

Accompanied By:

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: Joel Bunis, Bureau Chief, at 150 N. 18th Ave., Suite 440, Phoenix, Arizona 85007-3242, Phone: (602) 364-2675, FAX: (602) 324-0993, E-Mail: Joel.Bunis@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, 3737 N. 7th St., Suite 209, Phoenix, AZ 85014 (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.

Brian Bulliet — 1/30/2017

Administrator/Director/Agency Representative Signature — Date:

☐ 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: 1/30/17

☒ Copy left with Administrator/Director/Agency Representative