STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **035197**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **10/09/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAVEN OF YUMA	**2470 SOUTH ARIZONA AVENUE 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 policy review, the facility failed to ensure that during an altercation involving three residents (#17, #64 and #144), one resident (#64) was free from physical abuse by another resident (#144). The deficient practice could result in other residents being subjected to abuse. Findings include: -Resident #17 was admitted on (MONTH) 1, (YEAR) with [DIAGNOSES REDACTED]. An annual MDS (Minimum Data Set) assessment dated (MONTH) 12, 2019 included the resident had a BIMS (Brief Interview for Mental Status) score of 12, which indicated moderate cognitive impairment, and that the resident utilized a wheelchair. The MDS did not include that the resident had any mood or behavioral indicators. A care plan included that resident #17 had a communication problem related to difficulty expressing himself. An intervention was to be conscious of the resident's position when in groups, activities and the dining room to promote proper communication with others. -Resident #64 was admitted on (MONTH) 5, (YEAR), with [DIAGNOSES REDACTED]. A significant change MDS assessment dated (MONTH) 30, 2019 included the resident had a BIMS score of 13, which indicated intact cognition. Per the MDS, the resident had no mood or behavioral indicators. Review of a care plan for impaired hearing and ability to understand and be understood revealed multiple interventions including to be conscious of the resident's position when in groups, activities and the dining room to promote proper communication with others. A health status note dated (MONTH) 1, 2019 at 3:06 p.m. included that resident #64 had an altercation with another resident (#144) at noon, and had acquired a scratch to the face, just above the upper lip on the right side, and sustained a skin tear to the left forearm. The note included the sites were cleansed with normal saline, a dry dressing was applied to the upper lip, and that skin closures were applied to the skin tear on the left forearm. -Resident #144 was admitted on (MONTH) 16, (YEAR) and readmitted on (MONTH) 9, 2019, with [DIAGNOSES REDACTED]. An admission MDS assessment dated (MONTH) 16, 2019 included the resident had a BIMS score of 13, which indicated the resident was cognitively intact. The assessment also included that resident #144 used a wheelchair, had no functional limitation with range of motion and moved about the unit with supervision. The assessment included that the resident did not have any mood or behavioral indicators. A Social Service Admission assessment dated (MONTH) 11, 2019 included that resident #144 was oriented to situation, place, time and person. Review of an investigative report dated (MONTH) 8, 2019 revealed that on (MONTH) 1, 2019 at 12:30 p.m., resident #144 and resident #17 had a verbal disagreement in the dining room, which escalated to insults. The report included that resident #144 directed his wheelchair in an aggressive manner towards resident #17, and another resident (#64) intervened, and resident #144 scratched resident #64 on the face and arm. The resident's were separated and the police were called. The investigative report also included a statement by resident #144, who reported that a verbal altercation had occurred between himself and resident #17, and that during the altercation he was approached by another resident (#64). He reported that resident #64 slapped him and then he punched resident #64 in the face. Review of the clinical record revealed resident #144 did not have any previous aggressive behaviors towards other residents. The clinical record documentation further included that resident #144 was discharged to the community on (MONTH) 3, 2019. An interview was conducted on (MONTH) 8, 2019 at 1:00 p.m. with a CNA (Certified Nursing Assistant/staff #26), who stated that she was present in the dining room on (MONTH) 1, 2019 at noon. The CNA stated that resident #144 and #17 were arguing while trays were being served and suddenly she heard resident #64 shout out. She said that she turned and observed resident #144 punch resident #64 in the center of his face. The CNA stated that she immediately placed herself between resident #144 and #64 and that resident #64 tried repeatedly to reach around her to punch resident #144, but was unable to reach him. An interview was conducted on (MONTH) 9, 2019 at 10:57 p.m. with the Director of Nursing (DON/staff #155) and a Corporate Nursing Consultant (staff #154). The DON stated that if a resident is identified to be at high risk for aggressive or assaultive towards other residents, staff will observe the resident's behavior and if the resident does not cause any issues, they will assess the need for a higher level of care. The DON said if there is a situation that involves a resident behaving aggressively towards another resident, staff will separate the residents and investigate what happened. Review of the Abuse policy revealed that the facility strives to prevent the abuse of all their residents and further recognizes that due to the proximity of our residents to one another and an individual's freedom of choice, that situations may arise where it is not possible to completely prevent all incidents of abuse. The policy included that abuse is the willful infliction of injury and includes verbal, physical and mental abuse and that potential abusers can be residents.
