STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035096	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAVEN OF SANDPOINTE, LLC	**2222 SOUTH AVENUE A YUMA, AZ 85364**

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 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews, facility documentation and policies and procedures, the facility failed to ensure that one resident (#30) was free from physical abuse by another resident (#80). The deficient practice could result in additional incidents of resident to resident abuse. Findings include: -Resident #30 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A care plan for behavioral symptoms (with an initiation date of January 12, 2018) revealed the resident has behaviors of becoming angry quickly, when care is not given right away, screams out, pulls her hair, accuses others of moving her things, attempts to bite staff, grabs visitors by their clothing and sees men in her room when there is no one there. Interventions included medications as ordered, one to one redirection, attempt to divert and/or reorient, provide resident with snacks when upset and psychiatry consult as needed. The annual MDS assessment dated [DATE] included a BIMS score of 3, indicating severe cognitive impairment. The MDS included the resident required extensive assistance of one person physical with bed mobility, dressing, toilet use and personal hygiene; and required limited assistance with transfers. Review of a nursing note dated December 9, 2019 revealed that at 6:25 p.m., a CNA (certified nursing assistant) reported seeing resident #80 kick the right leg of resident #30. Per the note, resident #30 also told the CNA that resident #80 had kicked her leg. -Resident #80 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The care plan for cognition dated June 6, 2019 included the resident has mild cognitive impairment. A goal was for the resident to display appropriate response to situation. Interventions were to observe and report changes in cognitive status and to orient the resident to person, place, time and situation as needed. The quarterly MDS assessment dated [DATE] revealed a BIMS score of 15, indicating the resident was cognitively intact. The MDS also included the resident required supervision with activities of daily living. A nursing note dated December 9, 2019 included that at 6:25 p.m., a CNA reported that she saw both residents (#30 and #80) near the nurse's station when she saw resident #80 kick the right leg of resident #30. Per the note, resident #80 was asked why she kicked resident #30 and resident #80 stated she was tired of resident #30 and that she felt sorry for what she did. Review of a facility's investigative report revealed that on December 9, 2019 at 6:25 p.m., a CNA (staff #172) reported that resident #30 was sitting in her wheelchair across from the 500 hall nurse's station in the middle of the hallway. Resident #80 became agitated as resident #30 was in her way. The CNA (staff #172) witnessed resident #80 kick the right leg of resident #30. Staff #172 reported that resident #80 could have gone around resident #30, but clearly wanted to kick the resident. Both residents were immediately separated and resident #30 did not recall the incident. When resident #80 was asked about the incident, resident #80 said, I am tired of her lately. The report included that there were no injuries to either resident. A phone interview with the CNA (staff #172) who witnessed the incident was conducted on March 4, 2020 at 9:36 a.m. She said the incident happened right after dinner time, when staff were busy putting residents to bed. She stated resident #30 and #80 were at the nurse's station right by the nursing cart, because they were waiting for their bedtime medications to be administered. She stated that she was heading back to the nurse's station and saw that resident #30 was facing and in front of resident #80, who was heading towards her room. She stated there was enough room for resident #80 to go around. She said that resident #80 told resident #30 to move out of her way. She said she then saw resident #80 kick resident #30 on the right knee/leg. She said when resident #30 saw her, she said resident #30 also told her that resident #80 hit her and pointed to her right knee area. She stated both residents were separated from each other. Regarding resident #80, staff #172 stated the resident was alert and oriented and knew what she did to resident #30. She stated that after the two residents were separated, resident #80 came out of her room and told staff #72 that she did not mean to hit resident #30 and that she was sorry. Regarding resident #30, staff #172 stated the resident is very confused, is not alert and oriented, and does not like to be alone so the resident follows staff. She stated resident #30 is verbally aggressive to staff only during cares, but is not aggressive to other residents. Staff #172 continued to say that resident #80 never really liked resident #30, because resident #30 is very loud and screams. Staff #172 further said that when staff see resident #30 and #80 are close to each other, they immediately keep them apart. A phone interview was conducted on March 4, 2020 at 10:24 a.m. with a RN (staff #89), who was on shift on December 9, 2019. She stated she was on shift, but she did not witness the incident. Staff #89 stated initially resident #80 denied kicking resident #30. Staff #89 stated that resident #80 was aware of what she did, because later that night resident #80 came to her and said she was sorry for kicking resident #30. In an interview with a licensed practical nurse (staff #67) conducted on March 4, 2020 at 10:59 a.m., she stated that resident #80 gets upset when residents or staff speak Spanish, because the resident does not understand and thinks that what is being said is about her. She stated resident #30 is hard of hearing and speaks Spanish only, so when resident #30 converses with resident #80, resident #30 tends to speak loudly and resident #80 thinks that resident #30 is yelling at her. She stated resident #30 also wanders into the room of resident #80, who gets upset when this happens. Review of the Abuse policy revealed that Abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment resulting in physical harm, pain or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, can cause physical harm, pain or mental anguish. The policy also defined willful as used in the definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. The policy included that the facility recognizes and respects that each resident has the right to be free from abuse, neglect, misappropriation of resident's property and exploitation. A policy regarding Managing Residents with Aggression included a purpose that each resident will be provided with a safe place of residence.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews, facility documentation and policy review, the facility failed to ensure an allegation of abuse involving two residents (#30 and #80) was reported to Adult Protective Services (APS), within two hours after the allegation was made. The deficient practice could result in APS not being notified of allegations of abuse as required. Findings include: -Resident #30 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The annual MDS assessment dated [DATE] included the resident had severe cognitive impairment. -Resident #80 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The quarterly MDS assessment dated [DATE] revealed the resident was cognitively intact. Review of a facility's investigative report revealed that on December 9, 2019 at 6:25 p.m., a CNA (staff #172) reported that resident #30 was sitting in her wheelchair across from the 500 hall nurse's station in the

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 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) middle of the hallway. Resident #80 became agitated as resident #30 was in her way. The CNA (staff #172) witnessed resident #80 kick the right leg of resident #30. Staff #172 reported that resident #80 could have gone around resident #30, but clearly wanted to kick the resident. Both residents were immediately separated and resident #30 did not recall the incident. When resident #80 was asked about the incident, resident #80 said, I am tired of her lately. The report included there were no injuries to either resident. Further review of the facility's investigative report revealed that the incident was reported online to the State Survey Agency on December 9, 2019 at 7:09 p.m., however, the allegation of abuse was not reported to APS until December 16, 2019 at 3:19 p.m., which was 7 days after the allegation was made. In a phone interview conducted on March 4, 2020 at 10:24 a.m., a registered nurse (RN/staff #89) stated that she was on shift that day, but she did not witness the incident. She said a CNA (staff #172) reported to her that resident #80 kicked resident #30 on the leg. She said the incident was physical abuse so she reported it to the Director of Nursing (DON/staff #17) right away. She further stated that she did not know if the incident was reported to APS. During an interview with the DON conducted on March 5, 2020 at 3:16 p.m., he stated that incidents such as resident to resident altercations must be reported to APS. He stated the incident between resident #30 and #80 was reported to APS electronically on December 16, 2019 at 3:19 p.m. However, he could not explain why there was a delay in reporting the incident to APS. Review of a policy on Abuse Reporting revealed that the organization will maintain systems to ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse .to the administrator of the facility or his or her designee, and to other officials, including to the State Survey Agency and Adult Protective Services where state law provides for jurisdiction in Long Term Care facilities, in accordance with State law.