STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035107	A. BUILDING _____ B. WING _____	06/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAVEN OF PHOENIX	4202 NORTH 20TH AVENUE PHOENIX, AZ 85015

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review and review of policies and procedures, the facility failed to ensure that one resident's (#1) representative was immediately informed of a significant change in condition, and failed to ensure that the resident's physician was notified immediately of a critical laboratory test result. The deficient practice could result in a delay in medical treatment. Findings include: Resident #1 was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of records revealed an admission record that included contact information for the resident's wife. An admission MDS (Minimum Data Set) assessment dated [DATE] included that resident #1 had a BIMS (Brief Interview for Mental Status Score) of 13, which indicated that resident #1 was cognitively intact. The MDS assessment also included that resident #1 required extensive assistance from two persons for transferring, required set-up help and supervision for eating and drinking, used a wheelchair for mobility and received [MEDICAL TREATMENT] treatments. A Health Status Note dated [DATE] at 7:11 a.m. included that on several occasions during the night shift the resident had a temperature of ,[DATE].9, and that Tylenol had been given and fluids were encouraged. The note included that the resident was alert and oriented and that he also had red tinged sputum. The note included that the physician was called, physicians orders were received for stat (immediately) laboratory orders and the on-coming shift nurse was made aware of the situation. Review of the clinical record revealed a physicians order dated [DATE] at 6:30 a.m. included for the resident to have a stat CBC (Complete Blood Count) and CMP (Comprehensive Metabolic Panel, and a physicians order dated [DATE] at 6:32 p.m. for a stat chest X-ray to rule out pneumonia. The Health Status Note dated [DATE] at 7:11 a.m. did not include any additional information that the resident's wife had been notified of the resident's fever, or that stat laboratory tests had been ordered. A laboratory report dated [DATE] included that the resident had a fasting glucose level of 24, and was marked as CL (Critical Level). The report included that the reference range for fasting glucose was ,[DATE] mg/dl (milligrams/deciliters), and that the result had been reported on [DATE] at 11:20 a.m. A laboratory report form titled Haven of Phoenix Lab Results Report dated [DATE] was flagged for critical result and included that the resident's fasting glucose was 24, the report included that the critical result had been reported on [DATE] at 12:21 p.m. Review of the clinical record did not reveal any additional information that the resident's family or physician had been notified that the resident's fasting glucose was 24 from 11:20 a.m., until 9:11 p.m. An eMAR note (electronic Medication Administration Record) dated [DATE] at 9:11 p.m. included Stat labs and X-ray results sent to MD, no new orders. A Health Status Note dated [DATE] at 3:20 p.m. included that at 3:15 a.m. a nurse had been called into the resident's room by a CNA (Certified Nursing Assistant). The note included that the resident had no heart beat or respirations, fixed pupils and did not respond to sternal rub. The note included that the physician was called and it was determined that the resident had expired. The note also included that the resident's wife was notified. During an interview conducted on [DATE] at 10:30 a.m. with the DON (Director of Nursing/Staff #33), the DON stated that changes in condition are reported immediately to the physician and to the family of the resident. The Director stated that lab (laboratory) results are linked to the facility's electronic record system, and that when laboratory results are reported to the facility, the report prints out at the nurses station at the same time that it is entered into the electronic record, which can be accessed remotely by the physician and the DON. During an interview conducted on [DATE] at 12:27 p.m. with an LPN (Licensed Practical Nurse/staff #81) she stated that on the night shift of [DATE] the resident had complained of not feeling well, had a small amount of bloody sputum, and had a low grade fever. Staff #81 stated that she called the physician and obtained orders for lab tests and a chest X-Ray. Staff #81 stated that she did not notify the resident's family that resident #1 had a fever and needed lab tests because she felt that the resident had only a little bit of a change and it wasn't enough to call the family. During an interview conducted on [DATE] at 12:42 p.m. with an LPN/Staff #41 she stated that when she reported to duty on the morning of [DATE] she received a report from the off-going night nurse (Staff #81) that stat labs (laboratory testing) and a chest x-ray had been ordered. Staff #41 stated that later, when the stat laboratory results had printed at the nurses station, she took a picture with her cell phone and texted the results to the physician. Staff #41 stated that the physician did not call her back. Staff #41 stated that although she sent a text to the physician, she did not actually call him or speak with him on the phone. Staff #41 stated that when she received the stat lab test results for resident #1, there was nothing in the results that was significant. When asked if she was aware that the resident's fasting glucose was 24, she stated I'm not sure, and when I got the lab results I forwarded them to the doctor. Staff #41 stated that she did not inform the resident's family that the resident had a fever earlier in the morning, or that laboratory testing had been ordered stat for the resident. During an interview conducted on [DATE] at 1:13 p.m. with an RN (Registered Nurse/Staff #27) she stated that she was the nurse supervisor on duty on [DATE] and that the resident's wife had come to the facility in the afternoon to inquire about the resident's condition because she had spoken to the resident and he didn't sound well, she had no specific complaints. Staff #27 stated she did an assessment of the resident while the resident's wife waited outside of the facility, and found the resident to have vital signs within normal limits, he was alert and oriented and watching television and using his cell phone. Staff #27 stated she reported that the resident was well to the resident's wife. Staff #27 stated that although she was aware that stat lab testing had been ordered for the resident, she did not know that the results had been received. Staff #27 stated that when a resident has a fever, the physician and the family are to be notified. Staff #27 stated that when a critical lab test result is received, the nurse is to notify the doctor of the result and to notify her also. Staff #27 stated that there should have been a progress note that the physician had been notified of the lab test results and that she was unable to find a note by the nurse that the physician had been notified. A policy and procedure titled Lab and Diagnostic Test Results-Clinical Protocol included A nurse will review all results and that if the staff who first receive or review lab and diagnostic test results cannot follow the remainder of this procedure for reporting and documenting the results and their implications, another nurse in the facility)supervisor, charge nurse. etc) should follow or coordinate the procedure. A policy and procedure titled Change in a Resident's Condition Status included that the facility shall promptly notify the resident, his or her Attending Physician, and representative of changes in the resident's medical/mental condition and/or status. The policy included that a significant change of condition is a major decline or improvement in the resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease related interventions, and impacts more than one area of the resident's health status.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record reviews and review of policies and procedures, the facility failed to ensure that all visitors are screened for infections including COVID-19. The deficient practice could result in the spread of infections

