QUALITY RATING CERTIFICATE

ARIZONA DEPARTMENT OF HEALTH SERVICES
NURSING CARE INSTITUTION

ADHS

Issued To:

Sapphire of Tucson Nursing and Rehab, L.L.C.
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	25	0
II. Resident Rights	20	5
III. Administration	20	5
IV. Environment and Infection Control	10	5
V. Food Services	10	0
TOTAL CRITERIA MET	85	15

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: 1/10/19 To: 12/31/19

Issued: 2/20/19

Number: NCI-2643

Recommended By: Duane Eckles

Issued By

Assistant Director

TO BE FRAMED AND DISPLAYED IN A CONSPICUOUS PLACE

ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

April 8, 2019

IMPORTANT NOTICE- PLEASE READ CAREFULLY

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

Dear Ms. Wiggins:

On April 5, 2019, an offsite revisit was conducted for your facility by the Arizona Department of Public Health, Licensing, and Certification Bureau, to determine if your facility was in compliance with 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,

Sandy Farmer

Sandy Farmer
Customer Service Representative IV

\sf

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 04/05/2019

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 The follow up State Annual and complaint investigation survey was conducted on 4/5/19, there were no deficiencies cited.	{Y 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
NCI-2643 Y1	A. Building B. Wing Y2	4/5/2019 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 Y0350	Correction	ID Prefix Y0401	Correction	ID Prefix Y0703	Correction
Reg. # R9-10-403.C.5.a.	Completed	Reg. # R9-10-404.1.a.	Completed	Reg. # R9-10-407.2.	Completed
LSC	04/05/2019	LSC	04/05/2019	LSC	04/05/2019
ID Prefix Y1047	Correction	ID Prefix Y1215	Correction	ID Prefix Y1419	Correction
Reg. # R9-10-410.B.4.d.i.	Completed	Reg. # R9-10-412.B.2.	Completed	Reg. # R9-10-414.A.1.d.v.(2).	Completed
LSC	04/05/2019	LSC	04/05/2019	LSC	04/05/2019
ID Prefix Y1449	Correction	ID Prefix Y1473	Correction	ID Prefix Y1477	Correction
Reg. # R9-10-414.A.1.d.xvi.	Completed	Reg. # R9-10-414.B.2.	Completed	Reg. # R9-10-414.B.3.b.	Completed
LSC	04/05/2019	LSC	04/05/2019	LSC	04/05/2019
ID Prefix Y1911	Correction	ID Prefix Y2141	Correction	ID Prefix Y2503	Correction
Reg. # R9-10-419.2.e.	Completed	Reg. # R9-10-421.B.4.a.	Completed	Reg. # R9-10-425.A.1.b.	Completed
LSC	04/05/2019	LSC	04/05/2019	LSC	04/05/2019
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
☒	DA	4/5/19	Dale Adam	4/5/19
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 1/10/2019

☐ 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

March 19, 2019

Receipt Of This Notice Is Presumed To Be 03/19/2019
Important Notice - Please Read Carefully

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

Dear . Wiggins:

The State Agency has received, the Statement of Deficiencies and Plan of Correction for the annual survey investigation conducted on January 10, 2019 which was submitted to the Bureau of Long Term Care on March 5, 2019.

The Plan of Correction is unacceptable for the following reasons:

F000: Initial comments: Need to delete in the last sentence the words ..."required by the provisions of the Federal and State law." Replace with wording that the facility is demonstrating compliance for the deficiencies cited.

F552: Send the policy and procedure for the nurse designee to obtain all psychotropic consents and what happens when that nurse is unavailable.

F578: Send copies of newly signed consents for residents# 121 & 164.
Send copies of material that was taught for the in-service on obtaining consents along with sign-in sheets for all those that attended

F584: Send copy of policy and procedure for Quality of Life-Homelike Environment.
Send copy of in-service material taught to staff along with the sign-in sheets for those staff members that attended.

F600: Send copy of in-service material taught for de-escalation techniques training to staff along with the sign-in sheets for those staff members that attended.
How are you reducing the resident to resident abuse allegations necessary to be put back in compliance?
Send copies of staffing needs for each unit.
Send copies of tracking log of behaviors to date.
Send your policy on monitoring cameras in the facility.
Send policy for observing residents during a CNAs shift; is it every 15, 30 minutes or 1 Hour?
You did not address monitoring every 15 minutes for residents that are elopement risks. How are you auditing this monitoring by staff?

F607: Send copy of newly revised abuse policy and procedure.
When will staff be updated on new abuse policy and procedure in an In-service?

F609: Send copy of updated Policy done on 3/4/2019.

F623: Send updated copy of discharges for December 2018.
Send copy of the monthly discharge notifications to the Ombudsman for January, February 2019.

F645: Send copy of PASARR Level 2 screening for resident #61.
Send copy of tracking log for Level 2 screenings needed and done.

F657: Send copy of updated care plan for resident #74.

F695: Send a copy of the updated oxygen administration policy.
Send copy of audit oxygen tubing change to date.

F698: Send copy of physician order for dialysis for resident #151.
Send copy of dialysis audits for accurate physician orders to date.

F725: Send a copy of the updated call-in policy. F758: Send copy of all audits conducted to date.

Y000: Initial comments: Please delete your initial comments and if you choose you may use the State AG's office of the approved initial comments or leave blank, "This Plan of Correction is submitted to meet the requirements established by State law. This Plan of Correction constitutes the facility's demonstration of compliance for the deficiencies cited. Submission of this Plan of Correction is not an admission that a deficiency existed or that one was correctly cited."

The requested documents are required to be returned to this office no later than **March 26, 2019**, please retaining a copy for your files. If the requested documents for the Plan of Correction are not received by this office on or before **March 26, 2019** licensure action and/or civil penalties may be assessed.

Thank you for your cooperation. If you have any questions, please call the Bureau of Long Term Care at (602) 364-2690.

Sincerely,

Diane Eckles

Diane Eckles
Bureau Chief
DE\sg
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 _____	01/10/2019

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 The State compliance survey was conducted from January 7 through January 10, 2019, in conjunction with the following Complaint investigations: AZ00147662, AZ00152817, AZ00151707, AZ00153440 and AZ00152668. 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 the facility's demonstration of compliance for the deficiencies cited. Submission of the Plan of Correction is not an admission that a deficiency existed or that one was correctly cited.	
Y 350	R9-10-403.C.5.a. Administration R9-10-403.C. An administrator shall ensure that: R9-10-403.C.5. Unless otherwise stated: R9-10-403.C.5.a. Documentation required by this Article is provided to the Department within two hours after a Department request; and This RULE is not met as evidenced by: Based on record review, staff interviews and policies and procedures, the facility failed to ensure electronic and paper health records for one resident (#225) were provided to the State Survey Team within two hours after the State Survey Team request. Findings include: Resident #225 was admitted on July 22, 2015 with diagnoses that included dementia with behavioral disturbance, mental disorder due to known physiological condition, delusional disorder, and altered mental status. Resident #225 was discharged on April 5, 2018. During random reviews of the facility electronic records conducted on January 7, 2019 it was revealed the electronic health records for resident	Y 350	1. The facility does have a policy that allows access to all electronic medical records. The current owners of this facility took over August 2018. During the certification survey conducted 1/7-1/10 the facility made multiple attempts to obtain the electronic medical records for Resident #225 from the previous owners. The previous owners (Avalon) would not send electronically to PCC (Point Click Care) but did send through email therefore allowing Sapphire of Tucson to print the medical record for the survey team. 2. The residents who are affected by this alleged deficiency would be discharged residents that were under the control of the previous owners. 3. If there are future request for medical records under the control of the previous owners, this facility will make every effort to obtain the records for all entities and agencies that request them. 4. The Administrator will monitor and be the point person for this issue. RECEIVED APR - 5 2019 By	3/3/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 3/29/19

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 _____	01/10/2019

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 The State compliance survey was conducted from January 7 through January 10, 2019, in conjunction with the following Complaint investigations: AZ00147662, AZ00152817, AZ00151707, AZ00153440 and AZ00152668. 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 the facility's demonstration of compliance for the deficiencies cited. Submission of the Plan of Correction is not an admission that a deficiency existed or that one was correctly cited.	
Y 350	R9-10-403.C.5.a. Administration R9-10-403.C. An administrator shall ensure that: R9-10-403.C.5. Unless otherwise stated: R9-10-403.C.5.a. Documentation required by this Article is provided to the Department within two hours after a Department request; and This RULE is not met as evidenced by: Based on record review, staff interviews and policies and procedures, the facility failed to ensure electronic and paper health records for one resident (#225) were provided to the State Survey Team within two hours after the State Survey Team request. Findings include: Resident #225 was admitted on July 22, 2015 with diagnoses that included dementia with behavioral disturbance, mental disorder due to known physiological condition, delusional disorder, and altered mental status. Resident #225 was discharged on April 5, 2018. During random reviews of the facility electronic records conducted on January 7, 2019 it was revealed the electronic health records for resident	Y 350	1. The facility does have a policy that allows access to all electronic medical records. The current owners of this facility took over August 2018. During the certification survey conducted 1/7-1/10 the facility made multiple attempts to obtain the electronic medical records for Resident #225 from the previous owners. The previous owners (Avalon) would not send electronically to PCC (Point Click Care) but did send through email therefore allowing Sapphire of Tucson to print the medical record for the survey team. 2. The residents who are affected by this alleged deficiency would be discharged residents that were under the control of the previous owners. 3. If there are future request for medical records under the control of the previous owners, this facility will make every effort to obtain the records for all entities and agencies that request them. 4. The Administrator will monitor and be the point person for this issue.	3/3/19

