STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035084	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plaza Healthcare	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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43863 Based on clinical record review, staff interviews, and facility policy review, the facility failed to maintain medical records that are complete and accurate in accordance with professional standards for 4 of 26 sampled residents (# 9, 240, 241, 236). The deficient practice could result in records that do not accurately and completely reflect the care and services provided to residents. Findings include: -Regarding Resident #236 Resident #236 was admitted on [DATE] with diagnoses that included chronic respiratory failure with hypoxia, tracheostomy, morbid obesity, anxiety disorder, psychotic disorder with delusions, and type 2 diabetes with retinopathy of the right eye. A Minimum Data Set assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. Review of a facility self-report dated November 15, 2024 revealed that the resident reported she was missing 6 sports bras, 4 panties and $40.00 in cash to a nurse. However, review of the clinical record revealed no evidence that the resident reported the missing items and money to nursing on November 15, 2024, or that the claim was being investigated. The facility provided no evidence that a Make it Right form had been completed for the resident's missing items on November 15, 2024. Review of a care plan revised on November 22, 2024, revealed no evidence of the missing items or money reported by the resident on November 15, 2024. The last update was dated October 23 2024, revised on 11/22/2024, that revealed the resident continues to make unfounded accusations. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	An interview was conducted on January 22, 2025 at 3:39 PM with a Social Worker (staff # 88), who stated that a thorough investigation is conducted when items are reported missing, including searching the resident's room and laundry. She further stated they have a Make it Right program that will replace the missing items if they are not found. The Social Worker stated they document reports of missing items in progress notes and keep a list of the items replaced through the Make it Right program. The Social Worker stated that they would document in the clinical record that the resident reported missing items, and on the Make it Right list. She stated that before she documented in the clinical record, she would try to find the items, then document in the clinical record and on the Make it Right list. She further stated that Resident #236 had made false accusations in the past regarding missing items. She also stated that an investigation was conducted regarding the items reported missing on November 15, 2024, and the missing items and money were not found. She reviewed the clinical record and stated that there was no evidence of social services documentation in the clinical record regarding the resident's report of missing items and money. An interview was conducted on January 23, 2025 at 8:56 AM with Social Services (staff # 87), who stated that they would investigate any reports of missing items, and if the items were not found the resident would be reimbursed. She stated that they noticed a trend that the resident would say that items were missing. She further stated that the last 2 occasions that the resident alleged theft would not be documented in the clinical record because an investigation had been conducted. Staff #87 stated that the resident had admitted to law enforcement that she was not being honest regarding her November 15, 2024 report of missing items and money. She further stated that documentation of missing items would be found in the Make it Right program notes. Staff #87 reviewed the clinical record and stated that there was no evidence of the resident's report of missing items and money on November 15, 2024. An interview was conducted on January 23, 2025 at 10:31 AM with a Licensed Practical Nurse (LPN/staff #126), who stated that nurses should document follow-up notes, change of condition, daily notes, and anything outside of that in progress notes. She also stated that if a resident reported missing items or money, she would inform the unit manager or the Director of Nursing (DON), let the resident know that they were searching for the items, and document who she spoke to in a progress note. She further stated that this process would not be any different for a resident who complains of missing items regularly. An interview was conducted on January 23, 2025 at 2:59 PM with the Chief Clinical Officer (CCO/staff # 218), who stated that she would expect social services to document reports of missing items, and complete an investigation. She further stated that reports of missing items are not in the medical record because it is not a medical issue. She also stated that the missing items and investigation should be documented in the care plan. An interview was conducted on January 23, 2025 at 12:48 PM with an LPN (staff #164), who stated that any reports of missing money or items reported by residents should be documented in progress notes. He further stated that he would document everything that occurred on his shift, and that is the facility expectation. 50166 -Regarding Resident #241: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Plaza Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1475 North Granite Reef Road Scottsdale, AZ 85257	