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews, facility documentation and policy review, the facility failed to ensure that thorough investigations involving two residents (#89 and #70) were completed. The deficient practice could result in inaccurate investigations and as a result, a lack of interventions being implemented. Findings include: -Resident #89 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The resident resided on the secured dementia unit. Review of the facility's investigative documentation revealed that on December 4, 2019 at 1 p.m., resident #89 was being toileted by a Certified Nursing Assistant (CNA/staff #137) and CNA (staff #39). Per the documentation, staff #39 reported that while the resident was being toileted, staff #137 grabbed the abdominal fat of the resident, shook it and then told the resident You look like a cow. Staff #39 immediately reported this incident to the Director of Nursing (DON/staff #17) and staff #137 was immediately removed from the floor and suspended pending the investigation. Further review of the facility's investigative report revealed it was not thorough, as there were no interviews with other residents who had been provided care by staff #137, and there were no additional interviews with staff who had worked with staff #137. An interview was conducted with the Director of Nursing (DON/staff #17) on March 4, 2020 at 1:07 p.m. He stated when there is an allegation of abuse, additional staff and residents are interviewed, as part of the investigation to determine if the alleged aggressor may have abused other residents. He stated there is no documentation of additional interviews with residents and staff, per facility protocol. -Resident #70 was admitted [DATE], with [DIAGNOSES REDACTED]. Review of the facility's abuse investigation revealed that on February 4, 2020 at 12:00 p.m., the resident reported that she had 3 rings, 2 bracelets and 1 necklace which were missing. The report included the resident reported that the items were in a hospital specimen bag at the bedside. The resident stated that she lost them about a week ago and she does not recall the last day that she saw the items. The report also included the family reported that they did not take these items home. Per the report, the resident was cognitively intact. Further review of the facility's investigation regarding an allegation of misappropriation of resident property revealed that the investigation was not thorough, as other residents were not interviewed, in order to determine if additional resident's had items that were missing. An interview was conducted on March 5, 2020 at 10:24 a.m. with the Administrator (staff #200), who said that when a missing item is reported they investigate it. He said if the item is not found, then a more thorough investigation is done. He said he does not think that any residents were interviewed, but he would have to talk to the Director of Nursing (DON/staff #17). An interview was conducted on March 5, 2020 at 2:22 p.m. with the DON, who said that if there is an incident, they investigate it thoroughly including residents and staff members involved. He stated that they did not interview other residents. Review of the policy regarding Abuse Investigations revealed that a designated staff will immediately review and investigate all allegations or observations of abuse. The results of all investigations are to be communicated to the administrator or his/her designated representative and to other officials in accordance with the State law, including State Survey Agency, within 5 working days of the incident and if the alleged violation is verified, appropriate corrective action must be taken. Review of the Abuse policy revealed that the organization will maintain systems to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately. The policy included that analysis will be coordinated with the Quality Assurance/Performance Improvement Committee. However, no policy addressed the necessary components of a thorough investigation.
F 0645 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**PASARR screening for Mental disorders or Intellectual Disabilities** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews, the facility failed to ensure the Level I Pre-Admission Screening and Resident Review (PASRR) was completed for one resident (#73), after the stay in the facility was over 30 days. The deficient practice could result in specialized services needed not being identified and provided to residents. Findings include: Resident #73 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of the Level I PASRR dated January 25, 2020 revealed the resident was admitted to the facility from the hospital, and met the criteria for a 30 day convalescent stay at the facility. The PASRR also included a statement that the facility had to update the Level I PASRR, if the resident's stay exceeded 30 days. A review of the clinical record revealed that the resident continued to reside in the facility from admission through March 5, 2020. However, there was no evidence that the Level I PASRR had been updated/completed, despite the resident continuing to reside in the facility. An interview was conducted with social services (staff #71) on March 5, 2020 at 3:25 p.m. Staff #71 stated the Level I PASRR for resident #73 needed to be updated after he had resided at the facility for longer than 30 days. Staff #71 said that updating the PASRR would help in determining if the resident was in need of any behavioral services, due to a [DIAGNOSES REDACTED].#71 stated the facility would follow the guidelines as outlined on the actual PASRR form. An interview was conducted with the Director of Nursing (staff #3) on March 5, 2020 at 3:40 p.m. She stated the PASRR should be reviewed to make sure it is complete and accurate and the PASRR Level I should have been updated for resident #73, after his stay of 30 days. Staff #3 said it would be important so that any recommendations could be acted upon.
F 0686 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record reviews, staff interviews and policy and procedures, the facility failed to ensure that two residents (#27 and #83) received care consistent with professional standards of practice to prevent pressure ulcer/injury development, and/or to promote the healing of existing pressure ulcers. The deficient practice resulted in a lack of timely and thorough pressure ulcer assessments being done and/or identifying wound deterioration timely and/or treatments being missed. Findings include: -Resident #27 was admitted on [DATE], with [DIAGNOSES REDACTED]. A Braden Skin assessment dated [DATE] revealed the resident was considered to be at high risk for the development of pressure sores. A care plan for pressure ulcer risk included a goal to minimize risk for pressure ulcers. Interventions were to encourage the resident to turn and reposition frequently and incontinence care as promptly as possible to keep the resident clean and dry. A nursing progress note dated February 4, 2019 included the resident had redness to bilateral medial balls of her feet. The note stated that it looked like the resident's shoes may be too tight, causing irritation and that the family was notified. Regarding the left metatarsal: On February 5, 2019, a nursing progress note included that the wound nurse had been notified that the resident had redness/abrasions to bilateral feet. Upon assessment, the resident was noted with a protruding lateral metatarsal head with blanchable redness, consistent with characteristics of a bunion. Left metatarsal had an old, dry scabbed abrasion that measured 0.3 cm x 0.5 cm x depth (unable to determine/UTD) and no signs or symptoms