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

Administrator | 3/25/19

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

February 20, 2019

Receipt Of This Notice Is Presumed To Be 02/20/2019
Important Notice - Please Read Carefully

Sheila Wiggins, Administrator
Sapphire of Tucson Nursing and Rehab, L.L.C.
2900 East Milber Street
Tucson, Arizona 85714

Dear Ms. Wiggins:

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

Enclosed is a statement of **STATE** deficiencies noted during the inspection of your facility on January 10, 2019. 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 **March 2, 2019**. You must include all pages of the Statement of Deficiencies when submitting your PoC. **Plans of correction sent via fax will not be accepted.** 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

Diane Eckles
Bureau Chief

DE:sf

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 _____	01/10/2019

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 The State compliance survey was conducted from January 7 through January 10, 2019, in conjunction with the following Complaint investigations: AZ00147662, AZ00152817, AZ00151707, AZ00153440 and AZ00152668. The following deficiencies were cited.	Y 000	Preparation and/or execution of the Plan of Correction does not constitute admission or agreement by the Provider of the truth of the facts alleged of the convictions set forth in the statement of deficiencies required by the provisions of the Federal and State law.	
Y 350	R9-10-403.C.5.a. Administration R9-10-403.C. An administrator shall ensure that: R9-10-403.C.5. Unless otherwise stated: R9-10-403.C.5.a. Documentation required by this Article is provided to the Department within two hours after a Department request; and This RULE is not met as evidenced by: Based on record review, staff interviews and policies and procedures, the facility failed to ensure electronic and paper health records for one resident (#225) were provided to the State Survey Team within two hours after the State Survey Team request. Findings include: Resident #225 was admitted on July 22, 2015 with diagnoses that included dementia with behavioral disturbance, mental disorder due to known physiological condition, delusional disorder, and altered mental status. Resident #225 was discharged on April 5, 2018. During random reviews of the facility electronic records conducted on January 7, 2019 it was revealed the electronic health records for resident	Y 350	1. The facility does have a policy that allows access to all electronic medical records. The current owners of this facility took over August 2018. During the certification survey conducted 1/7-1/10 the facility made multiple attempts to obtain the electronic medical records for Resident #225 from the previous owners. The previous owners (Avalon) would not send electronically to PCC (Point Click Care) but did send through email therefore allowing Sapphire of Tucson to print the medical record for the survey team. 2. The residents who are affected by this alleged deficiency would be discharged residents that were under the control of the previous owners. 3. If there are future request for medical records under the control of the previous owners, this facility will make every effort to obtain the records for all entities and agencies that request them. 4. The Administrator will monitor and be the point person for this issue.	3/3/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Steven J. Wiggins — TITLE: Administrator — (X6) DATE: 3/2/19

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 _____	01/10/2019

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 350	Continued From page 1 #225 were not accessible in the data base provided by the facility. An interview was conducted with the administrator (staff #20) on January 7, 2019 at 10:15 a.m. The administrator stated that the facility did not have access to electronic records for resident #225, and that access to those records had been removed by the previous owner of the facility when the facility was purchased by the current owner in August 2018. The Administrator stated that he would notify the previous owner that access to the records was needed, and that the facility staff were aware that they were supposed to have access to all electronic health records for resident #225. An interview was conducted with a corporate staff member (staff #220) on January 7, 2019 at 1:45 p.m. Staff #220 stated that he was aware of the requirement that access to medical records was to be maintained for 7 years. Staff #220 also stated that staff were in communication with the previous owners of the facility to obtain access to the health records for resident #225. An interview was conducted on January 8, 2019 at 8:30 a.m. with medical records (staff #184). Staff #184 stated that the paper records and electronic health records for resident #225 were not accessible, because the records had been removed by the previous owner of the facility. Staff #184 stated that the previous owner was scanning records to the facility. She stated that the process of uploading the documents would take hours and that the documents would be printed after the upload. Staff #184 stated that she did not know whether or not the records for resident #225 were being pre-screened by the previous owner prior to being uploaded.	Y 350		

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 _____	01/10/2019

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 350	Continued From page 2 During an interview conducted with the administrator on January 8, 2019 at 9:24 a.m., the administrator stated that they were unable to obtain access to electronic health records from the previous owner of the facility. In a follow-up interview with staff #184 conducted on January 8, 2019 at 2:08 p.m., the staff #184 provided a stack of printed paper records for resident #225 and stated that there would be no access to electronic health records for resident #225. Review of the facility's policy and procedure titled Electronic Medical Records included a statement that authorized Federal and State survey agents as outlined in current regulations may be granted access to electronic medical records.	Y 350		
Y 401	R9-10-404.1.a. Quality Management R9-10-404. An administrator shall ensure that: R9-10-404.1. A plan is established, documented, and implemented for an ongoing quality management program that, at a minimum, includes: R9-10-404.1.a. A method to identify, document, and evaluate incidents; This RULE is not met as evidenced by: Based on concerns identified during the survey, staff interview and policy review, the Administrator failed to identify quality concerns and implement appropriate plans of action to correct the quality deficiencies.	Y 401	What corrective action will be accomplished for those residents found to be affected by the alleged deficient practice. 1. A new administrator was hired effective 1/11/19 2. All residents could be affected by this alleged deficiency. 3. The QAA Committee will ensure quality concerns are identified and implement appropriate plans of actions to correct the quality deficiencies. An in-service was conducted on 2/27/19 with the QAA Committee reviewing the requirements for systems to address care and management practices. 4. The Administrator will monitor to ensure concerns are being addressed and that the monthly QAA meetings are held as scheduled. The is will be an ongoing process.	3/3/19

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 _____	01/10/2019

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 401	Continued From page 3 Findings include: During the facility's annual survey, multiple concerns were identified in the following areas: -Pervasive odors throughout the facility. -Resident to resident abuse involving 5 residents. -One resident eloped from the facility. -Implement facility policy regarding reporting an allegation of neglect. -Report an allegation of neglect within two hours. -A physician's order was not obtained for dialysis. -Failed to maintain adequate staffing. -Failed to provide access to electronic records timely. An interview was conducted with the administrator (staff #20) on January 10, 2019 at 2:26 p.m. Staff #20 stated that when staff identify a quality concern they bring their concerns to the QAA committee. Staff #20 stated that if a performance improvement plan is developed the QAA committee monitors the progress. The administrator further acknowledged there were no action plans regarding the quality concerns identified during the survey and that the QAA process had not identified the above issues. Review of the facility's policy regarding Quality Assurance and Performance Improvement (QAPI) Committee revealed "...The primary goals of the QAPI Committee are to...Help identify actual and potential negative outcomes relative to resident care and resolve them appropriately..."	Y 401		
Y 703	R9-10-407.2. Admission R9-10-407. An administrator shall ensure that:	Y 703		

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 _____	01/10/2019

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 703	Continued From page 4 R9-10-407.2. The physician's admitting order includes the nursing care institution services required to meet the immediate needs of a resident such as medication and food services; This RULE is not met as evidenced by: Based on clinical record review, staff interviews, and policy review, the facility failed to ensure the physician's admission orders met the immediate needs of one resident (#151) regarding dialysis treatments and care. Findings include: Resident #151 was admitted to the facility on November 16, 2018 with diagnoses that included end stage renal disease, sepsis, and bacteremia. An admission Minimum Data Set (MDS) assessment dated November 23, 2018 included the resident had short-term and long-term memory problems and had severe impairment with daily decision making. The MDS assessment also included the resident was receiving dialysis. A nursing note dated November 23, 2018 revealed the resident had a right sided vascular catheter. Review of the clinical record revealed the resident went out to dialysis appointments on several occasions in November and December 2018 and January 2019. A care plan dated December 21, 2018 included the resident needs dialysis related to end stage renal disease. Interventions included checking	Y 703	1. Physician order for dialysis was obtained on 1/10/19. 2. All residents who receive dialysis could be affected by this alleged deficiency. An audit was conducted on 2/27/19 for all residents receiving dialysis to ensure orders are in place. 100% audited records had the correct orders. 3. The admission audit process will identify residents needing dialysis to ensure there are current physician orders. 4. The DON/Designee will monitor for compliance and report to the QAA Committee for three months.	3/3/19