F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and policy review, the facility failed to develop a comprehensive care plan for one resident (#144) with [MEDICAL CONDITION]. The survey sample size was one of 41 residents with documented psychiatric diagnosis. Findings include: Resident #144 was admitted on (MONTH) 16, (YEAR) and readmitted on (MONTH) 9, 2019, with [DIAGNOSES REDACTED]. An admission MDS (Minimum Data Set) assessment dated (MONTH) 6, 2019 included the resident had a BIMS (Brief Interview for Mental Status) score of 13, which indicated the resident was cognitively intact. The assessment also included that resident #144 used a wheelchair, had no functional limitation with range of motion and moved about the unit with supervision. A Social Service Admission assessment dated (MONTH) 11, 2019 included the resident was oriented to situation, place, time and person. The assessment included a psychiatric [DIAGNOSES REDACTED]. The assessment also included Will assist with DC (discharge) needs and unmet psychosocial needs as they occur. A Health Status note dated (MONTH) 20, 2019 at 4:13 p.m. included that resident #144 had expressed killing himself and that the resident crisis hotline had been notified, and that (crisis staff) were at the facility speaking with the resident.

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 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) A Daily Skilled assessment dated (MONTH) 20, 2019 at 5:07 p.m. included the resident had stated that he was going to kill himself, a crisis team assessed the resident and cleared him, and the resident had stated that he did not have a plan. Review of the clinical record revealed a form titled, Crisis Mobil Team Safety Plan dated (MONTH) 20, 2019, which was signed by resident #144 and a member of the Crisis Mobile Team. The form included that the resident agreed to the following behavioral safety plan as follows: -Safety precautions: No danger to self and no danger to others, lock up all sharps, medications and chemicals, one on one supervision when out of the room. -Coping skills: Go to church and singing at church, practice positive coping skills, walking, listening to the radio and facility activities. -Other plans discussed with the (crisis) team: Call the crisis hotline if in crisis. However, there was no comprehensive care plan which had been developed that addressed the resident's suicidal ideation's and behaviors, nor were the interventions which were listed in the Crisis Mobile Team Safety Plan, added to any of the resident's care plans. Per the clinical record documentation, resident #144 was discharged to the community on (MONTH) 3, 2019. An interview was conducted on (MONTH) 9, 2019 at 10:05 a.m. with a LPN (Licensed Practical Nurse/staff #66), who stated that if a resident has a new behavior, she notifies the DON (Director of Nursing) and the MDS Nurse and they will write a care plan for the new behavior. Staff #66 said that although she is able to update care plans to include additional problems such as behaviors, she does not do that herself, and helps the DON and the MDS nurse to update the care plan. An interview was conducted on (MONTH) 9, 2019 at 10:27 a.m. with the MDS nurse (staff #61). Staff #61 said if a resident has a new behavior, a care plan would be initiated, while staff try to determine the root cause of the behavior. Staff #61 reviewed the resident's care plans and stated that the care plans for resident #144 did not include any behavioral interventions for the resident. Staff #61 said there should have been a care plan for behaviors, including interventions to maintain the resident's safety. An interview was conducted on (MONTH) 9, 2019 at 10:57 a.m. with the DON (staff #121). The DON stated that all of the nurses have been trained on how to write care plans and enter interventions for care plans. The DON said the nurses are to care plan behaviors that the residents are experiencing. The DON stated when the nurse updates a resident's care plan, the nurse is to communicate that to the manager, and the new care plan will be reviewed and updated as needed in the morning staff meeting the following day. The DON also stated the resident should have a care plan which included behaviors. Review of a policy titled Care Plans, Comprehensive Person-Centered revealed a comprehensive, person centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs should be developed and implemented for each resident. The policy included that the comprehensive person-centered care plan will describe services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being.