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) of infection noted. The physician was notified, an order was obtained and the new treatment was carried out. A physician's order dated February 5, 2019 included to cleanse the left lateral metatarsal head abrasion/scab with wound cleanser, pat dry, apply [MEDICATION NAME] (topical antibiotic) ointment, leave open to air, every day until resolved. The orders also included to monitor for adverse changes and notify medical doctor (MD) of any adverse changes. Review of February 2019 through April 2019 TAR's revealed that treatments were carried out per physician's orders. However, review of the clinical record revealed there were no further wound assessments of the left lateral metatarsal head from February 6, 2019 through May 5, 2019, nor documentation if or when the wound had healed. A nursing progress note dated May 6, 2019 included that the wound care nurse had been notified that the resident had a popped blister to the left metatarsal head, which measured 2.5 cm x 2.0 cm x 0.1 cm. The wound bed was described as pink and moist, partially covered by a skin flap, wound edge defined, peri wound with mild [DIAGNOSES REDACTED] extending 1.0 cm from wound edge, scant serous exudate, no odor and no signs or symptoms of infection. The note stated the resident had chronic bunions to bilateral medial metatarsal heads. The physician was in the facility and was notified, and an order was obtained and carried out. A physician's order dated May 6, 2019 revealed to cleanse the popped blister to left medial metatarsal head with wound cleanser, pat dry, apply [MEDICATION NAME] (antimicrobial) wound gel, cover with Xeroform (occlusive) gauze, and cover with a dry dressing every day and as needed until resolved. The order included to monitor for adverse changes and notify MD. A weekly skin assessment dated [DATE] included that the resident had a popped blister to the left medial metatarsal. A care plan for at risk for development of additional pressure ulcers was developed on May 20, 2019. The care plan included that the resident's shoes were too tight. A goal was for the pressure ulcer to resolve with no complications. Interventions included to remove shoes that do not fit well and provide shoes that fit appropriately, pressure reducing mattress, skin assessment as needed, treatment as ordered, and to turn and reposition as often as needed. Further review of the clinical record revealed there was no evidence that the left medial metatarsal was thoroughly assessed to include measurements, a description of the wound bed, surrounding tissue and if any drainage was present from May 7 through May 20, 2019. A nursing progress note dated May 21, 2019 by the wound care nurse included the left medial metatarsal head which had a popped blister was now a stage III pressure injury, due to location. The wound measured 3.5 cm x 3.5 cm x 0.1 cm., wound bed was pink and moist, previously noted to be covered with a skin flap however, no flap was currently present, wound edge was defined, peri wound with mild [DIAGNOSES REDACTED] now extending 2.2 cm from wound edge, warm to touch, scant serous exudate and no odor. The note stated the physician had been notified, an order was obtained and carried out. A physician's order dated May 21, 2019 included to cleanse the pressure injury to the left medial metatarsal head with wound cleanser, pat dry, apply [MEDICATION NAME] wound gel, cover with Xeroform gauze, and cover with a foam dressing every day and as needed until resolved. Another physician's order dated May 21, 2019 included for [MEDICATION NAME] (antibiotic) 500 milligrams (mg) by mouth twice daily for 10 days for left medial metatarsal head infection. Review of the May 2019 Medication Administration Record [REDACTED]. Review of the May TAR revealed that treatments were administered per physician's orders. Continued review of the clinical record revealed no evidence that the left medical metatarsal stage III pressure ulcer was thoroughly assessed from May 22 through June 1, 2019. A wound rounds progress note dated June 2, 2019 included that the stage III pressure injury to the left medial metatarsal head had slightly increased in size from the previous assessment. The wound measured 3.8 cm x 3.5 cm x 0.1 cm. The wound bed was described as pink and moist, the wound edge was defined, peri wound with mild [DIAGNOSES REDACTED] which now extended 2.6 cm from wound edge, scant exudate and no odor. The note included the MD was updated on wound status. Preventative measures in place included weekly skin assessments, offloading with Prevalon (heel protection) boots when in bed as tolerated, and to administer treatment per MD order. The note stated that the resident's family had provided new shoes to the resident. A nursing note three days later dated June 5, 2019, revealed that the wound nurse had notified the Family Nurse Practitioner (FNP) that the stage III pressure ulcer to the left medial metatarsal head had 20% moist black eschar and 80% pink moist tissue. The note stated the wound was now classified as an unstageable pressure injury and a new order was received and carried out. A physician's order dated June 5, 2019 included to cleanse pressure injury with normal saline, pat dry, apply nickel thick layer of Santyl (enzymatic debridement ointment), cover with foam dressing every day and as needed until resolved, and to monitor for adverse changes and notify MD. Review of June 2019 TAR revealed that treatments were administered daily as ordered. A wound rounds progress note dated June 8, 2019 included that the unstageable pressure injury to the left medial metatarsal head had slightly increased in size from the last assessment and measured 3.8 cm x 3.5 cm x depth (unable to determine/UTD). The wound bed continues with 20% moist black eschar, 80% moist pink tissue, wound edge defined, periwound with increased [DIAGNOSES REDACTED], now extending 3.0 from wound edge, scant serous exudate and MD updated on status. The note indicated that preventative measures in place included off-loading with Prevalon boots when in bed as tolerated, to ensure proper fitting footwear is worn and to administer treatment per MD order. A nursing progress note dated June 11, 2019 included the wound nurse had notified the NP of increased [DIAGNOSES REDACTED] to the periwound and left medial metatarsal head unstageable pressure injury. The note stated the site remained at 3.8 cm x 3.5 cm x UTD, wound bed continued with 20% moist black eschar, 80% moist pink tissue, wound edge defined, peri wound with increased [DIAGNOSES REDACTED], now extending 4.0 cm from wound edge, scant serous exudate, no odor and was warm to touch. The note included that a new order had been obtained and carried out. Review of a physician's order dated June 11, 2019 included for [MEDICATION NAME]-[MEDICATION NAME] (antibiotic) 400/80 mg, twice daily for wound infection for 10 days. A wound rounds progress note dated June 15, 2019 revealed the unstageable pressure injury to the left medial metatarsal head remained at 3.8 cm x 3.5 cm x UTD. The wound bed continues with 20% moist black eschar, 80% moist pink tissue, wound edge defined, peri wound with increased [DIAGNOSES REDACTED], now extending 4.0 cm from wound edge, scant serous exudate, no odor and warm to touch. MD updated on wound status. A physician's order dated June 18, 2019 revealed for follow up with podiatry for wound to left medial metatarsal head. The wound rounds progress note on June 22, 2019 indicated the wound status remained the same. A nursing progress note dated June 26, 2019 included that the resident returned from a podiatrist appointment with orders to wash the foot with soap and water, apply Santyl collagenous in 1/8 thickness to wound. Cover with [MEDICATION NAME] 4 x 4 and 4, Kerlix to be done every day until healed. A MD progress note dated June 27, 2019 included that the resident had been referred to the podiatrist and that debridement had been done, with instructions for local wound care. A wound rounds progress note dated June 28, 2019 included that the unstageable pressure injury to the left medial metatarsal head was now classified as a stage III pressure injury, with increased size due to a debridement procedure on June 26, at the physician's office. The wound measurements were 6.0 cm x 3.0 cm x 0.2 cm and the wound bed was described as 100% pink moist tissue, wound edge defined, peri wound with decreased [DIAGNOSES REDACTED], now extending 1.2 cm from wound edge, continues with scant serous exudate, no odor and no signs or symptoms of infection. MD updated on wound status. Review of the June 2019 TAR revealed that wound care was provided daily in accordance with physician's orders. However, review of the clinical record revealed that the left medial metatarsal head pressure ulcer was not thoroughly assessed again until July 7, 2019. A wound rounds progress note dated July 7, 2019 revealed the resident had a stage III pressure injury that remained at 6.0 cm x 3.0 cm x 0.2 cm. The wound bed was described with 100% pink moist tissue, wound edge defined, peri wound with decreased [DIAGNOSES REDACTED] now extending 1.0 cm from wound edge, continues with scant serous exudate, no odor, and no signs or symptoms of infection. Review of the quarterly MDS assessment dated [DATE] revealed the resident had severe cognitive impairment and required extensive assistance with activities of daily living. Per the MDS, the resident was at risk for pressure ulcer development and had two stage 2 pressure ulcers and one stage 3. Review of July 2019 wound round progress notes revealed that thorough wound assessments were provided on July 14, 20, and 27. Review of the July 2019 TAR revealed that treatments were provided per physician's orders. Review of August 2019 wound round progress notes revealed that thorough wound assessments were provided on August 3, 10, and 17. A wound rounds progress note dated August 24, 2019 included for a stage III pressure injury to the left great metatarsal, which measured 1.7 cm x 1.6 cm x 0.1 cm. The wound bed was described with 100% pink moist granulation tissue, wound edge defined and continues with merging [MEDICATION NAME] tissue, peri wound within normal limits, decrease in exudate, now with scant serosanguineous exudate, no odor, and no signs or symptoms of infection. However, review of the clinical record revealed the wound to the resident's left metatarsal was not thoroughly reassessed, including wound measurements, a description of wound bed and peri wound, any exudate, odor, and signs and symptoms of infection until September 7, 2019. A wound rounds progress note dated September 7, 2019 included the left metatarsal wound measured 1.3 cm x 1.4 cm x 0.1 cm. The wound bed was described as 100% pink moist granulation tissue, wound edge defined and continues with merging [MEDICATION NAME] tissue, peri wound within normal limits, scant serous exudate, no odor and no signs or symptoms of infection. A wound rounds progress note dated September 12, 2019 included the stage III pressure injury to the left great metatarsal head had a slight decrease in size from the previous assessment dated [DATE], and measured 1.2 cm x 1.1 cm x 0.1 cm. The wound bed

