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 _____	**03/12/2020**

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

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F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, and policy, the facility failed to ensure one resident's (#47) physician's orders were accurate regarding advance directives. The sample size was one resident. The deficient practice could result in resident's wishes not being honored in an emergency medical situation. Findings Include: Resident #47 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of a significant change Minimum Data Set (MDS) assessment dated [DATE], revealed the resident scored a two on the Brief Interview for Mental Status (BI[CONDITION]), indicating severe cognitive impairment. Review of the physician's orders revealed an order dated [DATE] to admit the resident to hospice services. The recapitulation of physician's orders for February 2020 revealed the resident was to be a full code status, indicating that the resident wanted Cardiopulmonary Resuscitation (CPR) in the case of an emergency. Review of advance directive paperwork revealed that Do Not Resuscitate (DNR) paperwork was completed on [DATE]. The advance directive care plan revealed that the resident had advance directives completed and was a full code status. There was no evidence in the clinical record that the DNR paperwork had been acknowledged or that the order for full code status had been changed to reflect the DNR paperwork. An interview was conducted on [DATE] at 9:17 a.m. with a Licensed Practical Nurse (LPN/staff #97). She stated that the facility will complete advance directive paperwork upon admission and when there are changes. She said that after the paperwork is complete, a physician's order is obtained. She stated that if she needs to know what a resident's code status is in the case of an emergency, she can review the physician's order on the Electronic Health Record (EHR). She said that the order shows in multiple places such as on the resident's facesheet, the physician's orders, and the Medication Administration Record [REDACTED]. She reviewed the advance directive paperwork and stated that the order was not correct as the resident should not be considered full code any longer. She said that she did not know why the order did not match the paperwork, but said that the resident had recently become a hospice resident and she wondered if the hospice staff had updated this information and it was not communicated to the facility staff. She said that this was an oversight and would need to be changed in the EHR. In an interview with the Director of Nursing (DON/staff #93) on [DATE] at 10:13 a.m., he stated that the process for advance directive paperwork is that residents generally come into the facility with advance directive paperwork from the hospital. He said that once admitted , the paperwork is reviewed with the resident and/or the resident's family to ensure the resident's wishes are being honored. He said that if there are changes, the resident and/or the family will complete new advance directive paperwork. He stated that it is the expectation that all staff have to follow the advance directive wishes of each resident. Review of the facility's advance directives policy revealed a policy statement that advance directives will be respected in accordance with state law and facility policy. The policy implementation included that prior to or upon admission of a resident to the facility, the facility will provide written information to the resident concerning his/her right to make decisions regarding medical care and to formulate advance directives. The policy included that information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record. The policy included that the resident has the right to refuse treatment and will not be treated against their wishes and that the plan of care for each resident will be consistent with his or her documented advance directive. The policy included that the DON or designee will notify the physician of advance directives so that appropriate orders can be document in the resident's medical record and plan of care.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, and facility policy, the facility failed to ensure one resident (#240) received assistance with nail care. The sample size was four residents. The deficient practice could result in hygiene needs not being met and skin injury. Findings include: Resident #240 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. Review of the resident's Activity of Daily Living (ADL) care plan dated February 27, 2020, revealed the resident had an ADL performance deficit related to generalized weakness. An intervention included encouraging the resident to participate to the fullest extent possible in ADLS. A shower sheet for February 29, 2020 revealed the resident's fingernails were checked and cleaned during his shower. The shower sheet did not include documentation to indicate if the resident's nails were trimmed and/or filed. The admission Minimum Data Set (MDS) assessment dated [DATE], included a Brief Interview for Mental Status (BI[CONDITION]) score of 15, indicating that the resident was cognitively intact. The MDS coded the resident as not having had hallucinations or delusions, and that he did not reject care. The assessment also included that the resident required extensive assistance with hygiene tasks. The shower sheets revealed that the resident's fingernails were checked and cleaned on March 4, 2020, and March 11, 2020 by staff when he received a shower. The resident was also assisted with showering on March 7, 2020, but the form did not indicate that the resident's fingernails were checked and cleaned. The shower sheets did not include documentation to indicate if the resident's nails were trimmed and/or filed. Review of the clinical record revealed no evidence that the resident's nails had been trimmed and/or filed. During an interview with the resident