

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035094	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2024
NAME OF PROVIDER OR SUPPLIER Haven of Sedona		STREET ADDRESS, CITY, STATE, ZIP CODE 505 Jacks Canyon Road Sedona, AZ 86351	

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)
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46606</p> <p>Based on clinical record review, interviews, and review of policies, the facility failed to ensure one resident (#4), was free from significant medication errors, related to the resident receiving the wrong dosage of Parkinson's disease medication. The deficient practice could result in complications and adverse medication side effects.</p> <p>Findings include:</p> <p>Resident #500 was admitted to the facility for respite care on June 18, 2024 with diagnoses that included Parkinson's disease, anxiety disorder, and depression.</p> <p>Review of the order summary revealed a prescription for Carbidopa-Levodopa tablet 25-100MG (milligrams) with an order date of June 17, 2024 which indicated to give 1 tablet by mouth four times a day for Parkinson's Disease.</p> <p>Additionally, the Hospice Admitting Orders dated June 17, 2024 indicated an order for Carbidopa-Levodopa 25-100mg QID (four times a day) for Parkinson's disease.</p> <p>A care plan identifying that the resident is on hospice, initiated June 18, 2024 included an intervention that directed to medicate as ordered to ensure comfort.</p> <p>A progress note dated June 19, 2024 documented that the resident was found kneeling on the floor by his bed. During assessment, a small skin scrape on the left forearm was noted.</p> <p>Review of the Medication Administration Record dated June 2024 revealed the following orders that were current from June 18-21, 2024:</p> <ul style="list-style-type: none"> -Carbidopa-Levodopa ER Tablet Extended Release 50-200 MG (milligram), give 1 tablet by mouth one time a day for Parkinson's disease. -Carbidopa-Levodopa Tablet 25-100 MG (milligram), give 1 tablet by mouth four times a day for Parkinson's disease. -Carbidopa-Levodopa Tablet 25-100 MG (milligram), give 1 tablet by mouth as needed for Parkinson's disease qdaily. <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of nursing notes for June 2024 revealed that medications administered:</p> <ul style="list-style-type: none"> - June 18: Carbidopa-Levodopa Tablet 25-100 MG, 1 tablet by mouth. - June 18: Carbidopa-Levodopa Tablet 25-100 MG, 1 tablet by mouth - effective. - June 19: Carbidopa-Levodopa Tablet 25-100 MG, 1 tablet by mouth, resident stated he felt like needed another. - June 20: Carbidopa-Levodopa Tablet 25-100 MG. 1 tablet by mouth, per patient's request for tremors and pain. - June 20: Carbidopa-Levodopa Tablet 25-100 MG, 1 tablet by mouth - effective. - June 21: Carbidopa-Levodopa Tablet 25-100 MG, 1 tablet by mouth. - June 21: Carbidopa-Levodopa Tablet 25-100 MG, 1 tablet - effective. <p>Further review of the resident's progress notes revealed a nursing note dated June 21, 2024 which documented that the resident is at the facility for respite care. The note indicated that per discharge orders from hospice, resident was to get 1 tablet of Sinemet (Carbidopa/Levodopa). The note stated that the resident's family informed the facility staff that the resident's prescribed order is two tablets every four hours instead of 1 tablet. The note documented that the nursing staff called hospice and a hospice nurse came in and did a medication reconciliation to correct the order.</p> <p>Another progress note dated June 21, 2024 documented that the facility received a verbal order from hospice to give 2 Carva Dopa 25-100 QID. The note indicated that the original order from hospice was for 1 tablet QID. The note also stated that a copy of hospice orders and facility orders were given to the resident's family as requested and that the DON (Director of Nursing) was aware.</p> <p>In another progress note also dated June 21, 2024, the note stated that Updated order for cab/levo ER , d+[DATE] mg to 2 tablets QID and PRN (as needed) Q4hrs per verbal order from hospice. The note stated that family is aware of change.</p> <p>Review of the discharge Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13 indicating that the resident is cognitively intact.</p> <p>A review of the list of self-reports and investigations in the last 90-days revealed that the facility reports did not include the issue with medication administration pertaining to resident #500.</p> <p>Review of the incident/accident log covering the last 90-days revealed that the medication administration issue pertaining to resident #500 was not included.</p> <p>The review of the grievance log revealed that a grievance was filed by resident #500's wife regarding customer service concerns. The resolution provided by the facility was marked as staff education.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A telephonic interview with the hospice Area Executive of Clinical Operations (staff #27) was conducted on July 22, 2024 at 11:53 a.m. According to staff #27 resident #500 was admitted to the facility for respite care from June 18-22, 2024. The resident discharged back to home on June 23, 2024. She noted that any questions regarding medications of respite residents is clarified with hospice. A hospice nurse comes into the facility to ensure everything is good to go. In addition, the facility's nurse can call hospice to clarify any questions. The Area Exec of Clinical Operations said that on June 21, 2024 the family raised concerns regarding resident #500's regarding the medication Carbidopa-Levodopa. The issue was that the resident received low dosage of Carbidopa-Levodopa. The resident complained that he received 1 tablet QID instead of 2 tablets QID. Staff #27 admitted that there was a transcription error made by their hospice nurse. The order that was written on an order sheet was transcribed incorrectly. However, the order sent via fax and the medication bottles had the correct order. The transcription error was corrected the same day. Staff #27 indicated that she would have the Director of Clinical Services call the surveyor/investigator to provide more info regarding the incident when she returns on Wednesday.