F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews, the facility failed to ensure that nephrostomy tube care was provided as ordered for one resident (#62). The deficient practice could result in care not being provided, resulting in possible complications. Findings include: Resident #62 was admitted to the facility on (MONTH) 4, 2019, with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. Review of the (MONTH) 2019 Treatment Administration Record (TAR) revealed the above order. However, there were blank areas on (MONTH) 6 and 27, on the day shift and on (MONTH) 5, on the night shift, indicating that the nephrostomy tube treatment was not provided. A physician's orders [REDACTED]. Review of the (MONTH) 2019 TAR revealed the above order. However, there were blank areas on (MONTH) 2, on day shift and on (MONTH) 4, on the night shift, indicating that the treatment was not provided. During an interview conducted at 12:58 p.m. on (MONTH) 9, 2019, the wound care nurse (staff #36) stated that she changes the resident's nephrostomy dressing on the days that she works. She said when she is not working, the other wound nurse does the dressing changes. She added that blank areas in the TAR may indicate that she forgot to sign it off or that the dressing change was not done. During an interview conducted at 2:04 p.m. on (MONTH) 9, 2019 with the Director of Nursing (staff #121), she stated that the resident's treatments should be completed and the TAR should be signed off every shift. She stated it is her expectation that there are no blank areas on the TAR's. She said that any blank areas would indicate that the nurses are not documenting procedures and this is a problem.
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, interviews and policy review, the facility failed to ensure that safety measures were in place for one resident (#78) as care planned. The deficient practice could result in residents sustaining injuries due to a lack of safety measures being implemented. Findings include: Resident #78 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A fall assessment was completed on 8/5/2019 and identified the resident as at high risk for falls. However, review of the resident's baseline care plans dated 8/5/2019 revealed that none of the care plans addressed the resident's risk for falls. A Minimum Data Set (MDS) assessment dated [DATE] revealed the Brief Interview for Mental Status (BIMS) score was 5, indicating the resident had severe cognitive impairment. Per the MDS, the resident required total assistance with bed mobility and transfers of at least 2 persons and utilizes a wheelchair for mobility. The MDS included that the resident did not have any falls prior to admission. The Interdisciplinary Team (IDT) Fall Review and Report revealed that on 9/5/2019, a Certified Nursing Assistant (CNA) observed the resident slipping out of bed onto the floor. When the nurse entered the room, the resident was lying on his left side next to the bed. The resident did not sustain any injuries from this fall. The IDT met on 9/6/2019 to review this fall. The interventions implemented from the IDT discussion were to have the resident placed in his wheelchair when awake and to notify Physical Therapy. A care plan was initiated by a Licensed Practical Nurse (LPN/staff #74) on 9/7/2019 related to the resident's risk for falls. The goal was to keep the resident free from falls through the target date of 10/13/2019. The interventions included anticipating the needs of the resident, ensuring the call light was within reach, place the resident in a wheelchair when awake, and to have Physical Therapy (PT) evaluate and treat the resident. Another fall assessment was completed on 9/10/2019 identifying the resident as a high fall risk. Review of a nursing note dated 9/11/2019 revealed that a CNA found the resident on the floor next to his bed. An incident report dated 9/11/2019 included that at 12:15 p.m., the resident was found kneeling at the bedside when a CNA entered the room. This occurred five minutes after the resident's family member left him alone. The resident did not sustain any injuries from this fall. The IDT met on 9/12/2019 to review this fall. The interventions implemented from the IDT discussion were to have a floor mat and to notify Physical Therapy.