on March 9, 2020 at 11:03 a.m., he stated that he asked staff to file his fingernails and they have not helped him with this. He said he wanted his nails filed down because they are too long and filing would ensure there are no jagged edges. He said that he preferred that they be filed, but said that he would allow the staff to clip his fingernails and then file them. An observation of the resident's fingernails was conducted on March 9, 2020 at 11:05 a.m. The resident's nails were approximately a quarter of an inch past his fingertips and had debris under them. His fingernails were square shaped and rough rather than round and smooth. A second interview was conducted with the resident on March 12, 2020 at 1:10 p.m. He stated that his nails have not been filed or trimmed and are too long. He stated that staff assisted him with a shower yesterday (March 11, 2020) but they did not clip or file his nails. During an observation of the resident's fingernails on March 12, 2020 at 1:13 p.m., his nails were observed to be about a quarter of an inch past his fingertips and appeared clean underneath. His fingernails were square shaped and rough rather than round and smooth. An interview was conducted with a Certified Nursing Assistant (CNA/staff #90) on March 12, 2020 at 1:14 p.m. She stated that she assists residents with hygiene needs such as showers and nail care. She said that when providing a resident with a shower, she clips the resident's nails if needed unless the resident has diabetes. She said that if a

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

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) resident has diabetes, she will inform the nurse and the nurse will be the one to cut the resident's nails. She said that she would document this care on the shower sheet. She said that she would respond to a resident request for nail care. She reviewed the shower sheets for this resident and stated that the resident received a shower on March 11, 2020 and the form indicated that the resident's fingernails were cleaned, but there was no documentation indicating that the resident's nails were clipped or filed. She observed the resident's fingernails and stated that they are too long. She asked the resident if he wanted his fingernails trimmed and he said that he would like them to be either filed or trimmed. During an interview with a Registered Nurse (RN/staff #4) on March 12, 2020 at 1:34 p.m., she stated that CNAs trim resident fingernails when they provide showers. She said that nurses can also trim nails as needed. She said that the resident told her that he wanted his fingernails filed when he had his last shower on March 11, 2020. She said she did not clip or file the resident's fingernails and that a CNA is able to do it even though the resident is diabetic. She said she had not told a CNA that the resident wanted his fingernails filed because she has been so busy that she did not even have time to sit down. An interview was conducted on March 12, 2020 at 2:13 p.m. with the Assistant Director of Nursing (ADON/staff #88), who stated that CNAs provide nail care if the resident does not have diabetes. She said the nurses provide nail care if the resident has diabetes. She said that since this resident has diabetes, the nurse should be providing nail care for the resident. She said that nail care can be provided at any time as needed. She said that if a resident is requesting nail care, the facility should be providing the care. The facility's nail care policy, revised February 2018, revealed the purpose of nail care is to clean the nail bed, keep nails trimmed, and to prevent infections. The policy noted that general guidelines include daily cleaning and regular trimming of nails to aid in the prevention of skin problems around the nail bed. The policy noted that trimmed and smooth nails prevent the resident from accidentally scratching and injuring their skin. The policy included to trim fingernails in an oval shape and smooth the nails with a file or emery board.
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, facility documentation, and manufacturer's instructions, the facility failed to ensure glucose solution bottles were labeled when opened in two of four medications carts. The deficient practice could result in inaccurate blood glucose (sugar) readings. Findings include: An observation of medication cart one on station one at 1:33 p.m. on [DATE] revealed an open level one glucometer control solution (lot number: CSRL16BN) with an expiration date of [DATE]. Also, there was an open level two glucometer control solution (Lot: CSRU24AM) with an expiration date of [DATE]. Neither of the solution bottles were labeled with a date of when they were opened or when they should be discarded after being opened. The box that the bottles were in included instructions which indicated to discard the bottles 90 days after opening. An observation of the west hall medication cart on station two at 1:47 p.m. on [DATE] revealed an open level one glucometer control solution (lot number: CSRL01AN) with an expiration date of [DATE]. Also, there was an open level two glucometer control solution (Lot: CSRU24BM) with an expiration date of [DATE]. Neither of the solution bottles were labeled with a date of when they were opened or when they should be discarded after being opened. The box that the bottles were in included instructions which indicated to discard the bottles 90 days after opening. Review of the blood glucose monitoring system: daily quality control records for [DATE] for medication cart one on station one and the west hall medication cart on station two revealed that the glucose solutions had been used daily. The lot numbers of the level one and level two solutions recorded on the records matched the solution bottles on the medications carts. The facility matrix included that there were 32 residents who were receiving [MED] in the facility with several of them being in the area of medication cart one on station one and