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

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

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) including COVID-19. Findings include: Resident #1 was admitted on [DATE] with [DIAGNOSES REDACTED]. An admission MDS (Minimum Data Set) assessment dated [DATE] included that resident #1 had a BIMS (Brief Interview for Mental Status Score) of 13, which indicated that resident #1 was cognitively intact. The MDS assessment included that resident #1 received [MEDICAL TREATMENT] treatments. A Health Status Note dated [DATE] at 3:20 p.m. included that at 3:15 a.m. a nurse had been called into the resident's room by a CNA (Certified Nursing Assistant). The note included that the resident had no heart beat or respirations, fixed pupils and did not respond to sternal rub. The note included that the physician was called and it was determined that the resident had expired. The note also included that the resident's wife was notified, and was coming to see the resident. A Health Status Note dated [DATE] at 9:00 a.m. included that the resident's family had retrieved all of the belongings from the resident's room. During an interview conducted on [DATE] at 10:30 a.m. with the Executive Director (Staff #99) and the DON (Director of Nursing/Staff #33), Director stated that it is the policy of the facility to follow the CDC (Centers for Disease Control) guidelines for visitors and that family members can only visit resident's two at a time when the resident is actually passing away. Family members may also speak with the resident by phone, or visit through windows. The DON stated that all visitors are screened and staff are to fill out a screening form for the visitor, and that this applies to all visitors, not just visitors to the COVID-19 unit. The DON stated that visitors are provided a mask and a gown when they enter the facility. During an interview conducted on [DATE] at 12:27 p.m. with an LPN (Licensed Practical Nurse/staff #81) she stated that on the night shift of [DATE] after resident #81 expired the family of the resident was notified and that seven family members came to the facility to view with the resident's remains. Staff #81 stated that she asked them as a group (while they waited outside of the facility) if any of them had COVID-19, then checked their temperatures individually, and provided them with face-masks to wear before allowing them to enter the facility two at a time. Staff #81 stated she did not complete visitor screening forms for any of the visitors, or ask them to sign the screening forms because they were already too upset and I was trying to deal with them being in a high state of grief. Review of a facility form titled Respiratory Illness Screening Form included the following statement: To help prevent the spread and reduce the potential risk of COVID-19 and other respiratory illnesses to our resident's and employees, we are implementing a mandatory screening questionnaire. The screening questionnaire included spaces to enter the visitor's name and phone number, and questions regarding the following areas of concern: -Have the visitor experienced a fever of 100 degrees or above in the last 30 days? -Have the visitor or any household members had contact with someone diagnosed with [REDACTED].? -Have the visitor or any household member traveled to an area affected by COVID-19 in the last 30 days? -Have the visitor or any household member experienced flu-like symptoms in the last 30 days? The screening questionnaire included included a space for the staff member who screened the visitor to enter the visitor's temperature, and a space to enter whether access to the facility was approved or denied. A policy and procedure titled Infection Control Policies and Procedures (COVID-19)-Version 020 included a statement that all visitations are temporarily restricted under direct request from the Centers for Medicare and Medicaid Services (CMS), except [MEDICATION NAME] visits during end of life situations. Visitors during end of life situations will be subject to COVID-19 screening criteria. The policy also included that facilities will keep a log of all persons who enter the room, including essential agency staff (i.e. hospice), visitors (if end of life situations) and those who care for the resident.