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 _____	01/10/2019

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 703	Continued From page 5 and changing the dressing daily at access site and document. However, review of the clinical record revealed no evidence that there was a physician's order for dialysis treatments, to monitor the dialysis site, or to check and change the access site dressing daily. In an interview with a licensed practical nurse (LPN/staff #165) on January 10, 2019 at 10:31 a.m., he stated that for a resident receiving dialysis, there should be an order for the dialysis treatment to include the days for dialysis and an order to monitor the dialysis site. He stated that if the resident has a port site then it should be monitored every day for bleeding. The nurse reviewed resident #151's electronic record and was unable to locate an order for the resident's dialysis treatment. During an interview conducted with the LPN (staff #153) caring for this resident on January 10, 2019 at 10:38 a.m., she stated the resident was currently at the dialysis center. She stated she knows when the resident is scheduled for dialysis based on an appointment log that is reviewed every day and her report sheet that has the dialysis days and time. The LPN also stated that when the resident returns from dialysis an assessment is done which includes checking the site. She stated the site should be assessed and documented every shift, and that there should be an order to monitor the site. In an interview with the Director of Nursing (DON/staff #125) on January 10, 2019 at 10:43 a.m., she stated there should be a physician's order in place for dialysis treatments which includes the location, day and time. She also	Y 703		

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 _____	01/10/2019

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 703	Continued From page 6 stated there should be an order to monitor the resident's dialysis site, whether it is a fistula or a port. Review of the facility's policy titled "Hemodialysis Access Care" did not include physician's orders regarding a resident receiving dialysis treatment. Per the DON, there was no other policy specific to dialysis.	Y 703		
Y1047	R9-10-410.B.4.d.i. 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.d. Is informed of the following: R9-10-410.B.4.d.i. The health care institution's policy on health care directives; and This RULE is not met as evidenced by: Based on clinical record reviews, staff interviews and policy review, the facility failed to ensure that two residents (#164 and #121) were informed of the right to formulate health care directives. Findings include: -Resident #164 was admitted to the facility on December 18, 2018, with diagnoses that included sepsis, end stage renal disease and type 2 diabetes mellitus. Review of an Admission Minimum Data Set (MDS) assessment dated 12/25/18, revealed the	Y1047	1. The facility obtained a consent for code status for resident #164 on 1/10/19. For resident #121 the facility located the signed consent for code status (dated and signed by the resident 11/20/18). The consents are located in PCC under the documents section and on the face sheets it shows current code status. 2. All residents have the potential to be affected by this alleged deficiency. 3. An in-service was conducted on 2/22/19 that included the instructions on obtaining mandatory consents upon admission including signed code status. This will be completed within 24 hours of admission. 4. The DON/Designee will monitor for compliance and be reviewed at monthly QAA Committee for 3 months.	3/3/19

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 _____	01/10/2019

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
Y1047	Continued From page 7 resident scored a 9 on the Brief Interview for Mental Status (BIMS), which indicated moderate cognitive impairment. Review of the resident's clinical record revealed no evidence of any advance directives for resident #164. There was also no documentation that the resident declined formulating advance directives. Further review of the clinical record revealed there was no code status listed on the resident's face sheet or in the available space specific for code status in the electronic record. According to the current physician's orders, there was no order for a code status for this resident. In an interview with a Licensed Practical Nurse (LPN/staff #153) on January 10, 2019 at 9:30 a.m., she stated if she needed to find out a resident's code status, she would look in the electronic record, as there is a place where the code status is easily viewable. Further, she stated the resident's code status is listed on their report sheet. She stated the code status should be updated, as soon as the resident is admitted. An interview with medical record staff (staff #184) was conducted on January 10, 2019 at 9:34 a.m. At this time, she reviewed resident #164's scanned documents and was unable to find any advance directives. She stated it could be in a stack of documents that are waiting to be scanned, however, no advanced directives were located. She also stated it could be in the physician's binder waiting to be signed by the physician, however, no advanced directives were found in the binder.	Y1047		

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 _____	01/10/2019

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
Y1047	Continued From page 8 In an interview with the Director of Nursing (DON/staff #125) on January 10, 2019 at 1:31 p.m., she stated an audit had just been done in late December, ensuring that all residents had advanced directive forms filled out. -Resident #121 was admitted to the facility on September 13, 2018, with diagnoses that included chronic osteomyelitis and quadriplegia. Review of the admission MDS assessment dated September 20, 2018, revealed the resident was cognitively intact. A physician's order dated November 20, 2018 indicated the resident was a full code. However, review of the clinical record revealed there were no advance directives which were signed by the resident. Also, the code status was not listed on the resident's face sheet or in the available space specific for code status in the resident's electronic record. An interview was conducted with a LPN (staff #150) on January 8, 2019 at 1:25 PM. The LPN stated that upon admission all consent forms are signed including advance directives. She stated that a resident's code status could be found on the face sheet or in the document section of the electronic medical record. Staff #150 was unable to locate any advanced directives which were signed by the resident. An interview was conducted with Medical Records (staff #183) on January 8, 2019 at 1:46 PM. She stated there was no record of advance directives on file for resident #121. She said the advance directives should be filled out upon admission or a few days later.	Y1047		

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 _____	01/10/2019

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
Y1047	Continued From page 9 An interview with the DON (staff #125) was conducted on January 10, 2019 at 11:40 AM. She stated the floor nurse is responsible for obtaining signed consents, including advance directives when the resident is admitted to the facility. She said if there is a problem social services should be notified. The DON stated she could not answer for what happened in September, as she was not employed by the facility at that time. The facility policy for Interpretation and Implementation for Advance Directives indicated that upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive, if he or she chooses to do so. The policy stated that the information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record. The Director of Nursing or designee will notify the attending physician of advance directives, so that appropriate orders can be documented in the resident's medical record and plan of care.	Y1047		
Y1215	R9-10-412.B.2. Nursing Services R9-10-412.B. A director of nursing shall ensure that: R9-10-412.B.2. Sufficient nursing personnel, as determined by the method in subsection (B)(1), are on the nursing care institution premises to meet the needs of a resident for nursing services; This RULE is not met as evidenced by: Based on resident and staff interviews, review of	Y1215		

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 _____	01/10/2019

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
Y1215	Continued From page 10 facility documentation and policies and procedures, the facility failed to ensure there was sufficient staffing to meet the needs of multiple residents. Findings include: Multiple resident interviews were conducted on January 7, 2018 regarding facility staffing. Ten random residents stated that there was not enough staff and that they have to wait too long for staff assistance and for their call lights to be answered. An interview was conducted with a CNA (certified nursing assistant). The CNA stated that the A-1 unit for high acuity behavioral residents was usually staffed with 3 CNA's to care for 20-24 residents. The CNA stated that one CNA is supposed to be in the hall at all times to monitor to prevent resident to resident altercations, but that does not always happen because of call ins. An interview was conducted with another CNA, who stated that someone is always supposed to be monitoring the hallway on the A-1 unit, but that does not always happen and it's kind of irritating. The CNA stated we do the best we can, but if there is a call in there is no one to monitor the hallway and the residents get in to altercations. An interview was conducted with another CNA who stated that it is challenging to care for the residents when there are call ins. An interview was conducted with a fourth CNA, who stated that sometimes it is hard to care for the residents when there are call ins. An interview was conducted with another CNA,	Y1215	1. The facility updated the call-in policy to reflect a more structured procedure for those who call in resulting in staff shortages. This policy was presented to staff on 2/22/19. There has been an increase in the hiring of C.N.A.'s and nurses to fill open positions. This will reduce the number of outside agency usage resulting in better and consistent patient care. The staffing patterns were reviewed to reflect a need for increased staffing on the Behavioral Unit. 2. All residents could be affected by this alleged deficiency. 3. The Resident Council Minutes are reviewed by the Administrator and monitored to ensure a response and action plan will be addressed for all concerns. An additional Guest Services Coordinator has been hired as of 3/1/19 to also address resident concerns and assist with any grievances. 4. The Administrator will monitor for compliance and report to the QAA Committee for three months.	3/3/19

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 _____	01/10/2019

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
Y1215	Continued From page 11 who stated that care and showers do not get done when there is not enough staff. The CNA further explained that care gets done but not like it should and showers get missed. An interview was conducted with another CNA, who stated that the facility attempts to staff adequately, but some days they are short. An interview was conducted with a seventh CNA, who stated that they used to have four CNA's for this hallway and now they have three. The CNA stated that it was hard to monitor the hallway, because most of the residents on this hallway require two staff to provide care. An interview was conducted with another CNA, who stated that she thought the afternoon shift could use more staff especially on the weekends. The CNA stated that they used to have a hall monitor, but do not anymore. An interview was conducted with a CNA, who stated that sometimes they only have two CNA's on 2nd shift for this hallway and it's hard because most of the residents on this hallway require two staff to provide care. The CNA stated that the facility is trying to staff adequately because they are now using agency staff. An interview was conducted with a LPN (licensed practical nurse). The LPN stated they could use more staff. The LPN stated that when they are short, I do not focus on my medications or paperwork and help the CNAs. An interview was conducted with another LPN, who stated that they used to have enough staff, but when the new management company took over they cut staff. The LPN stated we do the	Y1215		