</p> <p>During an interview with a Licensed Practical Nurse (LPN/staff #18) conducted on July 23, 2024 at 8:07 a.m., staff #18 that the process for transcribing orders for residents coming in for respite is that when they come in, the orders is given to the facility mostly by fax. Medical Records then puts it in the system for the staff to see and it will then be reflected on the MAR (Medication Administration Record). The LPN said that they believe it is the DON or the Unit Manager that is responsible for verifying that the medications are accurately transcribed. For respite residents, hospice is contacted to clarify any questions with an order. Staff #18 stated that the impact of an inaccurately transcribed medication depends on the medication but it can have some serious side effects. The LPN noted that she had a resident on respite that had an issue with one of his medications and the medication was Sinemet (Carbidopa-Levodopa). Staff #18 stated that during Medication Pass, the resident questioned only being given 1 tablet for Carbidopa-Levodopa. The resident said that he gets 2 tablets. The LPN checked the MAR (Medication Administration Record) and it said 1 tablet so the resident was informed and resident stated that it was wrong and that he takes 2 tablets. The resident wanted to call his wife, and the wife verified that he takes 2 tablets. Staff #18 then called hospice and they noted that it was 2 tablets. However, the received orders from hospice stated 1 tablet. Another hospice nurse also indicated that the resident gets 2 tablets. A hospice nurse then came in to do medication reconciliation. The LPN said that the discrepancy was not identified until the resident brought it up which was a few days after he was admitted . Staff #18 noted that the order received from hospice was a handwritten order. It was the only order that was seen and indicated 1 tablet.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview with a Licensed Practical Nurse (LPN/staff #9) was conducted on July 23, 2024 at 8:43 a.m. Staff #9 stated that the process for transcribing orders for residents coming in for respite care is that the facility staff puts in the prescription as ordered. The LPN stated that depending on what the prescription is, if it is new, it is normally received via fax. The fax is received by Medical Records and nurses are responsible for checking that it is the same as what is on the admission. Staff #9 stated that nurses are responsible for verifying that the medications are accurately transcribed. The LPN noted that if there is a question regarding an order, specifically if there is conflicting information regarding a medication, the doctor has to be contacted to clarify the order. Staff #9 said that sometimes you do not see that there is a discrepancy since they have to go by the information that was sent to them. The LPN noted that for hospice, especially for respite residents, the order is normally handed to the facility staff and informed that the resident is in for respite care. Staff #9 stated that it is less predictable since there is another nurse (from hospice) that had originally taken the order from the physician so the facility staff normally just turns around and puts in the order and the facility clears the prescription as such. The LPN noted that the facility staff is basically confirming another nurse's work, and the facility do not actually know what the doctor actually said/ordered. Staff #9 said that for respite residents, their medications are normally sent in typically in medicine bottles from home. Therefore, the resident/resident's family bring the medications and hands it to the facility. The LPN noted that they are familiar with resident #500. Staff #9 said that resident #500's orders were both faxed and some were handed to the nurse, which they were given since the nurse was on the floor. The LPN indicated that some faxed orders were never received. Staff #9 said that some of resident #500's medications were brought with him from hospice and some were brought by the family. The LPN noted that the medications from home were in bottles and some they got from hospice. Staff #9 stated that the medications from home's label/instructions were different from the order. However, the LPN noted that if a nurse looks at the bottle, they should check and verify with the MAR (Medication Administration Record) to compare that the information matches. If the information does not match, the nurse should get clarification. However, staff #9 indicated that some nurses think that if you have an updated info (newer date) on the order you can follow it even if the label on the medications has a different instruction. The LPN stated that nurses should get verification if there is discrepancy or conflicting order/direction regarding the administration of the medication before providing it to the resident. Staff #9 reiterated that it can be a cluster not dealing with the prescribing doctor directly. The LPN said that any medication should not be given if it is not correct. Staff #9 stated that for Carbidopa, wrongly given, it could cause the resident to have seizures and a lot of