west hall medication cart on station two. In an interview with the Director of Nursing (staff #93) at 1:25 p.m. on [DATE], he said that all four of the bottles in the medication carts were opened and had not been labeled with an open date. He said that he did not know this should be done and that the nurses who opened the bottles likely did not know this either. He stated that it does say on the box to discard the solution after 90 days of opening. An interview was conducted with a Licensed Practical Nurse (LPN/staff #78) at 10:34 a.m. on [DATE]. He said that he was aware that when a glucose control solution bottle is opened, it should be labeled since they should be discarded after 90 days. He said that he was not the nurse who was using the solution as the glucose controls are completed by the night nurses. During an interview with a resource nurse (staff #143) at 10:45 a.m. on [DATE], she stated that the facility has a policy regarding the use of the glucose control solutions, but that the policy did not include information regarding labeling the solution and that this is the only facility policy regarding the glucose control solution. She said that the facility uses the glucose control solutions daily and it is likely that the bottles run out of solution before they have been opened for 90 days. Review of the glucose control solution policy revealed a warning to check the expiration date shown on the vial label and to not use the solution if expired. The policy did not include any information about labeling the solution after opening. The manufacturer's instructions for the glucose control solution revealed warnings and precautions that included to not use the solutions beyond three months (90 days) after opening the vial. The instructions included to record the discard date (three months from the day the vial was opened) on the vial label.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on an observation, staff interviews, and facility documentation and policy reviews, the facility failed to ensure that raw meat was not stored above cooked meat and failed to follow proper procedure in regards to cooling food. The facility census was 96 residents. The deficient practice could result in unsafe food placing residents at risk for foodborne illnesses. Findings include: Regarding meat storage An observation of the kitchen was conducted at 8:03 a.m. on [DATE]20. In the walk-in refrigerator, a speed rack (a rack on wheels used to store food on trays) was observed to have various meats on trays. On the bottom tray there was a box containing pre-cooked bacon. There were slices of raw bacon on the tray directly above the pre-cooked bacon. A tray above the raw bacon contained pre-cooked breakfast sausage links. The tray above the sausage links had a small (about a pound) loosely wrapped chub of ground beef. The beef was thawed and there was some red juice coming out of the beef onto the tray. An interview was conducted at 8:15 a.m. on [DATE]20 with the dietary director (staff #76). He said that the raw meats should not be stored above the cooked meats. He said that he did not know why the meats were stored this way on the speed rack but thought that it likely happened over the weekend. Review of the facility's food storage policy revealed that the facility will store, prepare, and transport food by methods designed to prevent cross contamination. The facility's policy regarding general Hazard Analysis and Critical Control Points (HACCP) revealed a policy statement that food and nutrition services staff will be educated and supervised on food principles such as HACCP. The procedure included that meat thawing in the refrigerator will be stored in a drip proof container and in a way that prevents cross contamination. The policy included that raw meat should be kept on a lower shelf with nothing underneath or near it. Regarding cooling food Review of the cooling food temperature log revealed that the form included multiple entries starting from September 2019 until February 2020 for pork roast, pork loin, and turkey. The form instructions included to cool food from 135 degrees Fahrenheit (F) to 70 degrees F in two hours. The form included two columns to indicate if the food was cooled to 70 degrees F or less in two hours with options that included yes or no with instructions to record the temperature. If no is selected, the form indicated to reheat the food to 165 degrees F and restart the cooling process. For all of the entries from September 2019 through February 2020, the temperatures recorded after two hours were above 70 degrees F and despite being above 70 degrees F, were marked in the yes column of the form. There was no corrective action documented to show what was done after a temperature over 70 degrees F was measured. The log also included areas to document the temperatures for the third, fourth, fifth, and sixth hour. Instructions included that the food should be 41 degrees F or less at the six hour mark and if it is not, the form indicated to discard the food. None of the entries noted food over 41 degrees F after the sixth hour. An Interview was conducted on 03/11/2020 at 09:45 a.m. with the dietary