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 _____	01/10/2019

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
Y1215	Continued From page 12 best we can. The LPN further stated that there are more CNAs scheduled today, because the surveyors are here for the annual survey. Review of the Resident Council Minutes from February 2018 through December 2018 revealed the following concerns from residents: -February 26: "Not enough staff all shifts." -May 8: "The residents are concerned with ratio of staff and residents. The lights are not being answered promptly." -July 9: "Many say there's not enough staff (pending concern already)." -August 30: "Residents are concerned with lights not being answered promptly. Concerns with 7:00 a.m. - 3:00 p.m. B2 (long term care unit)." -September 13: "Residents feel like they lack staff." -October 12: "Call lights are not answered quick and residents and family are waiting more than 15 minutes on B2." -November 8: "Overworked and understaffed was stated by one resident. B2 (all shifts). CNA's do a very good job but most are exhausted." -December 6: "B2 resident stated there have been 2 CNA's to 30 patients and needs are not being met. Residents stated staffing issues for the dining room have happened three times this week. Residents need help with feeding and passing food." According to the resident council meeting documentation, a meeting was held on January 9, 2019 at 2:10 p.m., with six residents. Per the documentation, four of the six residents stated that there was not enough staff and that they had to wait extended periods of time for staff assistance.	Y1215		

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 _____	01/10/2019

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
Y1215	Continued From page 13 On the last page of the Resident Council Minutes for the above months was a section titled, "Interventions to be implemented" however, each month this section was blank. An interview was conducted with the activity director (staff #2) on January 9, 2019 at 2:45 p.m. Staff #2 stated that she has been the activity director since April 2018, and that she took the minutes for the resident council meeting. Staff #2 stated that she gave the staffing concerns to nursing and they are supposed to respond to the residents' concerns so that we could let the resident council know. Staff #2 stated that she had not received responses from nursing yet regarding staffing. An interview was conducted with the administrator (staff #20) on January 10, 2019 at 9:25 a.m. Staff #20 stated that there should be a monitor in the hallways of the A1 and B1 units. Staff #20 stated that the facility is aware of the residents concerns regarding staffing. An interview was conducted with the managing partner of the facility (staff #220) on January 10, 2018 at 10:40 a.m. Staff #220 stated that different units have different staffing needs. Staff #220 stated the facility has never had a resident to resident altercation that resulted in a serious injury, because of staffing. Staff #220 stated that ratio wise, there was enough staff and the concern could be the accountability of the staff. Staff #220 stated that he was not aware of the residents and staff concerns regarding staffing. Review of the facility's policy regarding Staffing revealed, "Our facility provides sufficient numbers of staff with the skill and competency necessary to provide care and services for all residents in	Y1215		

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 _____	01/10/2019

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
Y1215	Continued From page 14 accordance with resident care plans and the facility assessment...Inquiries or concerns relative to our facility's staffing should be directed to the Administrator or his/her designee."	Y1215		
Y1419	R9-10-414.A.1.d.v.(2). Comprehensive Assessment; Care Plan R9-10-414.A. A director of nursing shall ensure that: R9-10-414.A.1. A comprehensive assessment of a resident: R9-10-414.A.1.d. Includes the following information for the resident: R9-10-414.A.1.d.v. Whether the resident's mental status or behaviors: R9-10-414.A.1.d.v.(2) Significantly interfere with the resident's care, This RULE is not met as evidenced by: Based on clinical record review, staff interviews, and the Resident Assessment Instrument (RAI) manual, the facility failed to ensure a Minimum Data Set (MDS) assessment was accurate regarding behaviors for one resident (#62). Findings include: Resident #62 was admitted on November 06, 2015, with diagnoses that included schizophrenia, hypertension, dementia, and depression. Review of the physician's orders revealed the following:	Y1419	1. Resident #62 medical records and MDS were reassessed. A modification was submitted to CMS with correct information by 2/24/19. 2. Resident with behaviors such as refusing care could be affected by this alleged deficiency. 3. The MDS Director in-serviced the Coordinator on 2/25/19 on accurate completion of the MDS on 2/25/19. The MDS Director will audit a random sample of MDS for behaviors on a monthly basis for three months. 4. The MDS Director will monitor for compliance and report to QAA for three months.	3/3/19

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 _____	01/10/2019

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
Y1419	Continued From page 15 -Ipratropium Bromide HFA aerosol solution 17 micrograms (mcg) one puff orally every 6 hours for COPD (chronic obstructive pulmonary disease) dated August 24, 2018 -Metoprolol 25 mg by mouth once a day for hypertension dated August 25, 2018 -Levothyroxine 75 mcg by mouth once a day for hypothyroidism dated August 25, 2018. A review of the MAR for October 2018 revealed the resident refused Ipratropium Bromide from October 27-31 multiple times, refused Metoprolol on October 27, 28, and 29, and refused Levothyroxine on October 27 and 30. However, review of the quarterly MDS assessment dated November 1, 2018, revealed the resident displayed verbal behaviors directed towards others but did not reveal the resident displayed refusal of care behaviors during the 7 day look-back period. The MDS assessment also included a Brief Interview for Mental Status score of 15 which indicated the resident had no cognitive impairment. An interview was conducted with a MDS Coordinator (staff #182) on 01/09/19 at 11:31 AM. Staff #182 stated that information obtained from the nurses' notes and the medication records are used to code a MDS assessment. She also stated that information is obtained from speaking with the residents and the staff. She acknowledged that the quarterly MDS assessment dated November 1, 2018 was an error in documentation regarding refusal of care. During an interview conducted with the Director of Nursing (DON/staff #125) on 01/09/19 at 11:44 AM., the DON stated that her expectation is that	Y1419		

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 _____	01/10/2019

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
Y1419	Continued From page 16 the MDS assessments are accurate, and that incorrect information on the MDS assessment is not acceptable. The RAI manual for the MDS assessment states that the importance of accurately completing and submitting the MDS assessment cannot be over emphasized. The manual also included that the MDS assessment is the basis for the development of an individualized care plan. The RAI manual instructs to review the clinical record and interview staff for any refusal of care (e.g. taking medications) during the 7 day look-back period and code the behavior if it occurred.	Y1419		
Y1449	R9-10-414.A.1.d.xvi. Comprehensive Assessment; Care Plan R9-10-414.A. A director of nursing shall ensure that: R9-10-414.A.1. A comprehensive assessment of a resident: R9-10-414.A.1.d. Includes the following information for the resident: R9-10-414.A.1.d.xvi. Identification of any treatment or medication ordered for the resident; This RULE is not met as evidenced by: Based on clinical record review, staff interviews, and the Resident Assessment Instrument (RAI) manual, the facility failed to ensure a Minimum Data Set (MDS) assessment was accurate regarding medication for one resident (#62).	Y1449		

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 _____	01/10/2019

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
Y1449	Continued From page 17 Findings include: Resident #62 was admitted on November 06, 2015, with diagnoses that included schizophrenia, hypertension, dementia, and depression. Review of the physician's orders revealed an order for Bactrim 400-80 milligrams (mg) by mouth once a day by mouth for prophylaxis for chronic UTI dated October 16, 2018 A review of the MAR for October 2018 revealed that the resident was administered Bactrim from October 16-31. However, review of the quarterly MDS assessment dated November 1, 2018, revealed the resident did not receive an antibiotic during the 7 day look-back period. The MDS assessment also included a Brief Interview for Mental Status score of 15 which indicated the resident had no cognitive impairment. During an interview conducted with the Director of Nursing (DON/staff #125) on 01/09/19 at 11:44 AM., the DON stated that her expectation is that the MDS assessments are accurate, and that incorrect information on the MDS assessment is not acceptable. An interview was conducted with a MDS Coordinator (staff #181) on 01/10/19 at 01:18 PM. She stated that her hand written notes for November included the resident was on antibiotics through the end of October 2018. She agreed that the MDS assessment was marked incorrectly and stated that it was an oversight. The RAI manual for the MDS assessment states that the importance of accurately completing and	Y1449	1. Resident #62 medical records and MDS were reassessed. A modification was submitted to CMS with correct information by 2/24/19. 2. An audit of 25% of all residents on antibiotics will have their MDS reevaluated for accuracy and coding. 3. The MDS Director in-serviced the Coordinator on accurately completing the MDS on 2/25/19. The MDS Director will audit a random sample of MDS for antibiotics on a monthly basis for three months. The MDS Director will monitor for compliance and report to QA for three months.	3/3/19