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) was described with 100% pink moist granulation tissue, wound edge defined and continued with merging [MEDICATION NAME] tissue, peri wound within normal limits, scant serous exudate, no odor, and no signs or symptoms of infection noted. MD notified of wound status. Further review of the clinical record revealed the wound was not thoroughly assessed again until September 28, 2019, which included measurements, a description of the wound bed, peri wound, any exudate, odor, and signs and symptoms of infection. A wound rounds progress note dated September 28, 2019 revealed the left metatarsal head wound measured 0.8 cm x 0.6 cm x 0.1 cm. The wound bed was described with 100% pink moist granulation tissue, wound edge defined and continued with merging [MEDICATION NAME] tissue, peri wound within normal limits, scant serous exudate, no odor, and no signs or symptoms of infection noted. MD notified of wound status. A nursing progress note dated October 4, 2019 stated the wound care nurse had informed the MD that the stage III pressure injury to the left great metatarsal head was now resolved, and treatments were discontinued. However, a wound rounds progress note the following day dated October 5, 2019, revealed the stage III pressure injury to the left metatarsal head had significantly decreased in size from the assessment dated [DATE], and measured 0.2 cm x 0.1 cm x 0.1 cm. The wound bed was described with 100% pink moist granulation tissue, wound edge defined and continued with merging [MEDICATION NAME] tissue, peri wound within normal limits, scant serous exudate, no odor, and no signs or symptoms of infection noted. Review of a Minimum Data Set (MDS) progress note dated October 5, 2019 by the wound care nurse, revealed the stage III pressure injury to the resident's left metatarsal head was resolved. A late entry nursing progress note dated October 7, 2019 included that per the wound care nurse, the stage III pressure ulcer/injury to left metatarsal head had resolved. Regarding the right lateral/medial metatarsal head: A nursing progress note dated July 1, 2019 stated the wound nurse had notified the MD that the resident had a suspected deep tissue injury (SDTI) to the right lateral metatarsal head, which measured 1.3 cm x 2.0 cm x depth (UTD). The area was described as dark maroon in color; skin intact, no exudate, and no signs or symptoms of infection. The note included the resident had a chronic, large, protruding bunion to the area. An order was obtained and carried out; will continue to offload with Prevalon boots and monitor for adverse changes. A physician's order dated July 1, 2019 included to cleanse the pressure injury to the right medial metatarsal head with wound cleanser, pat dry, apply skin prep, leave open to air, every shift until resolved. Monitor for adverse changes and notify MD. Review of the wound rounds progress notes dated July 7, 14, 20, and 27, 2019 revealed that the right lateral metatarsal head wound (SDTI) had decreased in size slightly and skin had remained intact. Review of July 2019 TAR revealed that treatments were administered per physician's orders. Review of the wound rounds progress notes dated August 3, 2019 revealed a SDTI to the right medial metatarsal head which measured 1.0 cm x 1.5 cm x UTD. The area was described as dark maroon, skin intact, no exudate, and no signs or symptoms of infection noted. Wound rounds progress notes for August 10 and 18, 2019 revealed that the wound to the right metatarsal head was thoroughly assessed, with a slight decrease in size. A weekly wound rounds progress note dated August 24, 2019 revealed the SDTI to the right medial metatarsal head measured 0.5 cm x 0.5 cm x UTD, and the wound remained intact, with no changes in wound status. Review of the August 2019 TAR revealed treatments were administered according to physician's orders. However, further review of the clinical record revealed the wound to the right medial metatarsal was not assessed again until September 7, 2019. Review of the wound rounds progress note dated September 7, 2019 revealed the SDTI to the right medial metatarsal head had slightly decreased in size to 0.4 cm x 0.4 cm x UTD. Area remained stable with dark maroon intact skin, no exudate, and no signs or symptoms of infection noted. Review of the wound rounds progress note dated September 12, 2019 revealed no change in wound status. Review of the September 2019 TAR revealed that treatments were administered per physician's orders, until the order was discontinued on September 26. However, further review of the clinical record revealed the wound to the right medial metatarsal was not assessed from September 13 through 27, 2020, which included wound measurements, a description of the wound bed, exudate or signs or symptoms of infection. A physician's order dated September 27, 2019 included to cleanse pressure injury to right medial metatarsal head with wound cleanser, pat dry, apply Hydrogel (wound protectant) and Band-Aid every day until resolved. Monitor for adverse changes and notify MD, every day for bunion. A wound rounds progress note dated September 28, 2019 included that the right medial metatarsal head was initially a SDTI and was now a stage III pressure ulcer. The wound measured 0.3 cm x 0.3 cm x UTD. The wound bed was described as 100% pink moist tissue, no exudate, and no signs or symptoms of infection noted. The note stated that the resident had been seen by the podiatrist on September 26, 2019 and that the area had been debrided, and a new order had been put into place. Further review of the September 2019 TAR revealed that treatments were provided according to physician's orders. Review of the wound rounds progress note dated October 5, 2019 included a stage III pressure ulcer to the right medial metatarsal head, with measurements at 0.3 cm x 0.3 cm x 0.1 cm. The wound bed was described as 100% pink moist tissue, wound edge defined, peri wound with mild [DIAGNOSES REDACTED] extending 0.3 cm from wound edge, no exudate, and no signs or symptoms of infection noted. However, further review of the clinical record revealed the stage III pressure injury to the right medial metatarsal was not thoroughly assessed from October 6 through October 18, 2019. A wound rounds progress note dated October 19, 2019 included that the stage III pressure ulcer continued to measure 0.3 cm x 0.3 cm x 0.1 cm, with the wound bed described as 100% pink moist tissue. The wound edge was defined as having dry peeling skin, peri wound continues with mild [DIAGNOSES REDACTED] extending 0.3 cm from wound edge, had scant serous exudate, and no signs or symptoms of infection. MD updated on wound status. Review of the October 2019 TAR revealed that treatments were per provided per physician's orders, with the exception of October 20, on the PM shift. Further review of the clinical record revealed the stage III pressure injury to the right medial metatarsal head was not thoroughly assessed from October 20 through November 1, 2019. A wound rounds progress note dated November 2, 2019 revealed there was a slight decrease in the wound to 0.3 cm x 0.2 cm x 0.1 cm. The wound bed was described as 100% pink moist tissue, wound edge defined, peri wound continues with mild [DIAGNOSES REDACTED] extending 0.2 cm from wound edge, with scant serous exudate, and no signs or symptoms of infection noted. Wound rounds progress notes dated November 8, 2019 revealed there was no change in wound measurements and had a decrease in [DIAGNOSES REDACTED] to 0.1 cm from wound edge. A wound rounds progress note dated November 16, 2019 included a decrease in size to the right medial metatarsal head wound which measured 0.3 cm x 0.1 cm x 0.1 cm. The wound bed was described with 100% pink moist tissue, wound edge defined, peri wound within normal limits, continues with scant serous exudate, and no signs or symptoms of infection noted. Review of the clinical record revealed thorough wound assessments were provided on November 23 and 30, 2019, with a slight decrease in size. Review of the November 2019 TAR revealed that treatments were administered per physician's orders. Wound rounds progress notes dated December 7 and 14, 2019 revealed thorough assessments were completed. The annual MDS assessment dated [DATE] revealed the resident had severe cognitive impairment and required extensive 2+ person physical assistance with activities of daily living. Per the MDS, the resident was at risk for pressure ulcer development