things the could have been dangerous. The LPN said that they believed resident #500 had an issue with his medications - there might have been a discrepancy that had to be brought to the attention of hospice. Staff #9 stated that in the case of resident #500 whose medications dosage were different from the transcribed/faxed medication list, clarification with hospice should have been done since that is where the orders originated from. The LPN noted that they were not sure how the discrepancy was caught-believed that family said something. Not sure if it could have been caught sooner. It took that long since it was the family that identified the discrepancy. Staff #9 said that their expectation is that the nurse verify/compare the information on the MAR with the medication's information prior to administering the medication. The LPN said that the wrong dosage could have been prevented/caught sooner by the nurse if they noticed that the info on the bottles/medications were not the same as the info on the MAR. The mismatched info should have triggered a need to clarify the order. Staff #9 said that there is no inventory or medications if it comes from hospice or the family. The LPN noted that it is a problem since they cannot verify if the medications they are receiving from the family is what it is supposed to be and whether the doctor agrees. Staff #9 said that it is hard to say what the impact of the wrong dosage was on the resident since resident #500 was behavioral from square1. During head to toe exam, he was upset to be in the facility. He was having movements that Parkinson's patients have, he was fidgety, and uncomfortable-it made it hard to define his baseline or if it was medication related. The LPN said that the Carbidopa-Levodopa being administered according to physician's orders is important because it is for the resident's Parkinson's disease.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A telephonic interview was conducted with a Registered Nurse (RN/staff #45) on July 23, 2024 at 9:38 a.m. Staff #45 stated that the front office normally have the arrangements with hospice so that medications can be inputted in the system but sometimes they get a copy of the medication list from hospice. The RN said that they cross reference orders for what is put in the computer. The nurse verifies that the medications were accurately transcribed. If there are questions, contact the doctor; if the resident is in hospice then contact hospice. Staff #45 said that hospice is responsible for medications and it either comes from the resident's home or hospice supplies the medication. The RN stated that respite residents' medications are normally in bottles but sometimes they come in blister packs. Either way, the medication has the info of what it is and what the dosage is. Staff #45 said that you compare the info on the meds versus the info on the MAR (Medication Administration Record). If the info is not the same, then you cannot use it or you have to get clarification to change the order.</p> <p>During the telephonic interview with the hospice Associate Medical Director (AMD/staff #36) conducted on July 23, 2024 at 10:10 a.m., staff #36 stated that it is very important for patients with Parkinson's disease to receive Carbidopa-Levodopa as ordered. The AMD said that once they have a patient on a certain dose, they can start to withdraw, so you cannot just stop it abruptly since it will cause the patient to have agitation. Staff #36 said that they have to make sure that patients are at the recommended dose to manage their symptoms. The AMD stated that if a patient do not receive the medication as ordered, specifically, at the right dosage, they can have confusion and issues with rigidity of muscles. Staff #36 said you do not want to stop it or only reduce dose when it was assessed based on symptoms since you do not want side effects related to withdrawal. The AMD said that her expectation of nursing staff with regards to administration of medication is that they follow the orders given, have an updated medication list, and notify provider if there are issues. Staff #36 stated that they are familiar with resident #500. The AMD said that resident #500 is a gentleman, who in mid-March received a primary diagnosis of Parkinson's disease and was sent to the facility in June for respite care. He is on Carbidopa-Levodopa as treatment for Parkinson's disease. Staff #36 noted that a hospice nurse filled out a handwritten medication list and instead of 2 tablets QID, he received 1 table for a period of about June 19 until the family noticed and notified the facility on June 21. Hospice was notified and corrected the error. The AMD acknowledged that hospice provided the list and that it was a hospice error that the medication list was written wrong based on records. Staff #36 noted that medications are brought from home or if it was picked up from pharmacy, those medications would still have the right name and dosage of the medications. It would have been noticed if the administering nurse double checked the actual medications and label against the orders. The AMD said the mismatched info should have triggered a clarification for that medication order. Staff #36 said that based on report, on the June 21, the facility's nursing staff called hospice and they did a medication reconciliation that day. The AMD noted that resident #500 had a fall with a minor injury which was a scrape on his right forearm while he was at the facility. However, it is unsure whether the fall was due to low dose of Carbidopa-Levodopa. Additionally, the resident had confusion but they are unsure whether it was related to low dose of Carbidopa-Levodopa. Staff #36 stated that the low dose could have contributed to what was going on with him (fall, confusion, agitation). If they are withdrawing, he was getting less than before and it can cause agitation, and behaviors, irritability, and it can present. The AMD said that at the time of resident #500's admission, Parkinson's disease, anxiety, and depression were his diagnoses. Staff #36 stated that the resident's medication was effective in controlling and try to keep him at the dose.