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) The risk for falls care plan was revised on 9/12/2019 by staff #74 to reflect a floor mat beside the resident's bed and for staff to follow the Falling Leaf Program. Per the clinical record documentation, the resident was discharged to the hospital on [DATE] and was readmitted back to the facility on [DATE], with [DIAGNOSES REDACTED]. A fall assessment was completed on 9/16/2019 which identified the resident as at high risk for falls. A nursing note dated 9/18/2019 revealed the resident was found lying on his left side on the floor next to his bed. The nurse noted the resident was assessed for injuries and his skin was intact. Review of an incident report dated 9/18/2019 revealed that at 10:30 p.m., the resident was again found on the floor by a CN[NAME] There was no clinical record or investigative documentation if the fall mat was in place, prior to the fall as care planned. Another fall assessment was completed on 9/18/2019 which identified the resident a high risk for falls. The IDT met on 9/19/2019 and the interventions included the following: PT notified and for the bed to be placed against the wall. The fall care plan was revised on 9/19/2019 by the Director of Nursing (RN/staff #121). This revision added the intervention of placing the resident's bed against the wall. An observation of the resident's room was conducted on 10/07/19 at 10:59 a.m. The resident was lying in his bed and the left side of the bed was positioned against the wall. There was no mat on the floor, as care planned. At this time, a family member was interviewed and stated that the resident had fallen three times before they placed a fall mat in his old room. She stated that after the resident changed rooms, she has yet to see the mat at all. An interview was conducted with a Certified Nursing Assistant (CNA/staff #39) on 10/08/19 at 10:20 a.m. She stated that she takes care of the resident. She said when a resident is on fall precautions they lower the bed, use non-skid socks, place a green fall leaf on the door, and that she checks on them often. Staff #39 was unable to give a specific timeframe for how often these checks are performed. She stated that sometimes they use floor mats, but the resident does not have a mat that she knows of. An interview was conducted with a Registered Nurse (RN/staff #33) on 10/08/19 at 10:47 a.m. He stated that he takes care of the resident. He stated the admission nurse puts in the information into the care plan including the fall assessments. He stated they use the green fall leaf sticker on the door frame to inform the staff the resident is a fall risk, along with the green wrist bracelet. He said this is part of the facilities fall program. Staff #33 stated that sometimes they use floor mats with an order, but they do not use them often. He said they educate the resident on using the call light for help and provide added supervision. He said the resident is on fall precautions at this time. An observation of the resident was conducted on 10/08/19 at 1:05 p.m. The resident was observed lying in his bed with the left side of his bed against the wall. There was no mat on the floor. An interview was conducted with the Regional Educator (RN/staff #154) and the DON (staff #121) on 10/08/19 at 1:16 p.m. This interview was conducted in the resident's doorway. The resident was observed in bed, without a fall mat in place. Staff #121 stated that the resident was recently moved and maybe the mat did not follow him. She said that he was moved from across the hall several days ago. Staff #154 said that if there is a fall mat on his plan of care, then he should have one on the floor. Another interview was conducted with staff #154 and staff #121 on 10/09/19 at 9:59 a.m. Staff #121 stated that residents on the falling leaf program have a specific care plan to identify potential risks and implement procedures to reduce the risk of falls. Staff #154 stated that any intervention on the care plan should be enforced, including a mat on the floor if the resident was not alert and oriented. A policy titled, Fall Prevention Program stated the facility is to develop a culture of safety for the residents. A component of this is the Falling Leaf Program. The policy stated that any change in level with or without injury or when a resident is found on the floor would be considered a fall. Residents identified as candidates for the program meet the criteria of an actual fall or a resident assessed with [REDACTED]. Review of the Fall Intervention Guide revealed that for fall factors related to cognitive impairment, the recommended interventions include a mat.