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 _____	01/10/2019

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
Y1449	Continued From page 18 submitting the MDS assessment cannot be over emphasized. The manual also included that the MDS assessment is the basis for the development of an individualized care plan. The RAI manual instructs to review the clinical record for documentation regarding any antibiotics that were received by the resident during the 7 day look-back period and record the number of days it was received.	Y1449		
Y1473	R9-10-414.B.2. Comprehensive Assessment; Care Plan R9-10-414.B. An administrator shall ensure that a care plan for a resident: R9-10-414.B.2. Is reviewed and revised based on any change to the resident's comprehensive assessment; and This RULE is not met as evidenced by: Based on clinical record review, staff interview, and policy and procedure, the facility failed to ensure a care plan was revised for one resident (#74). Findings include: Resident #74 was admitted to the facility on December 7, 2017 with diagnoses that included multiple sclerosis and quadriplegia. A physician's order dated July 23, 2018, revealed the order to apply splints to both arms at night at bedtime and take off in the morning to prevent contractures was discontinued.	Y1473	1. The Care Plan for Resident #74 has been updated to reflect the discontinuance of the splints on 2/24/19. The resident care plan is scheduled for review on 2/28/19. 2. Residents with adaptive equipment have the potential to be affected by this practice. 3. The IDT team will review new orders from the previous 24 hours and on Monday from the weekends and update care plans when change of condition occur. Education will be provided to the IDT on 2/25/2019 to ensure understanding and compliance. 4. The DON/Designee will monitor for compliance and report to the QAA Committee for three months.	3/3/19

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 _____	01/10/2019

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
Y1473	Continued From page 19 The quarterly Minimum Data Set (MDS) assessment dated November 8, 2018 revealed the resident was cognitively intact and required extensive/total assist with activities of daily living (ADLS). Review of the care plan for mobility dated November 24, 2018 revealed the resident had limited physical mobility related to current co-morbidities including multiple sclerosis (MS). Interventions included applying splints to both arms at night and removing in the morning. Further review of the care plan revealed it was not revised to reflect the splints had been discontinued. An interview was conducted with the Assistant Director of Nursing (ADON/staff #21) on January 9, 2019 at 3:46 PM. Staff #21 stated the resident's splints had been discontinued. She stated that she did not know why the care plan had not been updated. The ADON stated all departments are responsible for updating the care plan, including nursing. She said the nursing management meets every morning to discuss residents' care plans, change of condition, etc. An interview was conducted with the Director of Nursing (DON/staff #125) on January 10, 2019 at 9:29 AM. The DON stated anything in the care plan related to nursing is updated daily. She said they have an interdisciplinary team (IDT) meeting every morning. She stated they are good at adding to the care plan but need to get better at discontinuing things. The DON said the splints should have been resolved in the care plan. Review of the facility's policy titled "Care Plans - Comprehensive" revealed assessments of	Y1473		

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 _____	01/10/2019

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
Y1473	Continued From page 20 residents are ongoing and care plans are revised as information about the resident and the resident's condition change.	Y1473		
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 well-being according to the resident's comprehensive assessment. This RULE is not met as evidenced by: Based on observation, clinical record reviews, staff and resident interviews, facility documents and policies and procedures, the facility failed to assist residents in maintaining their highest practicable well-being, by failing to provide adequate supervision to prevent one resident (#225) with dementia and behaviors from eloping, and by failing to provide adequate supervision to prevent resident to resident altercations involving five residents (#'s 61, 21, 62, 275 and 117). Findings include: -Resident #225 was admitted on July 22, 2015 and readmitted on April 16, 2018, with diagnoses that included dementia with behavioral disturbance, mental disorder due to known physiological condition, delusional disorder and	Y1477	1. Resident # 225 discharged on 4/5/18 Resident # 275 discharged on 12/19/18 Resident #62 discharged on 2/7/19 The above residents did not return to the facility. Resident #117 was moved to another room on 9/30/18 to be further away from Resident #61.Residents were assigned different dining locations. Resident #117 was moved off the secured unit on 11/29/18 to unit C1, a separate behavioral unit. 2. All residents have the potential to be affected by this alleged deficiency. The Behavioral Health Nursing Director identified other residents to be affected through behavioral tracking. An audit was conducted for the Elopement Risk assessment to determine if there were other residents at risk for elopement and care plans update accordingly. 3. The facility conducted de-escalating techniques training to recognize the first signs of possible altercations on 4/10/18. Activities have been increased on the units. The facility hired a LCSW as of 1/24/19 for Behavioral training and to address residents psychological needs. This is a permanent full time position.	

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 _____	01/10/2019

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
Y1477	Continued From page 21 altered mental status. Review of the clinical record revealed a written care plan initiated on July 11, 2016, with a revision date of April 16, 2018, which identified that the resident was an elopement risk/wanderer, related to escapist behavior and history of attempts to leave the facility unattended. A goal included the resident would not leave the facility unattended. Interventions included identifying a pattern of wandering and intervening as appropriate, monitoring the resident's location every 30 minutes and documenting wandering behavior. A quarterly MDS (Minimum Data Set) assessment dated January 25, 2018 included a BIMS (Brief Interview for Mental Status) score of 9, which indicated the resident had moderate cognitive impairment. The MDS also included the resident was delusional, had physical and verbal behavioral symptoms directed at others, refused care, wandered daily and had dementia and psychotic disorder. A nurse practitioner assessment dated February 2, 2018, revealed the resident had dementia, wandering, delirium, anxiety, adjustment disorder and depression. The assessment included the resident was residing on the behavioral unit "for safety" and received psychiatric services. The assessment also included the resident "desperately tries to escape if given the chance." She speaks Spanish mostly, but understands a lot of English. Under assessment and plan it included the following: wandering-provide a safe and nuturing environment. A nursing note dated March 17, 2018 at 6:34 a.m. included the resident had been exit seeking from	Y1477	The facility initiated a Behavioral Health tracking log to analyze patterns of behaviors that will enable the facility to identify residents at high risk for behaviors. This will be reviewed with the Behavioral Health Team and with the Behavioral Health Team weekly meetings. 4. The Behavioral Health Nurse Manager will present at the monthly QAA Committee meetings for 3 months and as determined by the Committee.	3/3/19

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 _____	01/10/2019

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
Y1477	Continued From page 22 the unit through the main locked door to the unit and also by a (locked) back door to the unit. A nursing note dated March 23, 2018 included the following: the resident had been exit seeking and had attempted to leave through the front door, and had struck a staff member when redirected back to the unit. A nursing note dated April 5, 2018 at 10:05 a.m. revealed the resident was discovered missing at 8:15 a.m. The note included the resident was not discovered in her room and that a "code yellow" had been initiated. Continued review of the closed record for resident #225 revealed that the resident did not return to the facility after she eloped. Review of the facility's investigative report dated April 5, 2018 revealed that on the morning of April 5, 2018, the resident had not reported for breakfast and the missing person procedures were immediately implemented. The investigation included the resident was able to leave the facility, obtain transportation, cross the border into Mexico, and after entering Mexico obtained transportation to a family home in Mexico, arriving unharmed. The report also included that the resident had been residing on a behavioral health (secured) unit, and that exit seeking and wandering behaviors were being monitored. Continued review of the investigative report revealed a written staff statement obtained by a CNA (Certified Nursing Assistant/staff #222) dated April 5, 2018 at 2:45 p.m. The statement included that the resident was last seen in the resident dining room on April 4, 2018 between 8:30 p.m. and 9:00 p.m. The report further	Y1477		

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 _____	01/10/2019

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
Y1477	Continued From page 23 included that facility policies were not followed, as safety checks were missed. An interview was conducted with the Administrator (staff #20) on January 7, 2019 at 10:15 a.m. The Administrator stated that it had been determined through the facility investigation that resident #225 had obtained an identification badge from a staff member (which the staff member thought had been misplaced) two weeks prior to her elopement from the facility, and had obtained money in small increments over time from her visitors, which enabled her to purchase bus fare. The Administrator also stated that the security camera footage, which had been examined during the investigation showed the resident had used a staff badge to open the exit door and then quickly exited the unit. An interview was conducted on January 8, 2019 at 12:30 p.m. with a CNA (staff #97), who stated that she had been assigned to provide care to resident #225 on April 5, 2018 on the night shift (11:00 p.m. until 7:00 a.m.). She stated that when she arrived at 11:00 p.m., the previous CNA reported to her that all of the residents in her section were in bed, including resident #225 and that she observed the door to the resident's room was closed. Staff #97 stated that there were other residents in her section who were very ill and she was unable to check on resident #225, because she was busy caring for the residents who were ill. Staff #97 said the facility protocol was to check the residents every 15-30 minutes but not less than hourly, and that she did not check the resident that night. She stated that she assumed her co-worker (CNA/staff #49) who was assigned to another section was checking on all of the residents and assumed that resident #225 was in her room, because the door to her room was	Y1477		