and had one stage III pressure ulcer. Interventions included for pressure-relieving devices for her chair and bed, nutrition and hydration interventions to manage skin problems, pressure ulcer care, and application of ointment. A physician's order dated December 16, 2019 included for cleansing the pressure injury to the right medial metatarsal head with wound cleanser, pat dry, apply thin layer of Anacept (antimicrobial) gel, apply collagen powder (1/32 inch) and cover with dry dressing every day shift every Monday, Tuesday, Wednesday, Thursday and Friday until resolved. A wound rounds progress note dated December 21, 2019 revealed for a stage III pressure injury to the right medial metatarsal head, which continued to measure at 0.2 cm x 0.1 cm x 0.1 cm. The wound bed was described as 100% moist pink tissue, wound edge defined, peri wound within normal limits, continues with scant exudate, no odor noted, and no signs or symptoms of infection. A wound rounds progress note dated December 28, 2019 included that a thorough wound assessment was completed, with slight decrease in size of wound and no change in status. Review of December 2019 TAR revealed that treatments were administered as ordered by the physician. A wound round assessment dated [DATE] included a stage III pressure injury to the right medial metatarsal head, which measured at 0.2 cm x 0.1 cm x 0.1 cm. Wound bed was described as 100% pink moist tissue, wound edge defined, peri wound within normal limits, continues with scant exudate, and no signs or symptoms of infection noted. Review of a wound rounds progress note dated January 11, 2020 revealed that a thorough wound assessment of the right medial metatarsal head had a slight decrease in size and no change in wound status. Continued review of the clinical record revealed the wound to the right medial metatarsal head was not thoroughly assessed from January 5 through January 24, 2020. A wound rounds progress note dated January 25, 2020 revealed the stage III pressure injury to the right medial metatarsal head measured 0.1 cm x 0.1 cm x 0.1 cm. The wound bed was described as 100% pink moist tissue, wound edge defined, peri wound within normal limits, continues with scant exudate, and no signs or symptoms of infection noted. Review of the January 2020 TAR revealed that treatments were administered per physician's orders. Further review of the clinical record revealed there was no nursing documentation to indicate if the right medial metatarsal head pressure ulcer had healed from January 26 through 31, 2020. Review of the physician orders revealed there was an order dated February 1, 2020 to discontinue the treatment to the right medial metatarsal. During the survey from

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 4) March 2 through 5, 2020, a wound care observation was unable to be performed, as per the resident's family preference. An interview was conducted with a Certified Nursing Assistant (CNA/staff #42) on March 5, 2020 at 9:44 a.m. She stated that she didn't remember anything about the resident wearing shoes that were too tight. She stated if a resident's foot was red or had open areas, she would tell the nurse. On March 5, 2020 at 10:45 a.m., an interview was conducted with the wound nurse/Assistant Director of Nursing (staff #57). She said that she did not know whether or not the pressure injuries to the resident's feet were caused by the shoes that were too tight. She stated she could not speak for the wound nurse prior to her, but that her process is to provide wound assessments on a weekly basis and to document the wound assessments in the resident's progress notes. She said the wound assessments include wound measurements, description of the wound bed, wound edge, peri wound area, amount of exudate, odor, and signs or symptoms of infection. -Resident #83 was readmitted to the facility on [DATE] and readmitted on [DATE], with [DIAGNOSES REDACTED]. Regarding the sacrum/coccyx pressure ulcer: Review of the clinical record revealed the resident had developed a stage 2 coccyx pressure ulcer, which had resolved by December 2, 2019. A nursing progress note dated December 17, 2019 included the resident had been sent to the hospital for an evaluation. The discharge Minimum Data Set (MDS) assessment dated [DATE] revealed the resident scored 8 on the Brief Interview for Mental Status (BIMS) assessment, indicating moderate cognitive impairment. The resident required extensive 2+ person physical assistance with most activities of daily living (ADLs), and was at risk for pressure ulcer development. Pressure ulcer interventions in place included a pressure-reducing device for chair and bed, and pressure ulcer care. Another nursing note dated December 18, 2019 at 4:09 a.m. revealed the resident had been admitted to the hospital. A nursing progress note dated December 22, 2019 included the resident had returned to the facility at 1:32 p.m. Per the report from the hospital, the resident was dependent on all ADLs, required assistance with feedings, and was incontinent of bowel. A Braden scale for predicting pressure sore risk dated December 22, 2019 revealed the resident scored a 13.0, indicating she was at moderate risk for the development of pressure sores. The nursing admission skin assessment dated [DATE] did not include documentation of any skin breakdown or pressure ulcers to the coccyx/sacrum. Review of the weekly skin assessment dated [DATE] revealed no documentation that the resident had any skin breakdown to the coccyx/sacrum. A nursing progress note dated January 3, 2020 included that during a weekly skin check, an open area was noted to the resident's sacrum. The note stated that the MD was notified and an order was obtained. There was no further description of the open area to the sacrum. A physician's order dated January 3, 2020 included to cleanse the sacrum with normal saline, pat dry, and apply a foam dressing every day shift. Review of the clinical record revealed there was no documentation of a thorough assessment of the open area to the sacrum from January 3 through 6, 2020, which included measurements, a description of the wound bed, if any exudate was present, any odor or the stage of the pressure ulcer. A nursing progress note dated January 7, 2020 revealed the wound care nurse had been notified that the resident had an open area to the coccyx. Upon assessment, the resident was noted with a reopened stage II pressure ulcer measuring 1.8 cm x 2.0 cm x 0.1 cm. The wound bed was described as pink moist tissue, with wound edge defined, peri wound within normal limits, scant exudate, no odor and no signs or symptoms of infection. MD was notified and an order was obtained and treatment carried out. A physician's order dated January 8, 2020 included to cleanse the pressure injury to coccyx with wound cleanser, pat dry, apply [MEDICATION NAME] (antimicrobial) wound gel, Xeroform gauze (occlusive sterile dressing) and cover with foam dressing every day and as needed until resolved. The order included to notify MD of any changes. Review of a wound rounds progress note dated January 11, 2020 revealed the coccyx wound measured 1.8 cm x 2.0 cm x 0.1 cm. The wound bed was described as pink moist tissue, wound edge defined, peri wound within normal limits, scant exudate, no odor and no signs or symptoms of infection. Preventative measures in place included weekly skin assessments, re-positioning every 2 hours as tolerated while in bed and pressure reducing mattress. Review of a wound rounds progress note dated January 18, 2020 revealed a stage II pressure ulcer to the resident's coccyx. The wound measured 1.5 cm x 1.8 cm x 0.1 cm and had pink moist tissue, wound edge defined, peri wound within normal limits, scant exudate, no odor and no signs or symptoms of infection. A wound rounds progress note dated January 25, 2020 included a stage II pressure ulcer to the coccyx, which measured 1.0 cm x 1.8 cm x 0.1 cm. The wound bed was described as pink moist tissue, wound edge defined, peri wound within normal limits, scant exudate, no odor and no signs or symptoms of infection. A registered dietitian progress note dated January 30, 2020 revealed the resident's meal intake was approximately 68% for the last 20 meals. A recommendation was to discontinue Nepro one can daily, and begin Nepro 8 ounces twice daily to meet increased needs. Review of the physician's orders for January 2020 revealed there was no order for Nepro as recommended by dietary. Review of the January 2020 TAR revealed that wound treatments were administered in accordance with the physician's orders. A wound rounds progress note dated February 1, 2020 revealed the coccyx wound measured 1.0 cm x 1.5 cm x 0.1 cm. The wound bed was described as pink moist tissue, wound edge defined, peri wound within normal limits, scant exudate, no odor and no signs or symptoms of infection. A Braden scale for predicting pressure sore risk dated February 7, 2020 revealed the resident scored a 13.0, indicating at moderate risk for the development of pressure sores. A physician's order dated February 7, 2020 now included for Nepro daily, however, it was not ordered twice a day as recommended by dietary on January 30. A wound rounds progress note dated February 8, 2020 revealed the stage II pressure ulcer on the coccyx measured 1.0 cm x 1.5 cm x 0.1 cm. The wound bed