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 that each residents drug regimen was free from unnecessary drugs, by failing to administer medications in accordance with physician's orders [REDACTED].#71 and #89). The deficient practice could result in residents receiving unnecessary medications. Findings include: -Resident #71 was admitted on (MONTH) 6, 2019, with [DIAGNOSES REDACTED]. The 14 day Minimum Data Set (MDS) assessment dated (MONTH) 20, 2019 revealed the resident scored 13 on the Brief Interview for Mental Status (BIMS), indicating she was cognitively intact. A hypertensive care plan dated (MONTH) 6, 2019 revealed a goal for the resident to remain free of complications related to hypertension through the review date. Interventions included to give antihypertensive medications as ordered, to monitor/record side effects such as orthostatic [MEDICAL CONDITION], increased heart rate, effectiveness and to report to the medical doctor as necessary. A physician's orders [REDACTED]. Review of the (MONTH) 2019 Medication Administration Record (MAR) revealed that [MEDICATION NAME] 12.5 mg was administered on six occasions when the resident's SBP was below the order parameters as follows: September 10: PM shift for a blood pressure of 102/50 September 12: PM shift for a blood pressure of 88/49 September 13: PM shift for a blood pressure of 89/54 September 24: PM shift for a blood pressure of 100/58 September 26: PM shift for a blood pressure of 100/50 September 28: PM shift for a blood pressure of 102/49 Review of the (MONTH) 2019 MAR revealed that [MEDICATION NAME] 12.5 mg was administered on five occasions when the resident's SBP was below the order parameters as follows: October 1: PM shift for a blood pressure of 98/50 October 4: PM shift for a blood pressure of 100/59 October 5: AM and PM shifts for blood pressures of 92/41 and 99/51 October 6: AM shift for a blood pressure of 101/51 -Resident #89 was admitted on (MONTH) 18, 2019, with [DIAGNOSES REDACTED]. An altered cardiovascular status care plan dated (MONTH) 1, 2019 related to a [DIAGNOSES REDACTED]. Interventions included to assess the resident for chest pain every shift, enforce the need to call for assistance if pain starts, monitor/document/report to medical doctor as needed any signs or symptoms of [MEDICAL CONDITION], vital signs every shift and notify physician of any abnormal readings. A physician's orders [REDACTED]. Another physician's orders [REDACTED]. Review of the (MONTH) 2019 MAR revealed that [MEDICATION NAME] HCl 40 mg was administered on four occasions when the resident's pulse was below the order parameters as follows: September 20: AM shift for a pulse of 56 BPM September 23: AM shift for a pulse of 58 BPM September 24: PM shift for a pulse of 58 BPM September 26: AM shift for a pulse of 55 BPM Further review of the (MONTH) 2019 MAR revealed that [MEDICATION NAME] 25 mg was administered once when the resident's pulse was below the ordered parameters as follows: September 26: AM shift for a pulse of 55 BPM Review of the (MONTH) 2019 MAR revealed that [MEDICATION NAME] HCl 40 mg was administered on four occasions when the

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F 0757 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) resident's pulse was below the order parameters as follows: October 2: PM shift for a pulse of 58 BPM October 5: AM shift for a pulse of 56 BPM, and a second dose on the same date for a pulse of 58 BPM On (MONTH) 8, 2019 at 1:19 p.m., an interview was conducted with a Licensed Practical Nurse (LPN/staff #68). She stated her process for administrating an antihypertensive medication included reviewing the resident's blood pressure and pulse to discern whether or not it would be appropriate to give the medication. She said if the blood pressure is too low, she would hold the medication and make a note on the MAR and in the resident's clinical record. On (MONTH) 9, 2019 at 9:14 a.m., an interview was conducted with the Director of Nursing (DON/staff #121). She stated her expectation for nurses who are administrating an antihypertensive medication would include to review the resident's blood pressure and pulse, and hold the medication if either was below the physician's orders [REDACTED]. The facility policy titled, Administering Medications stated that medications shall be administered in a safe and timely manner, and as prescribed. The policy also included that medications must be administered in accordance with the orders and that vitals signs must be checked/verified, prior to administering medications.