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview with the Director of Nursing (DON/staff #63) was conducted on July 23, 2024 at 11:30 a.m. Staff #63 stated that her expectation with regards to administering medications especially if medications are from hospice/resident's home is that staff check the order and use the current order that is on the paper. The DON said that staff should look at the info on the medication package but she expects that her staff follow the medication order on paper and follow the most recent order given. Staff #63 said that if the info on the medication label is different from the order, then they should call hospice to verify. The DON said that it is important to verify medication is right essentially because it goes back to medication rights-right dose and right medication. If the same medication, they can still use the same bottle but go off the current order. However, you still want to clarify which info is correct if it is in conflict. Staff #63 noted that with regards to resident #500, the issue could have been prevented or caught earlier by hospice. She said it was hospice that gave the order incorrectly. The DON noted that the resident was getting 1 tablet instead of 2. The resident was having behaviors. The facility called hospice and they did a whole new medication reconciliation but never caught the transcription error until the facility was giving the medication and it was brought up. Staff #63 acknowledged that medications are labeled with the name of the medication and the dosage regardless of whether the medication is in a blister pack or bottle. The DON said that staff should read the label when administering medication. Staff #63 also acknowledged that yes, the nurse could have caught the discrepancy sooner. The DON said that if they read the label and noticed that the info on the label and order was different. However, as nurses when new order comes thru, if what was sent was the wrong info it is not something they would recognize. Staff #63 said that if the info on the medication container is not matching the order then it should have triggered that there should have been a time out to verify what the actual order was. The DON said the nurse checks medication and dosage and compare it to MAR/TAR (Medication Administration Record/Treatment Administration Record) prior to administering medications. Staff #63 noted that it is important that the resident received the right dosage of Carbidopa-Levodopa. The DON said that as far as impact of the wrong dosage it is fair to say there was some-anxiety and impulsivity. However, from the medical side, staff #63 said in hospice, medications are for comfort and not necessarily work anymore. They mask but the treat the progression.</p> <p>During the exit conference conducted on July 23, 2024 at approximately 12:09 p.m., the [NAME] President of Clinical Operations (VP of Clinical Ops/staff #72) stated that it is not best practice to verify the label of the medication to compare it to the MAR (Medication Administration Record) when administering medication. Staff #72 said that it is not what happens in the real world. When asked is her staff is supposed to verify the medication to compare it to the MAR prior to giving the medication, she said all they have to do is follow the physician's orders and that is what her staff did.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A telephonic interview was conducted with the hospice Director of Clinical Services (staff 54) on July 24, 2024 at 10:35 a.m. The Director of Clinical Services said that resident #500's wife called on July 21, 2024 to report that the resident was getting the wrong medication and that the facility will not listen. Staff #54 said that an order for medication reconciliation was done. The Director of Clinical Services stated that there was a discrepancy in the handwritten order originally given to the facility. However, a printed order was also sent to the facility. Staff #54 stated that her expectation is that administering nurse compare the medication label to the medication sheet to ensure that the right medication/dosage is given. The Director of Clinical Services indicated that the facility giving the resident the wrong dosage upset the resident's family. Staff #54 said that if the staff administering the medication looked at the info on the medication and compared it against the medication sheet, the error could have been caught sooner. The Director of Clinical Services said that resident #500's wife reported that the resident fell because he was not getting the right dose. Staff #54 said that resident's behaviors possibly related to not getting the right dose but that the resident already had issues with falling.</p> <p>Review of the facility policy titled F027-Medications: Administering Oral Medications with an effective date of January 1, 2024, indicated that the purpose of this procedure is to provide guidelines for the safe administration of oral medications. The section Steps in the Procedure directed to Check the label on the medication and confirm the medication name and dose with the MAR. Additionally, it reiterated to Check the medication dose. Re-check to confirm the proper dose.</p>		