was described as pink moist tissue, wound edge defined, peri wound within normal limits, scant exudate, no odor and no signs or symptoms of infection. MD notified of wound status. A nutrition assessment dated [DATE] included the resident had a stage II pressure ulcer to the coccyx. The note stated the resident was receiving Nepro 8 oz daily, with 100% consumed. The recommendation again was to increase Nepro 8 oz to twice daily. Review of an annual MDS assessment dated [DATE] revealed the resident had moderate cognitive impairment with daily decision making skills. The resident required extensive assistance with bed mobility, transfers and eating. Per the MDS, the resident was at risk for developing pressure ulcers and had one stage 2 pressure ulcer. Review of a wound rounds progress note dated February 15, 2020 revealed the wound measured 1.0 cm x 1.0 cm x 0.1 cm. The wound bed was described as pink moist tissue, wound edge defined, peri wound within normal limits, scant exudate, no odor and no signs or symptoms of infection noted. MD notified of wound status. A registered dietician progress note dated February 18, 2020 stated the resident's oral intake was 70%. The note included the resident was receiving Nepro 8 oz daily. The RD recommendation again included for Nepro 8 oz to twice daily. However, review of the physician's order did not reveal an order to increase Nepro 8 oz to twice daily in February 2020. A wound rounds progress note dated February 22, 2020 revealed the stage II pressu
F 0688 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, resident and staff interviews and facility documentation, the facility failed to ensure that one of two sampled residents (#33) with limited range of motion (ROM) received the necessary treatment and services. The deficient practice could result in residents experiencing a decrease in ROM and functioning. Findings include: Resident #33 was readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of the clinical record revealed an OT (occupational therapy) evaluation dated November 19, 2018. Per the documentation, skilled OT was warranted to maximize independence with ADL's, increase functional activity tolerance and assess safety and independence with self care and functional task of choice, in order to enhance quality of life by improving ability to facilitate increased participation with functional daily activities and return to prior level of skill performance. Review of the documents from the discharging facility revealed a medication review report dated on/or after December 12, 2019, which included the following orders: -Resting hand splint to left hand to be worn at all times or as tolerated and to be removed for 15 minutes each shift for skin integrity checks -Restorative Nursing (RNA) services 3x per week for AROM (active ROM) to the right upper and lower extremities -RNA 3x per week for PROM (passive ROM) to the left upper and lower extremities The admission nursing assessment dated [DATE] included the resident was alert and oriented to person, place and time. [DIAGNOSES REDACTED]. The assessment did not include if the resident had contractures or limited ROM. Review of the admission physician orders [REDACTED]. The care plan included the resident required total dependence with ADL's and used a Hoyer lift. Also on the care plan was a box that was checked, which indicated for therapy services, with a goal to maintain current functional status. However, the boxes for RNA services and functional interventions were not marked. Review of the physician history and physical note dated December 20, 2019 revealed a [DIAGNOSES REDACTED]. Systems review revealed musculoskeletal finding was marked as positive, however, the assessment did not describe what the finding was. The box for contracture was not marked. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had

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F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) a BIMS (Brief Interview for Mental Status) score of 14, indicating intact cognition. The MDS included the resident required extensive assistance with bed mobility, transfers, dressing, toilet use and personal hygiene. The MDS also included resident had impaired functional limitation in ROM to one side of the upper extremity. Per the MDS, the resident was not coded as receiving restorative nursing services in the last 7 days. The CAA (Care Area Assessment) Summary triggered to proceed to care planning with ADL functional/Rehabilitation Potential. Review of the ADL care plan dated December 30, 2019 revealed the resident required assistance with ADL's related to [MEDICAL CONDITION] and late effects of [MEDICAL CONDITION]. The goal was that the resident would maintain locomotion ability. Interventions included providing extensive assistance with bed mobility and/or repositioning in the bed and chair as needed and assistance by 2 staff with transfers. The comprehensive care plan did not identify that the resident had limitation in ROM or was on a RNA program. Review of the clinical record revealed no evidence that the resident received RNA services or that the resting hand splint was applied to the left hand from readmission on December 17, 2019 through January 1, 2020. There was no documentation as to why the RNA services and the hand splint were not implemented. There was also no documentation that the resident refused RNA services or the resting hand splint from December 17, 2019 through January 1, 2020. On January 2, 2020, a physician's orders [REDACTED]. The physical therapy (PT) plan of care note dated January 2, 2020 included the resident was referred to skilled physical therapy, secondary to new LTC (long term care) resident with noted functional deficits. Per the plan of care, the resident would benefit from short-term skilled PT to improve strength, balance, and motor control to maximize safety and independence with functional mobility. The note included the resident was high risk for contractures, however, the documentation did not include whether the resident had contractures. The discharge plan included the resident would be discharged to long term care with RNA. The PT progress and discharge summary dated February 20, 2020 included progress ceased as the reason for discharge from physical therapy. Clinical impression was that the resident had met his highest therapeutic potential. Training included the resident was educated on compensatory [DIAGNOSES REDACTED] techniques for functional mobility. According to the note, the resident was at high risk for contractures and the discharge plan was for long term care with RNP (restorative nursing program). However, there was no evidence in the clinical record that the resident was on RNA services from February 21, 2020 through March 3, 2020. There was also no documentation of the reason why RNA services were not provided to the resident during this time frame. Review of the list of residents on the RNA program dated March 3, 2020 revealed the resident's name was not on the list. In an interview with resident #33 conducted on March 2, 2020 at 2:48 p.m., he stated that he has left-sided weakness due to a stroke. He stated that prior to admission to the facility, he had a splint for his left hand. He said after admission, he was told that he needed a splint that goes from his left hand all the way to his elbow. However, he stated he does not have that kind of splint for his left hand. He said that he still has his old splint, but does not use it because he was told not to. During this interview, the resident's left hand was observed to be bent forward from his wrist. The resident stated he could not move his left wrist and he was not on any therapy or exercise program. Another observation was conducted on March 3, 2020 at 1:09 p.m. of the resident sitting in his wheelchair. His left hand was bent forward from the wrist and he was not wearing any splint device. An interview with physical therapy staff (PT/staff #100) was conducted on March 4, 2020 at 10:45 a.m. She said that resident #33 was not on any therapy services at this time. An interview with a certified nursing assistant (CNA/staff #29) was conducted on March 4, 2020 at 12:42 p.m. Staff #29 stated the resident is alert and oriented and can tell staff his needs and wants. She stated when the resident was admitted to the facility, the resident required a Hoyer lift for assistance, but after therapy the resident currently requires extensive assistance with 1 person. She stated that she does not think the resident is on a RNA program. She said the resident cannot move his left wrist, as it is bent forward and it cannot be moved up and down. She stated the resident's left fingers cannot be moved also. She further said that the resident does not have any splint device for his left hand. An interview with another PT (staff #101) was conducted on March 4, 2020 at 1:36 p.m. Staff #101 stated she evaluated and provided treatment for [REDACTED]. She stated the resident is currently under RNA and that the paper documentation is located and maintained in the RNA office. She stated there was talk of splint placement for the resident's left hand, but the resident refused to wear the splint, so ROM exercises is performed for the resident. However, review of the clinical record revealed there is no documentation of the resident