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 _____	01/10/2019

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
Y1477	Continued From page 24 closed. She stated that she never actually saw the resident on her shift. She further stated that at approximately 2:00 a.m., she observed staff #49 enter the resident's room as he was passing water, and then exit the resident's room, and assumed the resident was in her room. The CNA stated she was aware that the resident had a history of elopement attempts. The CNA also stated later that morning after it was discovered the resident was missing, staff #49 told her that although he entered the resident's room to pass ice water during the night shift, he did not see the resident in her room and did not know where she was. During an interview conducted on January 8, 2019 at 12:35 p.m. with a CNA (staff #49), the CNA stated that he did not remember resident #225 and did not remember anything about a resident eloping from the facility. An interview was conducted on January 8, 2019 at 1:15 p.m. with a LPN (Licensed Practical Nurse/staff #201). Staff #201 stated that she worked on the secured behavioral unit on the night shift on April 5, 2018. Staff #210 said that she did not see the resident on her shift and the door to the resident's room was closed all night. The nurse stated that she was aware that the resident had made frequent statements that she was going to leave the facility and go to Mexico where she owned a home. The facility was unable to provide a written policy regarding frequent resident safety checks on the behavioral unit. A policy and procedure titled, Recognizing Signs and Symptoms of Abuse/Neglect included the definition of neglect, as the failure to provide	Y1477		

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 _____	01/10/2019

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
Y1477	Continued From page 25 goods and services as necessary to avoid physical harm, mental anguish, or mental illness. The policy also listed signs of actual physical neglect that included inadequate provision of care and leaving someone unattended who needs supervision. Review of the Reporting Abuse policy revealed that all suspected violations or substantiated incidents of abuse/neglect will be immediately reported to the State licensing/certification agency. -Resident #61 was admitted to the facility on February 20, 2014, with diagnoses that included unspecified psychosis not due to a substance or known physiological condition, Parkinson's disease, and schizoaffective disorder. Review of a Nursing Note dated February 4, 2018 revealed "...Resident has had a few outbursts when there is an excessive amount of noise. Resident had three episodes of yelling out (using profanity) and two episodes of attempting to go down to the room of the resident who was yelling out to shut him up. Staff was there to redirect resident immediately. A Nursing Note dated May 3, 2018 revealed "Resident had several verbal outbursts during shift. Resident primarily has these outbursts when other residents are having an increase in behaviors by making loud noises and yelling..." A Nursing Note dated May 21, 2018 revealed "Resident has episodes of yelling out when he is startled with other loud noises like other residents yelling or doors slamming..." A quarterly MDS assessment dated August 6,	Y1477		

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 _____	01/10/2019

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
Y1477	Continued From page 26 2018, revealed the resident had short-term and long-term memory problems and was severely impaired with daily decision making. The MDS also included the resident required extensive assistance with one staff assistance with activities of daily living. A Behavior care plan dated August 20, 2018 revealed resident #61 has behavior problems (agitation, poor safety awareness, verbal aggression, repetitive statements, disruptive/intrusive, wandering, mood issues, pacing, exit seeking, refusal of care, disorganized thinking and physical aggression), related to psychosis, anxiety, mood disorder and status post traumatic brain injury as evidenced by physical aggression towards others. The goal included the resident will have fewer episodes of behaviors. Interventions were to administer medications as ordered; assist the resident to develop more appropriate methods of coping and interacting with other dementia residents; encourage the resident to express feelings appropriately and if reasonable, discuss the resident's behavior; explain/reinforce why behavior is inappropriate and/or unacceptable; intervene as necessary to protect the rights and safety of others; approach/speak in a calm manner; divert attention; remove from situation and take to alternate location as needed; monitor behavior episodes and attempt to determine underlying cause; and when resident is sitting next to other peers, ensure appropriate space to prevent physical aggression towards peers. Review of a Nursing Note dated September 30, 2018 revealed "...Resident began having a verbal altercation with another resident and he went up to the other resident and struck her in the face on the right cheek. The other resident retaliated and	Y1477		

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 _____	01/10/2019

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
Y1477	Continued From page 27 struck this resident on both arms. Both residents were immediately separated. No visible injuries noted to this resident..." Review of the annual MDS assessment dated November 1, 2018 revealed resident #61 had a BIMS (Brief Interview for Mental Status) score of 9, which indicated moderate impaired cognition. A Nursing Note dated November 16, 2018 revealed a CNA reported to this writer that resident #61 and resident #275 were swinging their arms with closed fists. Both residents were separated. Resident #61 stated that resident #275 hit him in the face. Reddened area noted to resident face. -Resident #275 was admitted to the facility on June 27, 2017, with diagnoses that included unspecified dementia with behavioral disturbance, schizophrenia, major depressive disorder and anxiety disorder. Review of a Nursing Note dated May 17, 2018 revealed called into room by staff at 5:55 p.m., observed resident #275 laying in bed, and another resident was sitting on floor mat with blood on his face. The other resident was unable to explain what happened due to cognitive deficit. Resident #275 stated that the resident woke him up and was messing with his bed and he "hit peer in the face..." A Nursing Note dated July 11, 2018 revealed that resident #275 "started hitting a resident from another room with a wire waste basket in the hallway. Resident #275 was upset that another resident was wearing his hoodie. Resident #275 has shown that he is very territorial and aggressive with male residents that might wander	Y1477		

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 _____	01/10/2019

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
Y1477	Continued From page 28 into his room, let's not forget that this is a unit where many of the residents suffer from dementia..." A Behavior care plan dated August 20, 2018 revealed that resident #275 has a history of initiating physical aggression. The goal was resident will not initiate aggression towards other residents. Resident should have a quiet area to stay in after dinner. He is sensitive to noise and busyness. Interventions to prevent the behaviors were to anticipate and prevent new incidents of violence towards another resident; provide snack, provide activities that promote non-aggressive interactions with other residents like one to one social activity; and provide activity so resident is not focused on busyness after meal times, as it is becoming evident he is not able to tolerate noise. Review of the quarterly MDS assessment dated November 6, 2018, revealed a BIMS score of 1, which indicated the resident had severe cognitive impairment. A Nursing Note dated November 16, 2018 revealed this writer was notified by a CNA that resident #275 and resident #61 were swinging their arms with closed fists. Residents were quickly separated by CNA. Reddened area noted on resident #61's face. Further review of resident#275's clinical record revealed he had two more altercations with other residents on December 14 and 19, 2018 in which he was the aggressor. Resident #275 was discharged from the facility on December 19, 2018. An interview was conducted with a CNA who stated that the facility usually staffed three CNA's	Y1477		

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 _____	01/10/2019

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
Y1477	Continued From page 29 on this unit for 20-24 high acuity behavioral residents. The CNA stated that one CNA is supposed to monitor the hallway at all times to ensure that resident to resident altercations do not occur, but that doesn't always happen when staff call in. An interview was conducted with another CNA who stated that we are supposed to have someone monitor the hallway at all times, but that does not always happen. The CNA stated we do the best we can but if there is a call in we often do not have someone to monitor the hallway and that's when the residents get in to it. The CNA stated that resident #275 got into a lot of incidents with other residents and would laugh afterwards. The CNA stated that resident #61 does not like loud noises and doors slamming and that was usually when he got into altercations with other residents, because it upset him. The CNA stated that when resident #61 got upset he clapped his hands and said "shhh" and that irritated a lot of residents. The CNA further stated that a lot of the resident to resident altercations usually occurred when the facility did not have someone to monitor the hallway. An interview was conducted with a LPN who stated that resident #61 runs up and down the hall and resident #275 is paranoid. The LPN stated that staffing was recently cut on this high acuity behavioral unit and that they do the best they can. An interview was conducted with the administrator (staff #20) on January 10, 2019 at 9:25 a.m. Staff #20 stated that there should be a monitor on the hallway at all times on that unit. -Resident #117 was admitted to the facility on	Y1477		

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 _____	01/10/2019

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
Y1477	Continued From page 30 January 27, 2017, with diagnoses that included schizophrenia, anxiety disorder and dementia with behavioral disturbance. A care plan revised on June 28, 2018, included the resident required a secured unit due to diagnoses of schizophrenia and dementia, behaviors of being non-compliant with care and attempts to provoke peers. Interventions included redirecting the resident when having behaviors. A quarterly MDS assessment dated September 17, 2018 revealed the resident had short-term and long-term memory problems and was moderately impaired with daily decision making. The assessment also included the resident required supervision with set up help only for most activities of daily living and utilized a walker. Review of the clinical record revealed multiple nursing notes for September 2018 describing the resident as being verbally aggressive toward staff and laughing loudly at other residents. A nursing note dated September 30, 2018 revealed that at approximately 9:53 a.m., resident #117 began having a verbal altercation with another resident (#61), and the other resident struck resident #117 in the face on the right cheek. Resident #117 then struck resident #61 back, hitting him on the arms. Both residents were immediately separated. No visible injuries noted. Both residents will not be in the same dining hall as each other. Review of the facility's investigative documentation dated September 30, 2018, revealed that resident #117 was in the hallway by her room, which was across the hall from resident #61's room. Resident #117 began cursing in the	Y1477		

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 _____	01/10/2019

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
Y1477	Continued From page 31	Y1477		

hallway, as she has a history of this behavior. Resident #61 was sitting in his wheelchair in the doorway to his room and got up and confronted resident #117 in the hallway outside their rooms. They began yelling back and forth and before staff could intervene, resident #61 hit resident #117 and then resident #117 hit resident #61. The residents were separated and resident #117 was moved to another room. No injuries were noted. When resident #117 was asked about the incident, she stated "He hit me!" Per the report, a housekeeping staff (#135) witnessed the incident. She reported that resident #117 was cursing at her and resident #61 told resident #117 to be quiet. Resident #117 kept cursing, and then resident #61 got up, went to resident #117 and they both made contact with each other. A statement from a licensed practical nurse (LPN/staff #166) included that she did not witness the incident but was at the nurses' station and heard resident #117 yelling that resident #61 hit her. She immediately went to the hallway and found resident #61 standing in front of resident #117 with his fists up. The residents were separated immediately.