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Resident #241 was initially admitted to the facility on [DATE] with diagnoses that included mood disorder with depressive features, adjustment disorder with mixed anxiety and depressive mood, and osteomyelitis. A progress note dated July 29, 2023 revealed an x-ray result from July 28, 2023 was reviewed with no indication regarding why the x-ray was ordered. A Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score was 15, which indicated intact cognition. A care plan initiated on February 1, 2024 revealed a focus that indicated the resident was making statements and accusations which were unfounded. -Regarding Resident #9: Resident #9 was admitted to the facility on [DATE] with diagnoses that included chronic kidney disease and acquired absence of the right leg below the knee. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score was 15, which indicated intact cognition. Review of the facility investigation on January 23, 2025 revealed that on December 28, 2023, Resident #241 was playing a basketball arcade game in the dining room when Resident #9 wheeled his wheelchair into the back of Resident #241 from behind which made Resident #241 ' s wheelchair move into a metal bar underneath the basketball arcade game and pinned his leg. The residents continued to play the game together for 17 minutes, and nothing was reported to the staff until December 29, 2023 when the resident requested the police be notified of the incident. The facility investigation revealed that the police, the Arizona Department of Health Services, Adult Protective Services, and the ombudsman were notified of the incident. The investigation revealed that the clinical team was going to meet to review the plan moving forward. A progress note dated January 3, 2024 revealed that Resident #9 completed a verbal reevaluation for electric wheelchair use with no indication regarding why the evaluation was ordered. A request was made for all documentation in the clinical record regarding the incident between resident #241 and Resident #9, and the facility was not able to provide evidence that the incident occurred and to whom it was reported. The facility investigation was not included anywhere in the clinical record. Review of the video footage of the incident on January 23, 2025 revealed that Resident #9 did wheel his wheelchair behind Resident #241 ' s wheelchair and Resident #241 stated you got me, but it ' s alright. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	An interview was conducted on January 23, 2025 at 12:55 p.m. with an RN (Staff #224), who stated that if an allegation of abuse were made, she would first report it, but then she would document in the progress notes as well as in the daily nursing notes. In her notes, Staff #224 stated she would need to include the time of the incident, what the allegation was about, the patient involved, what was reviewed, who was notified, and what was done as a result of everything. Staff #224 stated that she would do both an incident report and progress note, and that it was not a personal preference, but it was facility policy to document incidents and allegations of abuse in the chart and progress notes. Staff #224 stated that the importance of documenting incidents in the clinical record would be to show a history of behaviors and to keep a true log of what has happened with residents to know if there are patterns. An interview was conducted on January 23, 2025 at 3:03 p.m. with an LPN (Staff #282), who stated that if an allegation of abuse were made, she would make a note in the progress notes that indicated who was notified and that the investigation would be continued by the unit manager. Staff #282 stated that it was facility policy to document incidents and allegations in the clinical record and progress notes, and the importance of doing so would be to protect the resident and herself to make sure someone else was in the loop. Staff #282 stated that if they did not document in the clinical record, there was risk of not protecting the residents because management needed to know things had occurred so something could be done to protect the residents. 51159 -Regarding Resident # 240 Resident #240 was admitted on [DATE] with diagnosis that included acute kidney failure, acute respiratory failure, pneumothorax, and depression. Minimum Data Set assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. A Facility self-report dated July 21, 2023, revealed that the resident reported to a Certified Nursing Assistance (CNA) that $ 331.00 cash was missing from his wallet. However, there was no evidence in the clinical record that the resident ' s report of missing money on July 21, 2023, had been reported to nursing, or that nursing reported the complaint to administration, and that the claim was being investigated. Review of a revised care plan dated July 23, 2023 revealed no evidence of missing money reported by the resident on July 21,2023. An interview was conducted on January 23, 2025 at 12:38 PM with Certified Nursing Assistant (CNA/Staff # 264) who stated that when missing items are reported to her she will inform the nurse and unit manager, they will notify the social worker, and staff will look for the missing item. The CNA also stated that they do their documentation on the computer. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	An interview was conducted on January 23, 2025 at 12:48 PM with Licensed Practical Nurse (LPN/Staff #164), who stated that she will notify the unit manager immediately for missing items, and inform the unit manager if the item has not been found. The LPN also stated that they will ask another staff to help them find the item. The LPN further stated that social services deals with missing money a bit more. The LPN stated that if money is missing or stolen they believe that documentation would be in the progress notes. The LPN stated that documentation would include management notification, including any follow-up p of the investigation. The LPN (Staff # 164) stated that the facility expectation is to document thoroughly, and take accountability. An interview was conducted on January 24, 2025 at 11:44 AM, with a Social Worker (staff #88) at 11:44 AM, who stated that social services looks out for their resident ' s psychosocial physical being, and advocates for their residents.She stated that when it comes to missing/stolen money or abuse they will immediately report the allegation to the supervisor. She stated that reports of missing items/money will be documented in progress notes and that there is a follow up in regards to the investigation that will also be included. She stated that they want to ensure that they are doing the right thing for the residents Review of the policy titled, Documentation Guidelines, revealed that documentation guidelines to ensure accurate, consistent, and compliant record keeping.