F 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews and policy review, the facility failed to ensure two of five sampled residents (#42 and #71) receiving PRN (as needed) psychoactive medications had 14 day stop dates or that the physician documented the rationale for its continued use. The deficient practice could result in resident's receiving medications that may not be necessary. Findings include: -Resident #42 was admitted to the facility on (MONTH) 3, 2019, with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. This order did not include a fourteen day stop date. A quarterly Minimum Data Set (MDS) assessment dated (MONTH) 12, 2019 revealed the resident scored an 11 on the Brief Interview for Mental Status (BIMS), which indicated moderate cognitive impairment. The MDS included the resident was totally dependent with transfers and toileting and needed extensive assistance with bed mobility. In the Mood and Behavior sections, the resident was assessed to not have any mood or behavior concerns. According to the Medication Administration Record [REDACTED]. A pharmacy consultation report dated (MONTH) 13, 2019 included there is a PRN order for an anxiolytic, ([MEDICATION NAME] 5 mg every 24 hours as needed for anxiety) without a stop date. The recommendation was to discontinue the medication. The recommendation further included if the medication cannot be discontinued at this time, current regulations require that the prescriber document the indication for use, the intended duration of therapy and the rationale for the extended time period. The rationale for the recommendation was that CMS (Center for Medicare and Medicaid Services) requires that PRN orders for non-antipsychotic [MEDICAL CONDITION] drugs be limited to 14 days unless the prescriber documents the diagnosed specific condition being treated, the rationale for the extended time period and the duration for the PRN order. However, there was no physician's response to the recommendations and the report was not signed by the physician. A psychological evaluation (MONTH) 19, 2019 by a consultant Psychiatric Mental Health Nurse Practitioner revealed that [MEDICATION NAME] was not on the list of [MEDICAL CONDITION] medications. The evaluation included that staff report no new concerns, no behavioral disturbances and that overall the patient was doing well. Recommendations included to continue the current treatment plan, with no medication changes. Review of the MAR for (MONTH) 2019 revealed the resident was administered [MEDICATION NAME] one time on (MONTH) 29. Further review of the clinical record revealed there were no orders for an end date for the as needed [MEDICATION NAME] for (MONTH) and (MONTH) 2019, and there was no documentation by the physician of the rationale for its continued use. A pharmacy consultation report dated (MONTH) 28, 2019 repeated the recommendation to discontinue the [MEDICATION NAME] 5 mg every 24 hours as needed related to an anxiety disorder. The recommendation further included if the medication cannot be discontinued at this time, current regulations require that the prescriber document the indication for use, the intended duration of therapy and the rationale for the extended time period. The physician agreed with the recommendation and to implement as written. The report was signed by the physician on (MONTH) 30, 2019. A psychological evaluation dated (MONTH) 31, 2019 by a consultant Psychiatric Mental Health Nurse Practitioner did not include [MEDICATION NAME] on the list of [MEDICAL CONDITION] medications. The evaluation included that staff report no new concerns and no behavioral disturbances. Recommendations included to continue the current treatment plan, with no medication changes. According to the (MONTH) 2019 MAR, [MEDICATION NAME] was not administered to the resident during the month. Review of the (MONTH) 2019 MAR indicated [REDACTED]. However, another physician's orders [REDACTED]. The order did not include a 14 day stop date or an end date. Further review of the clinical record revealed there was no documentation that the resident was experiencing any anxiety or of the rationale for restarting the [MEDICATION NAME] and the duration. Review of the (MONTH) 2019 MAR indicated [REDACTED]. The (MONTH) 2019 MAR indicated [REDACTED]. Review of the (MONTH) 2019 MAR indicated [REDACTED]. In an interview conducted on (MONTH) 10, 2019 at 10:10 a.m. with the Unit Manager (staff #66), she stated the Director of Nursing (DON) implements recommendations from the pharmacy that have been approved by the