In an interview with staff #135 on January 9, 2019 at 9:32 a.m., she stated she had worked at the facility for over three years and is usually on the secured behavioral unit. She said that resident #117 is constantly being verbally aggressive and intimidates a lot of people.

In an interview with a LPN (staff #148) on January 9, 2019 at 9:41 a.m., she stated that resident #61 usually hangs out in the hallway and is not one to instigate things. Staff #148 said he has a behavior of yelling out, which sometimes sets other residents off inadvertently, and he is easily triggered by noises. She stated when resident

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 _____	01/10/2019

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
Y1477	Continued From page 32 #117 used to be on her hall, her loud laughing and yelling would irritate resident #61. She stated staff tried to redirect resident #117 by asking her to stop or taking her to an activity or to a different area. In an interview with a LPN (staff #156) on January 9, 2019 at 9:49 a.m., he stated resident #117's behaviors include laughing out loud at random and yelling at others. He stated the other residents sometimes get agitated and they think resident #117 may be doing it on purpose. He stated sometimes she yells racial slurs and the other residents tell her to shut up. Additionally, he stated resident #117 is easily redirectable, but that does not work all the time. The LPN stated she is followed by the behavioral health team but for the most part, her behavior does not change. An observation was conducted on January 9, 2018 at 10:35 a.m., during a resident smoke break. Resident #117 was observed to be laughing loudly and sticking her tongue out, which appeared to be directed at no one in particular. The staff present redirected the resident who then sat back down and continued to smoke her cigarette without further incident. In an interview with the administrator (staff #20) on January 10, 2019 at 1:17 p.m., he stated when he receives an allegation of a resident to resident altercation, he will get more information about what happened, report to appropriate parties and begin an investigation. -Resident #21 was admitted to the facility on January 18, 2018, with diagnoses that included schizophrenia, depression and Parkinson's disease.	Y1477		

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 _____	01/10/2019

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
Y1477	Continued From page 33 A quarterly Minimum Data Set (MDS) assessment dated 10/08/2018 included the resident had a BIMS score of 15, indicating no cognitive impairment. The MDS assessment also included the resident had verbal behavioral symptoms directed toward others. Review of the care plan regarding antipsychotic medication related to schizophrenia included the following interventions: when the resident becomes agitated intervene before agitation escalates; guide the resident away from the source of distress; engage calmly in conversation; and if the response is aggressive remove other residents from the area and approach later. A nursing note dated 11/29/2018 revealed that at approximately 10:50 a.m., resident #21 was witnessed sitting towards the end of the hall in front of another resident's (#62) room. Resident #21 began to yell and curse in Spanish. Resident #62 approached the doorway and told resident #21 to "move." Both residents were yelling and swinging their arms at each other. The residents were immediately separated and redirected into opposite directions. No injuries noted at this time. -Resident #62 was admitted on November 06, 2015, with diagnoses that included schizophrenia, dementia and depression. A quarterly MDS assessment dated 11/01/2018 included a BIMS score of 15, which indicated the resident had no cognitive impairment. The MDS assessment also included the resident had verbal behavioral symptoms directed toward others. Review of the current behavior care plan revealed the resident had the potential to be physically	Y1477		

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 _____	01/10/2019

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
Y1477	Continued From page 34 aggressive and threatening toward other residents and staff. Interventions included for staff to escort the resident from room to destination and from destination to room, and keep him a safe distance from other residents. A nurse's note dated 11/29/2018 included that at approximately 10:50 a.m., resident #62 was witnessed standing in front of resident #21. Resident #21 was sitting in front of his doorway in a wheelchair and resident #62 told him to move. Resident #21 started to yell and curse at him in Spanish. Resident #62 then raised his left hand and with a closed fist, hit resident #21. Both residents were swinging their arms at each other. They were immediately separated and redirected into opposite directions. No injuries were noted. Review of the facility's investigative report revealed that on November 29, 2018 at 10:50 a.m., resident #21 was sitting in his wheelchair in front of the door to resident #62's room. Resident #62 asked resident #21 to move, and angry words were exchanged. The residents struck out at each other and no injuries were noted. The report also included a witness statement from the housekeeper (staff #135) that she heard the residents arguing in front of resident #62's door who was telling resident #21 to move. The statement included that resident #21 hit resident #62 in the face and that both residents were hitting each other. The report revealed that resident #21 was unable to recall the incident and resident #62 reported that "He kept cussing at me and I told him to stop. I told him if he didn't stop I would hit him, and he didn't stop, so I hit him." During an interview conducted with resident #62 on 1/8/19 at 2:29 p.m., the resident stated that resident #21 was sitting in front of his door and	Y1477		

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 _____	01/10/2019

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
Y1477	Continued From page 35 that he asked him to leave. Resident #62 stated that the resident called his mother names in Spanish and that he hit him. During an interview conducted with resident #21 on 1/8/2019 at 2:43 p.m., the resident stated that resident #62 yelled at him and he yelled back. Resident #21 stated that resident #62 hit him and that he hit him back and that they punched each other until they were separated. An interview was conducted with a LPN (staff #148) on 1/09/19 at 10:01 a.m. The LPN stated that she heard yelling and saw the housekeeper separating resident #21 and resident #62. She stated that she helped separate the residents and then assessed them for injuries. The LPN stated that both residents do occasionally yell and "blow off steam," but that resident #62 is often more verbal and physically threatening. The facility's policy regarding Unmanageable Residents revealed that each resident will be provided with a safe place of residence. The policy included that should a resident's behavior become abusive in any way that would jeopardize his or her safety or the safety of others, the Nurse Supervisor/Charge Nurse must immediately provide for the safety of all concerned. The policy also included unmanageable residents may not be retained by the facility. Review of a facility policy titled, "Resident-to-Resident Altercations" included that staff will monitor residents for aggressive/inappropriate behavior towards other residents.	Y1477		

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 _____	01/10/2019

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
Y1911	Continued From page 36	Y1911	1. The Policy and Procedure for Oxygen Administration was updated on 2/26/19 to include weekly tube change and date. 2. Residents who receive oxygen could be affected by this alleged deficiency. The facility audited all residents with oxygen orders on 2/27/19 to ensure that the orders reflect the policy change with the correct oxygen order and tubing change order. 3. Admission orders will be updated to include tube change and date. Nurse management will audit all new admissions to include reviewing all residents with oxygen orders to ensure accuracy. 4. The DON/Designee will monitor for compliance and report to QAA for three months.	3/3/19
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 review of the clinical record review, staff interviews and policy and procedure, the facility failed to provide respiratory care cervices to one resident (#50) according to the physician's order. Findings include: Resident #50 was readmitted to the facility on October 26, 2018, with diagnoses that included acute respiratory failure with hypoxia, adult failure to thrive, and paraplegia. Review of the current summary of physician's orders revealed an order for oxygen continuously at 2 liters per minute via nasal cannula dated October 26, 2018. Review of the quarterly MDS (Minimum Data Set) assessment dated October 31, 2018 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. The assessment also included the resident was receiving oxygen therapy.	Y1911		

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 _____	01/10/2019

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
Y1911	Continued From page 37 The current care plan revealed the resident had altered respiratory status related to respiratory failure with hypoxia. The interventions included administering medication/puffers as ordered and monitoring for effectiveness and side effects and monitoring/documenting/reporting abnormal breathing patterns to the physician. During an interview conducted with the resident on January 7, 2019 at 3:23 p.m., the oxygen machine was observed on at 2.5 liters but the resident was observed with the oxygen off. The nasal cannula was lying on the resident's tray. On January 9, 2019 at 12:28 p.m., the resident was observed sleeping in his wheelchair with the oxygen on at 2.5 liters. An interview was conducted with a certified nursing assistant (CNA/staff #58) on January 10, 2019 at 9:14 a.m. After observing the oxygen tubing, she confirmed that the level of oxygen was set at 2.5 liters per minute and that she did not know what is was supposed to be set at. An interview was conducted on January 10, 2019 at 9:22 a.m. with a licensed practical nurse (LPN/staff #159) who stated that the CNAs would not know what level to set the oxygen concentrator; that it is the nurse's responsibility to monitor the amount of oxygen received per a minute. After reviewing the orders, she stated that the order is for oxygen at 2 liters. The facility's policy "Oxygen Administration" included the following: -The purpose of this procedure is to provide guidelines for safe oxygen administration. -Verify that there is a physician's order for this procedure.	Y1911		