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F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) director (staff #76). He stated that the cooling log is not used and they do not save leftovers. After reviewing the cooling log entries, he stated that he did not know it was still being used. He said he would check with the staff. In an Interview with a cook (staff #67) on 03/11/2020 at 09:52 a.m., he stated he cooks pork and turkey ahead of time and then cools it for use at a later meal and that is when he uses the cooling log. He said that he was not aware of the requirement to reheat the meat if it was not 70 degrees F or below after the second hour. An Interview was conducted on 03/11/2020 at 10:00 a.m. with the dietary director (staff #76). He stated he realized what the cook was doing; the cook was prepping the meats before hand to be reheated at a later meal. He stated that this is not their normal procedure and the cook should not have been doing that and he would stop that procedure. He stated that the cook was not aware of the proper use of the cooling log or the proper procedure for cooling food. The facility's policy regarding general Hazard Analysis and Critical Control Points (HACCP) revealed a policy statement that food and nutrition service staff will be educated and supervised on food safety principles like HACCP. The policy included essentials of cooling to include cooling from 135 degrees F to 70 degrees F in two hours and from 70 degrees F to 41 degrees F in four additional hours (not to exceed six hours total). The policy noted that if food is not cooled to 41 degrees F within six hours, to reheat the food to 165 degrees F for at least 15 seconds within two hours and discard if not served immediately.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, interviews, and policy, the facility failed to ensure isolation precautions were implemented as ordered for one resident (#83). The facility census was 96 residents. The deficient practice could result in staff miscommunication and inaccurate resident records. The deficient practice could result in staff miscommunication and could result in staff not following isolation precautions as ordered. Findings include: Resident #83 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. The order included that this would only require wearing a mask. Review of the nursing notes revealed an infection surveillance note dated 2/21/2020 which indicated that the resident required [CONDITION] precautions in relation to his history of [PROC] . The note included that only a mask was required. Review of the admission Minimum Data Set ((MDS) dated [DATE] revealed that the resident scored 15 on the Brief Interview for Mental Status (BI[CONDITION]) which indicated the resident was cognitively intact. The resident's transplant care plan revealed that the resident was a [PROC] recipient related to [MEDICAL CONDITION]. The care plan included that the resident was taking anti-rejection medications. The goal for this care plan was that the resident be free from signs or symptoms of complications including infection. The care plan included that the resident was on [CONDITION] precautions while in the facility, but the care plan indicated that the precautions had been resolved. Review of the physician's orders [REDACTED]. An observation of the resident's room on [DATE]20 at 9:30 a.m. revealed no information outside of the room to indicate that the resident was on isolation precautions including no Personal Protective Equipment (PPE) to use when entering the room. At 9:35 a.m., a nurse entered the resident's room and provided the resident with medication. The nurse did not wear any PPE while providing the medication. During an observation of the resident's room on [DATE]20 at 1:35 p.m., a nurse knocked on the resident's door and entered the room without donning any PPE. The nurse provided the resident with medication and then left the room. An interview was conducted on [DATE]20 at 1:41 p.m. with a Registered Nurse (RN/staff #14). He stated that when the resident was admitted , there was an order to follow [CONDITION] precautions but that the physician only wanted the staff to worry about wearing a mask when entering the resident's room. He said that they are no longer following [CONDITION] precautions as the physician did not feel it was required any longer. He said that the order was no longer in place. He said that he believed the only precaution at this time is that the resident was not to have a roommate. During an interview with the Assistant Director of Nursing (ADON/staff #88) on 3/11/2020 at 8:40 a.m., she stated that infection surveillance notes are initiated when a resident comes in and has potential infection concerns. She said the resident would be monitored for the infection and daily infection surveillance notes would be completed. She stated that any kind of isolation precautions would be determined by the physician and then initiated by the nursing staff. She said that the precautions would be ongoing until the physician determined the precautions could be stopped. She stated that a physician's orders [REDACTED]. She said that regarding this resident, he has to be in a private room for his safety since his immune system is depressed in relation to his [PROC] status. She stated that the resident did have an order for [REDACTED]. She reviewed the resident's clinical record and said that the order should have been discontinued and said that she would ensure this happens. She also acknowledged that there was only one infection surveillance note in the clinical record. An interview was conducted with the Director of Nursing (DON/staff #93) on [DATE] at 10:13 a.m. He stated that the process in the facility is that isolation precautions are put into place by a physician's orders [REDACTED]. He said that the physician would decide when the precautions could be discontinued. He stated that a physician's orders [REDACTED]. During an interview with a resource nurse (staff #143) on [DATE] at 11:37 a.m., she stated that the facility does have a policy regarding isolation, but there is no specific policy relating to [CONDITION] precautions for residents. She stated that the facility follows the physician orders [REDACTED]. The facility's isolation policy covered transmission-based precautions including how and when to use them. This included that when transmission-based precautions are in effect, appropriate notification is placed on the room entrance door and on the front of the chart so that personnel and visitors are aware of the need for and the type of precautions. The policy included that the signage informs the staff of the type of precautions, instructions for use of PPE, and/or instructions to see a nurse before entering the room. The policy did not include information about [CONDITION] precautions.