physician and sometimes the unit managers assist. She stated that sometimes the doctors will not allow us to discontinue the medication. She said that whenever she speaks with the physician she puts the interaction with the doctor into the computer. In an interview conducted on (MONTH) 10, 2019 at 10:28 a.m. with the DON (staff #121) and the Clinical Compliance Manager (staff #154), the DON stated that she receives recommendations from the pharmacy monthly and she puts them in the computer. She stated the unit managers do their portion if she has too many to do. The Clinical Compliance Manager stated that each [MEDICAL CONDITION] medication needs a 14 day limitation and a review by the physician at the end of that time and a rational to continue. -Resident #71 was admitted on (MONTH) 6, 2019, with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. The order end date was listed as indefinite. Review of the clinical record revealed a [MEDICAL CONDITION] medication informed consent for [MEDICATION NAME] dated (MONTH) 7, 2019, which was signed by the resident. An antianxiety care plan included the resident received [MEDICATION NAME]. The goal was for the resident to be free from discomfort or adverse reactions related to antianxiety therapy through the review date. Interventions included to give antianxiety medications as ordered by the physician and to monitor/document side effects such as dry mouth, dry eyes, constipation, [MEDICAL CONDITION], depression, forgetfulness or suicidal ideation. A Nurse Practitioner (NP) progress note dated (MONTH) 16, 2019 included to change the [MEDICATION NAME] to 0.5 mg and continue to monitor. An order dated (MONTH) 16, 2019 inlcuded for [MEDICATION NAME] 0.25 mg, 2 tablets every 8 hours as needed for anxiety. The order end date was listed as indefinite. However, review of the clinical record revealed no documentation by the physician/prescriber of the rationale for it's continued use for an indefinite timeframe. The 14 day Minimum Data Set (MDS) assessment dated (MONTH) 20, 2019 revealed the resident scored 13 on the Brief Interview for Mental Status (BIMS) assessment, indicating she was cognitively intact. The assessment revealed the resident required extensive 2-person assistance with transfers and toileting, and that the resident received antianxiety medication for 7 out

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035197	A. BUILDING ______ B. WING _____	**10/09/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAVEN OF YUMA	**2470 SOUTH ARIZONA AVENUE 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 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 4) of 7 days of the lookback period. Review of the (MONTH) 2019 MAR indicated [REDACTED]. A physician's orders [REDACTED]. The order end date was listed as indefinite. However, review of the clinical record revealed no documentation by the physician/prescriber of the rationale for it's continued use for an indefinite timeframe. Review of the (MONTH) 2019 MAR indicated [REDACTED]. On (MONTH) 8, 2019 at 1:19 p.m., an interview was conducted with a Licensed Practical Nurse (LPN/staff #68). She stated that she gives the antianxiety medication as ordered by the physician. She said she had not noticed that the medication did not have a stop date. On (MONTH) 9, 2019 at 9:14 a.m., an interview was conducted with the DON. She stated her expectation for nurses regarding implementation of as needed [MEDICAL CONDITION] medication orders included obtaining a signed informed consent prior to administering the medication and ensuring their is clinical indication for it's use. She said she understood that as needed anxiolytic medications were to be prescribed for 14 days and if the provider decided to continue the medication, the expectation would be for the provider to document the rationale. She stated that the order should have an end date. A policy titled, [MEDICAL CONDITION] Medication Use included the facility should comply with the Psychopharmacological Dosage Guidelines created by the Centers for Medicare and Medicaid Services (CMS), the State Operations Manual, and all other applicable law relating to the use of psychopharmacological medications. The policy further included that as needed orders for [MEDICAL CONDITION] drugs should be limited to 14 days. If the physician or prescribing practitioner believes that it is appropriate for the as needed order to be extended beyond 14 days, he/she should document their rationale in the resident's medical record and indicate the duration of the as needed order.