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 _____	01/10/2019

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
Y1911	Continued From page 38 -Review the physician's order or facility protocol for oxygen administration. -Unless otherwise ordered, start the flow of oxygen at the rate of 2 to 3 liters per minute.	Y1911		
Y2141	R9-10-421.B.4.a. Medication Services R9-10-421.B. An administrator shall ensure that: R9-10-421.B.4. If a psychotropic medication is administered to a resident, the psychotropic medication: R9-10-421.B.4.a. Is only administered to a resident for a diagnosed medical condition; and This RULE is not met as evidenced by: Based on closed clinical record review, staff interviews and policies and procedures, the facility failed to ensure that one resident (#135) who was prescribed an antipsychotic medication upon admission, had a diagnosed medical condition for its use. Findings include: Resident #135 was admitted on November 7, 2018 with diagnoses that included Alzheimer's disease, toxic encephalopathy, and major depressive disorder. The resident was discharged December 26, 2018. Review of hospital records prior to the resident's admission, revealed a H&P (History and Physical) report dated November 5, 2018 that the resident had a significant history of Alzheimer's dementia	Y2141	1. Resident #135 was discharged on 12/26/18. 2. All residents could be affected by this alleged deficiency. The Behavioral Health nurse manager conducted an audit between 1/28/19-2/1/19 to determine correct diagnosis for use of psychotropic drugs. 3. The Behavioral Health nurse manager will conduct ongoing random audits on orders for psychotropic medications for the correct diagnosis. For all new admissions the orders will be reviewed by nurse managers to check for appropriate diagnosis. All other orders for in-house residents will be reviewed at daily clinical meeting. 4. The DON/Designee will monitor for compliance and report any issues to the QAA Committee for three months.	3/3/19

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 _____	01/10/2019

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
Y2141	Continued From page 39 and traumatic brain injury and was cooperative with normal mood and cognition. The hospital H&P included a list of medications that the resident was receiving in the hospital. The list did not include the Risperidone (antipsychotic) or any other antipsychotic medication. Continued review of the hospital records revealed a discharge summary dated November 7, 2018 that included an order for the resident to receive Risperidone 0.5 mg (milligram) tablet every 12 hours upon transfer to the facility. The discharge summary included the diagnoses dementia and depression but did not include a diagnosis of psychosis. Review of the closed clinical record revealed a physician's order dated November 7, 2018 for Risperidone 0.5 mg tablet two times daily for dementia. The Medication Administration Record for November 2018 revealed the resident was administered Risperidone as ordered. A discharge MDS (Minimum Data Set) assessment dated December 26, 2018 included a BIMS (Brief Interview for Mental Status) score of 11 which indicated the resident had moderately impaired cognition. The assessment included the resident felt tired, depressed, had difficulty sleeping, and verbal behaviors directed at others. The assessment also included the resident received antipsychotic medications. However, the assessment did not include the resident had a psychiatric mood disorder. Further review of the closed record did not reveal any additional documented evidence that the diagnosis of dementia for the use of the	Y2141		

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 _____	01/10/2019

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
Y2141	Continued From page 40 antipsychotic medication Risperidone had been clarified. An interview was conducted on January 10, 2019 at 9:17 a.m. with the Director of Nursing (DON/staff #125). The Director stated that a diagnosis is needed to support the use of specific medications and that if the physician prescribes a medication for which the resident does not have a diagnosis, the nurse is to question the doctor about the diagnosis. The DON stated that when a resident is admitted from the hospital, the medications that are prescribed must verify with the physician by the nurse. The DON stated that an antipsychotic drug cannot be prescribed for dementia unless there is a diagnosis to support the use of the antipsychotic drug. The DON further stated that the use of the antipsychotic drug for resident #135 should have been clarified with the physician. During an interview conducted on January 10, 2019 at 9:35 a.m. with a RN (Registered Nurse/staff #165), the nurse stated that if a diagnosis is inappropriate for an ordered medication, the nurse would bring it to the physician's attention. The facility's policy and procedure titled Antipsychotic Medication Use included a policy statement that antipsychotic medications may be considered for residents with dementia but only after medical, physical, functional, psychological, emotional psychiatric, social and environmental causes of behavioral symptoms have been identified and addressed. The policy included residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective.	Y2141		

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 _____	01/10/2019

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
Y2503	R9-10-425.A.1.b. Environmental Standards R9-10-425.A. An administrator shall ensure that: R9-10-425.A.1. A nursing care institution's premises and equipment are: R9-10-425.A.1.b. Free from a condition or situation that may cause a resident or an individual to suffer physical injury; This RULE is not met as evidenced by: Based on observations, staff interviews, and review of policies and procedures, the facility failed to ensure the premises were free from a condition or situation that may cause a resident or an individual to suffer physical injury, by failing to ensure a public restroom accessible to residents was free from accident hazards. Findings include: During an observation conducted on January 7, 2019 at 10:30 a.m., two unlocked restrooms were observed near the front entrance of the facility. When the door to restroom #1 was opened and released, the door rapidly slammed shut causing a potential accident hazard to residents who may use the restroom. Multiple residents passed by this area to go to the front lobby or go outside of the facility. An interview was conducted with a receptionist (staff #191) on January 8, 2019 at 9:25 a.m. Staff #191 stated that they asked the residents not to use the public restrooms but that some of them go in there anyway. Staff #191 stated that the residents probably use the public restrooms at	Y2503	1. On 1/10/19, the door closure for Restroom #1 was repaired to prevent the door from slamming shut. The locks to both restrooms were changed to require a key from the receptionist in order to enter the restroom. This was effective 1/10/19. 2. All residents who enter the lobby area and request a restroom could be affected. 3. The Maintenance Director will ensure the doors to the restroom are in working, safe condition. The receptionist will report any concerns to the Maintenance Director through a work order form. 4. The Maintenance Director will include door operations as part of his preventive maintenance program. The Administrator shall monitor for compliance and report to the QAA Committee for three months.	3/3/19

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 _____	01/10/2019

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
Y2503	Continued From page 42 night when no one is at the receptionist desk. Staff #191 further stated that the public bathroom doors used to be locked. Additional observations conducted on January 8, 9, and 10, 2019 revealed the area near the public restrooms and front lobby continued to be a high traffic area with residents going to the front lobby or out of the facility. An interview was conducted with another receptionist (staff #194) on January 10, 2019 at 11:00 a.m. Staff #194 stated that the residents were asked to not use the public restrooms. Staff #194 further stated the doors used to be locked. An interview was conducted with the managing partner of the facility (staff #220) on January 10, 2019 at 12:35 p.m. Staff #220 stated that the facility will be repairing the door today so that it does not slam shut. Review of the facility's policy Safety and Supervision of Residents revealed "Our facility strives to make the environment as free from accident hazards as possible". The policy included resident safety and supervision and assistance to prevent accidents are facility-wide priorities.	Y2503		

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: January 7, 2019
Survey Event ID: V3CM11			
Inspector/Team Coordinator: Chris Benson			
Accompanied By: Steve Schuman, Evelyn Welch, Teresa Gallego, Ernie Cull, Brenda Robinson, Brian Wachtendonk			

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.
   - x 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, 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.

Administrator/Director/Agency Representative Signature — Date: 1-7-19

☐ 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: 1-7-19

☒ 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

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	25	
II. Resident Rights	20	5
III. Administration	20	5
IV. Environment and Infection Control	10	5
V. Food Services	10	
TOTAL CRITERIA MET	85	15

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: 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	✓	
The nursing care institution ensures that each resident is free from medication errors that resulted in actual harm.	5	✓	
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	✓	

Points Yes 25

Points No _____

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	✓	
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	✓	
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		✓

Points Yes 20

Points No 5

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

Points Yes 20

Points No 5

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

Points Yes 10

Points No 5

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	/	
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	/	
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	/	
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	/	
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	/	
The nursing care institution provides food substitution of similar nutritive value for residents who refuse the food served or who request a substitution.	1	/	

Points Yes 10

Points No _____

Comments:

SAPPHIRE
OF TUCSON
NURSING AND REHAB

3/2/19

Diane Eckles, Bureau Chief
AZDHS
150 North 18th Ave., Ste 440
Phoenix, AZ 85007-3247

Re: Sapphire of Tucson Nursing and Rehab

Dear Ms. Eckles:

Please accept SAPPHIRE OF TUCSON NURSING AND REHAB's Plan of Correction for our State and Federal survey conducted 1/7/19-1/10/19. The facility is alleging substantial compliance as of 3/3/19. Please call if you have any questions concerning this Plan of Correction.

Sincerely,

Sheila Wiggins
Administrator

RECEIVED
MAR 5 - 2019
By

2900 E Milber Street Tucson, Arizona 85714 **office** 520.294.0005 **fax** 520.807.2500
sapphireoftucson.com