refusing to wear the splint. In an interview conducted on March 4, 2020 at 2:05 p.m. with the Director of Rehabilitation (staff #117), he stated resident #33 was seen by therapy on January 2, 2020 and was discharged from therapy on February 20, 2020, with a recommendation for RNA services. However, he stated that the recommendation was not carried over until today (March 4). He further stated there is no RNA documentation found, because RNA was not started. A review of the Therapy to Restorative Nursing Communication form dated March 4, 2020 included recommendation for restorative nursing for 12 weeks for a [DIAGNOSES REDACTED]. The goal was to maintain the current level of functioning. In another interview with the resident conducted on March 5, 2020 at 8:29 a.m., he stated he was told not to use his splint device prior to his admission at the facility, because the splint device is too short. He stated it has to run from his left hand to his elbow. He said they told him that they were trying to get a new order for the splint. He said that currently he is not on any exercise program or therapy. He said when the facility has a Zumba class as an activity, he attends the class because he gets his exercise there. During the interview, there was no splint device in place on the left forearm/hand. An interview was conducted on March 5, 2020 at 8:40 a.m. with a RNA (staff #77), who stated that therapy will communicate with her when a resident is placed on the RNA program and will give her the therapy sheet which would tell her what exercises will be provided to the resident. She stated she will then check whether there is an order for [REDACTED]. She said she has a list of residents which tells her who receives the RNA program daily or 3x per week. Regarding resident #33, staff #77 said the resident was on therapy for a while and was discharged . She stated the resident was not on the RNA program until yesterday (March 4). She stated that it was probably miscommunication between therapy and RNA. She stated the resident does not have any splint device at this time. During an interview with the Director of Rehabilitation (staff #117) conducted on March 5, 2020 at 1:30 p.m., he stated that once a resident is ready for discharge from therapy, a referral for RNA will be completed and will be given to the nursing department. He stated the RNA referral form will include what exercises, how frequent and for how long exercises will be provided to the resident. He said that all residents discharging from therapy will be placed on RNA program, unless the resident is being discharged to the community. He stated therapy screening or evaluation is done when the resident comes back from hospitalization or if there is a decline in the condition of a resident currently admitted to the facility. Regarding resident #33, staff #117 stated the resident was admitted on [DATE], but was not placed on therapy until January 2, 2020 after the nursing referral, because of a decline in the resident's transfers. He stated that he does not know why the resident was not placed on the RNA program after therapy discharge on February 20, 2020. He said the recommendation might have been missed. He further stated that due to a change in ownership, he does not have access to any therapy orders or documentation when the resident was admitted . An interview with a registered nurse (RN/staff #3) was conducted on March 5, 2020 at 1:58 p.m. Staff #3 that when a resident is admitted , she receives all the paperwork including discharge orders from the discharging facility such as hospital or another skilled nursing facility, and will call and/or verify the orders with the physician. Staff #3 said if the physician agrees with the order she will check it and if the physician disagrees she will draw a line over the order and put her initials. She stated all the orders that are verified and agreed upon by the physician will be carried out in the resident's record. In a later interview with staff #117 on March 5, 2020 at 2:07 p.m., he stated the resident has a contracture which he was admitted with and which was addressed by therapy from January 2, 2020 through February 20, 2020. He further stated, the resident does not have any splint device and this is one of the issues the occupational therapist (OT) will be addressing, as part of the facility's contracture management. An interview with the Director of Nursing (DON/staff #17) was conducted on March 5, 2020 at 3:16 p.m., with the Clinical Operations Director (staff #138) present. Staff #17 stated when a resident is admitted , the nurses will verify orders with the physician, who will agree or disagree with the orders. The DON said if the physician agrees the orders will be carried out in the clinical record and if the physician disagrees, the order will be crossed out. Regarding resident #33, he stated he does not know if the resident came in with a splint device or not. He stated that the admission assessment for resident #33 did not say anything about a contracture or splint device. He stated when therapy recommends RNA, nursing is expected to implement it. Staff #138 said the RNA program does not require a physician's orders [REDACTED]. She stated that this may be the reason why it was never carried out. The Facility Assessment completed on January 15, 2019 included that using a competency-based approach focuses on ensuring that each resident is provided care that allows the resident to maintain or attain their highest practicable physical, mental and psychosocial well-being. The policy which was provided titled, Restorative Nursing Program did not come into effect until February 28, 2020.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 6)
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and review of policies, the facility failed to ensure a dietary recommendation was acted upon for one resident (#87) who experienced a weight loss. The deficient practice could result in dietary recommendations not being implemented for residents with a weight loss or at nutritional risk. Findings include: Resident #87 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of the clinical record revealed the resident's admission weight was 169.8 pounds. The physician admission orders [REDACTED]. An admission nutritional care plan dated February 11, 2020 identified a concern that the resident was at risk for fluctuations in weight, with an intervention that included for the resident to be administered all medications as ordered. A dietary progress note dated February 12, 2020 revealed the resident's meal intakes varied between 25-75%, weight was 164 and that the resident was 134 % of her ideal weight range. Review of a dietary high risk meeting progress note dated February 19, 2020 revealed the resident had a weight loss of 4% within one week and was receiving a diuretic. Meal intakes were 25-100% and the physician was aware of the weight loss. A dietician note dated February 27, 2020 revealed the resident's nutritional status was reviewed and that the resident was most likely not meeting her nutritional needs. The recommendation was for Med Pass (nutritional supplement) three times daily to provide additional calories and increased protein to meet the resident's needs. However, review of the physician orders [REDACTED]. In addition, there was no evidence that the resident received Med Pass three times a day. An interview was conducted with the Assistant Director of Nursing (staff #57) on March 5, 2020 at 1:18 p.m. She stated this resident had been identified to be at high risk for weight loss. Staff #57 stated if the dietician made a recommendation like Med Pass, then the nursing staff would be responsible to notify the physician and get the order. Staff #57 said that she was unsure of how this was missed for resident #87 and that the resident continued to lose weight. An interview was conducted with the Director of Nursing (DON) on March 5, 2020 at 1:40 p.m. The DON started when the dietician makes a dietary or nutritional recommendation, it is communicated to the nursing department and then the nursing staff is responsible to notify the physician and get the order. The DON said the recommendation had most likely been overlooked due to many recent changes within the facility. The DON said despite this, the physician should have been The DON said today the physician wrote the order for Med Pass to be administered three times a day. According to a facility policy regarding Weight Assessment and Intervention the following was included: The multidisciplinary team will strive to monitor and intervene for undesirable weight loss for our residents. Interventions may include the use of supplementation. Review of a policy regarding nutrition revealed to aid in the development of an individualized care plan for nutritional interventions. The use of supplementation will be determined by the physician and the multidisciplinary team. Implement nutritional interventions according to the plan of care. A facility policy regarding Nutrition and Unplanned Weight Loss included that the dietician will estimate calorie and nutrient needs and with the physician, will identify if the resident's current intake is adequate to meet the nutritional needs. Strategies to increase a resident's intake of nutrients and calories may include nutritional supplementation.
