STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035172	A. Building B. Wing	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Safford	1933 Peppertree Drive Safford, AZ 85546

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47911 Based on clinical record reviews, facility documentation, interviews, and facility policies, the facility failed to ensure that medications were administered as ordered by the physician for one resident (#175). The deficient practice could result in medications not being available to meet the resident needs. Findings include: Resident #175 was admitted on [DATE] diagnosis of essential hypertension, other chest pain, atherosclerotic heart disease of native coronary artery without angina pectoris, and presence of aortocoronary bypass graft. The resident's comprehensive care plan included an intervention to administer medication as ordered. The health status note dated January 16, 2023 included the resident was alert and oriented x 4. A physician order dated January 16, 2023 included for ranolazine (anti-anginal drug) ER (extended release) 500 mg (milligrams) give one tablet by mouth two times a day for atherosclerotic heart disease of native coronary artery without angina pectoris. An eMAR (electronic medication administration record) note dated January 17, 2023 revealed medication not here yet and was on order The EMAR notes dated January 21 and 22, 2023 revealed Ranolazine ER was not on hand. A physician order dated January 23, 2023 again revealed the same order for Ranolazine ER. Review of the clinical record revealed documentation that Ranolazine was not available for following dates: January 17, 18, 19, 20, 21, 23, 24, 25, 28, 29, 30, 31 and February 1, 2023. An eMAR note dated January 23, 2023 included that the family was supplying medications, they have not supplied them and, the staff reminded the family when they were in the building. Another eMAR note dated January 27, 2023 revealed Ranolazine was not on hand. (continued on next page)

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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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The eMAR note dated January 28, 2023 included awaiting pharmacy delivery. However, it did not indicate which medication it was for. Another eMAR note dated January 29, 2023 revealed that Ranolazine was not on hand; and, was waiting on pharmacy. Despite documentation of the physician order for Ranolazine, the MAR (Medication Administration Record) for January and February 2023 revealed that Ranolazine ER, was coded as unavailable, and that, was documented as not administered from January 16, 2023 through February 1, 2023. There was no evidence found in the clinical record the physician was notified that the medication was not administered as ordered. An alert note dated January 30, 2023 revealed that the resident had not received Ranolazine; and that the staff contacted pharmacy. Per the documentation, pharmacy notified staff that it was the family who supplies the medication for the resident. It also included the nurse contacted the family who informed the nurse that they will bring the medication over ASAP. An observation conducted on January 31, 2023 at 9:38 a.m. revealed the medication, Ranolazine 500mg was on the bedside table wrapped in a plastic bag inside the room of resident #175. A subsequent observation on February 2, 2023 at 9:00 a.m. revealed that the medication was no longer on the bedside table. An interview was conducted on January 31, 2023 at 10:00 a.m. with the resident #175 and family who stated that neither of them speak English well; and requested for their family to be interviewed instead. A phone interview was conducted with the family immediately following the resident's request. The family stated that they were asked to bring in the medication (Ranolazine) as she had been told by nursing staff that the facility pharmacy was out of the medication. The family stated the resident had been out of the medication for about 8 days and this was why the family had provided the medication. An interview was conducted on February 1, 2023 with the registered nurse (RN/staff #19) who stated that when medications are not available, staff would use PYXIS (drug dispensing machine) for back-up medications first and then would notify the pharmacy to see about a subsequent delivery the same day. She stated the pharmacy delivers twice a day, at 3:00 p.m. and at 11:00 p.m.; and, if the medication cannot be obtained from either the PYXIS or the pharmacy that day, the physician would be notified. Staff #19 stated that the unavailability of the medication and steps taken to contact the pharmacy and physician are documented in the progress notes by the nursing staff. The RN stated that another potential option was to call the family if they have the medication at home and would be able to bring it to the facility. She stated that when medication is brought in by the family who notifies staff. She stated that the resident's name is placed on the medication, a pill count is conducted and the medication is securely stored in the medication cart. The RN stated the risk of not having the medication, Ranolazine available for resident #175, included a potential for blood pressure to spike and difficulty in getting the resident back to baseline. Further, the RN stated she was aware that resident #175 had been out of medication for a while; and that, the family had been asked to bring the medication in. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a later interview conducted with staff #19 on February 2, 2023 at 9:05 a.m., staff #19 stated the facility had received the medication from the family and it had been stored in the medication cart for resident #175. An interview was conducted with assistant Director of Nursing (ADON/staff #97) on February 2, 2023. The ADON stated that if the medication was not the first dose or an emergency dose, then staff should reach out to pharmacy and sometimes the pharmacy can send the request to another pharmacy to fill. The ADON stated that the next step would be to contact the physician at least a couple of hours before the dose was due; and that, staff should document all attempts made to obtain the medication and notification of the physician. During the interview, a review of the clinical record was conducted with the ADON who stated that there was documentation that the medication was not available. However, the ADON stated that there was no documentation in the clinical record that the physician was notified doctor that the medication was not available. The ADON also stated that if a medication is over a certain dollar amount and is not covered by the insurance then ultimately the cost could be absorbed by the facility. She also said that staff should be reaching back out to the physician to explore potential alternatives. Further, the ADON stated that risk factors, if the medication (Ranolazine) was not be administered, the resident could have adverse effects such as chest pain and could result in rehospitalization . Review of the facility policy on Provider Pharmacy Requirements revealed that the pharmacy agrees to assisting in determining the appropriate acquisition, receipt, accurately dispensing prescriptions based on orders as well as providing routine and timely pharmacy services per contractual agreement 24 hours a day/ 7 days a week.