

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  035084	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/31/2024
NAME OF PROVIDER OR SUPPLIER  Plaza Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE  1475 North Granite Reef Road Scottsdale, AZ 85257	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47910</b></p> <p>Based on documentation, staff interviews, and the facility policy and procedures, the facility failed to ensure that resident (#30) was not abused by another resident (#54). The deficient practice could result in residents being harmed emotionally and physically.</p> <p>Findings include:</p> <p>-Regarding Resident #30:</p> <p>Resident #30 was admitted to the facility on [DATE] with diagnoses that included end stage renal disease, dependence on renal dialysis, hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease.</p> <p>The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 10 indicating the resident had a moderate cognitive impairment.</p> <p>A progress note dated October 19, 2024 revealed remains at baseline and no new issue to report. Pt was social and engaged well with nurse. Pt played bingo with her peers. Pt was resting in room at end of shift with call light within reach.</p> <p>A care plan revised on October 29, 2024 revealed that resident #30 has times of verbal aggression and jovial facetious banter that may be misconstrued by others.</p> <p>-Regarding Resident #54:</p> <p>Resident #54 was admitted to the facility on [DATE] with diagnoses that included chronic kidney disease, stage 5, dependence on renal dialysis, acute kidney failure with tubular necrosis.</p> <p>The annual minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 15 indicating the resident cognition is intact.</p> <p>The care plan date revised on October 24, 2024 revealed resident at times is not aware of boundaries with others and need redirection due to poor impulse control and will attempt to multitask during activities that can be distracting to others. Interventions included to offer/remind to use headphones to listen to his phone.</p> <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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An attempt to conduct an interview with resident on October 30, 2024 at 10:00 a.m. was made. Resident was at a dialysis appointment.</p> <p>An interview was conducted October 30, 2024 at 10:46 a.m. with resident #9. Resident #9 stated she was at bingo for the first time and was seated right next to resident #30. She stated resident #54 was upset because resident #30 won the round of bingo. She stated resident #54 called resident #30 a whore, fucking bitch and a mother fucking whore. She stated I felt weird because it was my first time going to bingo.</p> <p>An interview was conducted on October 30, 2024 at 10:58 a.m. with resident #54. Resident #54 initially stated he did not want to discuss the issue that is over with, but then decided to share his side of the story. Resident #54 stated he was at bingo and was seated at a table by himself, listening to music. He stated resident #30 was seated at a table next to his playing bingo. He stated resident #30 kept disturbing and harassing him. Resident #54 stated I did not call her a black bitch.</p> <p>An interview was conducted on October 30, 2024 at 11:09 a.m. with the Receptionist (staff # 48). Staff #48 stated that she was seated next to resident # 30 on Saturday, October 19, 2024, during a bingo game. She stated she was at the table assisting residents with their numbers and assisting the activities assistant and seated at the table was resident #30. She stated resident #54 was seated at a table next to theirs. Staff #48 stated resident # 30 was excited, vocal and a little loud. She stated resident #54 kept asking resident #30 to be quiet, she stated resident #54 became irritated and turned and called resident #30 a black bitch. Resident #30 became upset like she could not believe he said that to her. She stated before resident #54 called her a bitch and he had asked resident #30 to be quite and she told him to shut up and that was when he turned around and called her that name. Staff #48 stated she did not intervene because she thought they were joking and she was unsure. Staff #48 stated she tried calming resident #30 down because she was very upset. She stated the game continued for another 10 minutes with both residents seated next to one another. Staff #48 stated when the game was over she took resident #30 to the lobby and went back to work. Staff #30 stated she did not report the incident to anyone. Staff #48 stated that she has had abuse training in the last year, in person.</p> <p>An interview was conducted October 30, 2024 at 11:34 a.m. with the Activities Assistant (staff/ # 77). Staff # 77 stated I don't know too much just that the two residents were sitting in front of me and they were bantering back and forth with their typical behavior. She stated that it did not seem that it was escalating. Staff # 77 stated after Bingo was over, resident #30 was sitting in the lobby and stated did you hear what that N word called me - he called me a black bitch she appeared upset and angry. Staff #77 stated she immediately reported it to her boss through text. Staff #77 stated she was told by her supervisor if it were to happen again to stop the bingo game and have the residents removed. Staff #77 stated she was never informed by staff #48 about what had happened and that the expectation would be for her to have informed her and stop the altercation between the residents. She stated the unit nurse was informed and asked that resident's #30 and #54 not attend bingo the following day.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted October 30, 2024 at 12:10 p.m. with Social Services Director (staff # 62). Staff #62 stated that she supervises the receptionists and that Staff #48 is under her directive. Upon hire staff complete in person training with verbal abuse is part of the curriculum. Staff #62 stated as a social worker they are expected to report immediately. Staff #62 stated she completed education with staff #48 when she became aware that she had not reported to anyone of the altercation between the two residents. She stated staff #48 should have stopped it immediately and if she did not feel comfortable should have informed staff #77 who was in the room with her or told a supervisor. Staff #62 stated she was disappointed in the way that she reacted or failed to react to the situation as it was clearly verbal abuse and failed to intervene and report the incident immediately. Staff #62 stated the facility has to protect the residents not just sit back and observe and that it does not matter what department you are in, that you are responsible for intervening and reporting.</p> <p>Review of the facility policy titled Abuse, Neglect, Mistreatment and Misappropriation of Resident Property states it is the policy of the facility that each resident will be free from abuse. Abuse can be verbal, mental, sexual, or physical abuse, corporal punishment, misappropriation of resident property, or involuntary seclusion.</p> <p>-Verbal abuse is defined as the use of oral, written, or gestural language that willfully includes disparaging or derogatory terms to resident's or their families, or within hearing distance, regardless of their age, ability to comprehend, or disability</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47910</b></p> <p>Based on clinical record review, staff interviews, and the facility policy and procedures, the facility failed to ensure staff intervened and reported resident to resident verbal abuse. The deficient practice could result in residents not being protected from further abuse and appropriate corrective action taken.</p> <p>Findings Include:</p> <p>- Regarding Resident #30:</p> <p>Resident #30 was admitted to the facility on [DATE] with diagnoses that included end stage renal disease, dependence on renal dialysis, hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease.</p> <p>The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 10 indicating the resident had a moderate cognitive impairment.</p> <p>A progress note dated October 19, 2024 revealed remains at baseline and no new issue to report. Pt was social and engaged well with nurse. Pt played bingo with her peers. Pt was resting in room at end of shift with call light within reach.</p> <p>A care plan revised on October 29, 2024 revealed that resident #30 has times of verbal aggression and jovial facetious banter that may be misconstrued by others.</p> <p>-Regarding Resident #54:</p> <p>Resident #54 was admitted to the facility on [DATE] with diagnoses that included chronic kidney disease, stage 5, dependence on renal dialysis, acute kidney failure with tubular necrosis.</p> <p>The annual minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 15 indicating the resident cognition is intact.</p> <p>The care plan date revised on October 24, 2024 revealed resident at times is not aware of boundaries with others and need redirection due to poor impulse control and will attempt to multitask during activities that can be distracting to others. Interventions included to offer/remind to use headphones to listen to his phone.</p> <p>An interview was conducted October 30, 2024 at 10:46 a.m. with resident #9. Resident #9 stated she was at bingo for the first time and was seated right next to resident #30. She stated resident #54 was upset because resident #30 won the round of bingo. She stated resident #54 called resident #30 a whore, fucking bitch and a mother fucking whore. She stated I felt weird because it was my first time going to bingo.</p> <p>(continued on next page)</p>		

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