F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews, and review of policy and procedures, the facility failed to ensure each resident's drug regimen was free of unnecessary drugs, by failing to ensure that two residents (#79 and #83) received medication in accordance with the physician's orders [REDACTED]. Findings include: -Resident #79 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A care plan for at risk for cardiac complications included a goal for no cardiac complications. An intervention included to administer medications as ordered. A physician's orders [REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had moderate cognitive impairment and required extensive assistance with most activities of daily living (ADLs). Review of the February 2020 Medication Administration Record [REDACTED]. -Resident #83 was readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. Another physician's orders [REDACTED]. The annual MDS assessment dated [DATE] revealed the resident had moderate cognitive impairment and required extensive assistance with most ADLs. A care plan for at risk for cardiac complications dated February 11, 2019 included a goal for no cardiac complications. An intervention was to administer medications as ordered. Review of the February 2020 MAR indicated [REDACTED]. Further review of the February 2020 MAR indicated [REDACTED]. On March 5, 2020 at 9:12 a.m., an interview was conducted with a Licensed Practical Nurse (LPN/staff #67). She stated that prior to administration of an antihypertensive; she checks the resident's blood pressure and pulse. She said she then double checks the order for the dose, route, and parameters. She stated that if the resident's blood pressure and pulse are within the ordered parameters, she administers the medication. She stated that some of the risks of administering antihypertensive medications outside the parameter would include a drop in the blood pressure, especially if the resident has multiple medications. Staff #67 reviewed the resident's MARs and stated the antihypertensives were administered incorrectly. An interview was conducted on March 5, 2020 at 9:53 a.m., with the Director of Nursing (DON/staff #17). He stated that his expectations for nursing include looking at the antihypertensive ordered parameters, and if the resident's blood pressure or heart rate were lower than the ordered parameters, the medication should be held and the physician called. Review of the policy titled, General Dose Preparation and Medication Administration revealed that staff should comply with applicable laws and the State Operations Manual, when administering medications. The policy stated that prior to administration of medication, facility staff should take all measures required by their policy and applicable law, including, but not limited to obtaining the vital signs.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and review of policy and procedures, the facility failed to ensure that multiple medications were labeled with an opened date and discarded when expired. The deficient practice may result in medications not being as effective. Findings include: A medication storage task observation was conducted on [DATE], with a Registered Nurse/Clinical Reimbursement Director (staff #139) and revealed the following: -In the medication storage room was a medication refrigerator which contained a vial of [MEDICATION NAME] Purified Protein Derivative (PPD/used for [MEDICATION NAME] skin tests). The vial had a handwritten opened date of [DATE] on the side of the bottle. An interview was conducted with staff #139 on [DATE] at 11:55 a.m. She stated that a vial of [MEDICATION NAME] PPD was good for 30 days after the vial was initially opened. She said the product was expired. -The 400 hall medication cart contained one vial of insulin [MEDICATION NAME] (long-acting insulin) 110 units per milliliter (units/mL) with a handwritten opened date of [DATE] on the label that was attached to the bottle and there were two opened vials of insulin [MEDICATION NAME] 100 units/mL, with no opened date. -The 500 hall medication cart contained one vial of insulin [MEDICATION NAME] 100 units/mL, with a handwritten opened date of [DATE] noted on the label that was attached to the bottle and there was one opened vial of insulin [MEDICATION NAME] 100 units/mL, with no opened date. An interview was conducted with a Licensed Practical Nurse (LPN/staff #90) on [DATE] at 12:18 p.m. She stated that she thought insulin might be good for 30 days after the vial was opened, but wasn't really sure. She said she wasn't sure how she would know when a vial of insulin had expired if the opened date was not recorded on the bottle or label. On [DATE] at 1:02 p.m., an interview was conducted with the Director of Nursing (DON/ staff #17). He stated that his expectation is that nursing only administers medications that have not expired and that the date opened is written on the product. Review of the facility policy regarding General Dose Preparation and Medication Administration revealed staff should enter the date opened on the label of medications with shortened expiration dates (e.g., insulin's etc.). Facility staff should comply with applicable law and the State Operations Manual when administering medications.

F 0867 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035096	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAVEN OF SANDPOINTE, LLC	**2222 SOUTH AVENUE A YUMA, AZ 85364**

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

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F 0867 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 7) Based on concerns identified during the revisit survey, facility documentation, and staff interviews, the facility's Quality Assessment and Assurance (QAA) committee failed to implement plans of action to correct quality deficiencies identified during the recertification survey regarding reporting allegations of abuse, range of motion/mobility services, nutrition maintenance, unnecessary medication, storage and labeling of drugs and biologicals, and failed to conduct audits as indicated in their plan of correction (POC). The deficient practice resulted in concerns identified on the recertification survey not being corrected and deficient practices continuing to exist. Findings include: During a revisit survey conducted August 24 through 28, 2020, the following concerns were identified: An allegation of abuse regarding missing property was not reported as required, two residents did not receive care and services to increase/prevent decrease in range of motion/mobility, dietary recommendations were not acted upon and/or not acted upon timely for one resident related to maintaining nutrition status, one resident received unnecessary medications when medications were administered outside of ordered parameters, and multiple medications were not stored/labeled as required. These areas of concern were also identified on the recertification survey and the facility had developed a plan of correction to address the issues in their QAA program. However, these concerns were again identified during the revisit survey. Regarding their POC The facility's POC included audits would be conducted for substantial compliance. The facility was unable to provide documentation that audits were conducted regarding range of motion/mobility and labeling/storing of medications, of the audit results for care and services related to maintaining nutrition status, and audits for May 2020 regarding unnecessary medications as indicated in their QAPI (Quality Assessment and Performance Improvement) meeting notes that audits were 100% complete for March, April, and May 2020. An interview was conducted with the Director of Nursing (DON/staff #116) on August 28, 2020 at 8:13 a.m. The administrator of a sister facility (staff #121), the clinical compliance director (staff #119), and the assistant DON (staff #51) were also present. The DON stated that all citation areas were covered in each QAPI meeting and that the areas not in compliance as indicated in their POC were a direct result of staffing challenges related to a Covid-19 outbreak in the facility and the need to ensure basic care was provided to all residents. Regarding range of motion/mobility, the DON stated RNA services were not being provided. The DON stated he or a designee were responsible for obtaining physician orders [REDACTED]. Regarding the audits, the DON stated there was no further audit documentation available other than what was provided to the survey team.