STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035088	A. Building B. Wing	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Camelback Post Acute Care and Rehabilitation	4635 North 14th Street Phoenix, AZ 85014

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581 Based on documentation, staff interviews, and the facility policy and procedures, the facility failed to assess one resident (#35) for pain and take vitals when admitted to the facility in a timely manner, and failed to administer pain medication with pain parameters for one resident (#27). The deficient practice could result in residents' pain not being identified and addressed, residents' being overmedicated or under-medicated. Findings include: Resident #35 was admitted to the facility on [DATE] with diagnoses that included displaced fracture of left tibial tuberosity, subsequent encounter for closed fracture with routine healing, Epilepsy, and type II diabetes. Review of the order summary revealed: -April 27, 2024, monitor level of pain for every shift/using the following scale: 0=no pain, 1-3=mild pain, 4-6=moderate pain, 7-10=severe pain. -April 27, 2024, Tylenol tablet 325 mg give two tablets by mouth every six hours as needed for pain 1-3. -April 27, 2024, Celecoxib capsule 200 mg give one capsule by mouth every 24 hours as needed for pain 4-7. -April 27, 2024, Norco oral tablet 5-325 mg give one tablet by mouth every six hours as needed for pain 8-10 for three days. Review of the Medication Administration Record (MAR) dated April 2024 did not reveal that the resident was assessed for pain during the day shift. A progress note dated April 27, 2024 at 9:32 p.m. revealed that the resident was alert and oriented times three, and able to make his own decisions. The resident admitted with a diagnosis of a left Tibial fracture after a ground fall. Internal fixation was placed on April 24, 2024. The resident denies pain, nausea, or shortness of breath. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A daily skilled progress note dated April 27, 2024 at 10:02 p.m. included vital signs: blood pressure 125/72, temperature 97.4, and pulse 62 at at 7:59 p.m. Heart rate 18, and oxygen 95.0 % at 9:01 p.m. Resident has no pain. At 10:33 p.m. resident had a pain scale of 5. Review of the (MAR) dated April 2024 revealed that the resident was assessed at a pain level of five at 10:33 p.m. and was administered Tylenol tablet 325 mg give two tablets by mouth every six hours as needed for pain 1-3. A progress note dated April 28, 2024 at 12:46 p.m. revealed that the resident was alert and oriented times four. The resident was able to make his needs known and expressed the need for a room change due to the pleasantly confused roommate, but before the room change could be complete, the resident chose to leave against medical advise due to sharing a bathroom and a room. An interview was conducted on May 28, 2024 at approximately 1:04 p.m. with the Director of Nursing (DON/staff #1), who stated that resident #35 was admitted to the facility on [DATE] at approximately 1:25 p. m. She reviewed the resident's clinical record and stated that there was no documention about the resident's pain level being assessed when admitted . She stated that the progress notes indicate that the resident was assessed for pain on April 27, 2024 at 9:32 p.m. An interview was conducted on May 28, 2024 at 1:59 p.m. with a licensed practical nurse (LPN/staff #72), who stated that if the admission nurse is not here, she tries to get orders in place, take vitals, and complete a pain assessment. She stated that it is important to complete the initial assessment during the initial admission, so there is a baseline and changes can be identified. She stated that a pain assessment should be included, so it can be determined if the resident is comfortable. During a second interview conducted on May 28, 2024 at 2:18 p.m. with the (DON/staff #1), she stated that the resident left the facility against medical advise, so the initial assessment and baseline care plan were not completed. The assessment and the baseline care plan was deleted, so there is no record of them being done. She stated that (LPN/staff #72) was supposed to complete the initial assessment when the resident was admitted , which would include a pain assessment. She acknowledged that the resident was not evaluated for pain until 9:30 p.m. on May 27, 2024 and stated that vitals and a pain assessment are recorded when the resident is admitted to determine a baseline, so staff know when there is a change of condition. The facility policy, Pain Management dated September 2023 states that the facility assists each resident with pain to maintain or achieve the highest practicable level of well-being and functioning by screening to determine if the resident has been or is experiencing pain. The resident will be assessed for pain on admission with a pain-related diagnosis, or if pain is indicated through the nursing admission evaluation. -Resident #27 was admitted to the facility on [DATE] with diagnoses that included fracture of unspecified parts of the lumbosacral spine and pelvis, subsequent encounter with routine healing, specified fracture of unspecified pubis, subsequent encounter for routine healing, stable burst fracture of unspecified lumbar vertebra, subsequent encounter for fracture with routine healing, and unspecified open wound of abdominal wall. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The care plan dated May 3, 2024 revealed that the resident has acute pain related to fractures and wounds. Interventions included to administer analgesia medication as per orders; give half an hour before treatments or care, follow pain scale to medicate as ordered. Review of the order summary revealed: -May 3, 2024, monitor level of pain for every shift/using the following scale: 0=no pain, 1-3=mild pain, 4-6=moderate pain, 7-10=severe pain. -May 3, 2024, Tylenol tablet 325 mg give two tablets by mouth every six hours as needed for pain 1-3. -May 7, 2024, Oxycodone HCl oral capsule 5 mg give 5 mg by mouth every six hours as needed for pain 4-10. Review of the MAR dated May 2024 revealed: -Oxycodone HCl oral capsule 5 mg give 5 mg by mouth every six hours as needed for pain 4-10 was administered on May 4, 2024 for a pain level of 0, and on May 7, 2024 for a pain level of 1. -Tylenol tablet 325 mg give two tablets by mouth every six hours as needed for pain 1-3 was administered on May 8, 2024 for a pain level of 8. The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 15 indicating the resident was cognitively intact. An interview was conducted on May 29, 2024 at 12:58 p.m. with (LPN/staff #106), who stated that orders for pain medications administered as needed (PRN), require a pain scale. She documents on the MAR the resident's level of pain prior to administering the pain medication and after administering the medication to determine if it was effective. She stated that there is risk of underdosing or overdosing a resident if the pain medication is given outside of the parameters on the order. Staff #106 reviewed the MAR dated May 2024 and stated that the Oxycodone HCl oral capsule 5 mg give 5 mg by mouth every six hours as needed for pain 4-10 was administered outside of parameters. She also stated that the resident can state that he doesn't want the stronger pain medication and request the Tylenol, but the nurse should document the resident's request in the progress notes and follow up to ensure the Tylenol was effective. She thinks the DON is responsible for monitoring the MAR to ensure that medications are administered as per the orders. An interview was conducted on May 29, 2024 at 1:24 p.m. with (DON/staff #1), who stated that there needs to be a pain scale on the order for PRN pain medications. She stated that there is a risk of the resident being undermedicated or overmedicated if the pain medication is given outside of parameters. She also stated that the resident the Tylenol instead of the Oxycodone even if the pain scale is higher than 1-3, but must document the resident's request and notify the physician. The facility policy, Medication Administration dated February 2024 states that medications must be administered in accordance with the written orders of the attending physician.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide and implement an infection prevention and control program. 40581 Based on observations, staff interviews, and the facility policy and procedures, the facility failed to ensure that soiled linens and laundry were not stored in public areas and were covered to prevent the spread of infection. The deficient practice could result in the spread of infection to residents. Findings include: On May 28, 2024 at approximately 8:01 a.m., a yellow round bin and one gray square bin full of soiled sheets and other laundry items were observed to be overflowing in the hallway on Hall 200 by the laundry room. There was also a smaller silver container full of dirty towels and the lid was not completely covering the bin. The hallway smelled of urine. On May 28, 2024 at approximately 8:05 a.m. a female staff was observed pushing the yellow round bin and gray square bin full of soiled laundry through the exit door near the laundry room and left them outside. The smaller silver container with dirty towels was left in the hallway. On May 28, 2024 at the Housekeeping Supervisor (staff #76) was observed entering the Hall 200 through the exit door when the soiled sheets and laundry were left outside and went into the laundry room. She did not remove the smaller silver container with dirty towels was left in the hallway. On May 28, 2024 at 9:42 a.m. an interview was conducted with a certified nursing assistant (CNA/staff #53), who stated that soiled sheets, towels, and laundry are suppose to go into a bag, the bag is tied, and taken directly to the soiled utility room. She stated that the purpose of tying the bags is to reduce the smell and prevent contamination. There is a risk of odor and possible contamination to the residents if the binds are left in common areas. She stated that she thinks the night shift is supposed to take the bins of soiled sheets, towels, and laundry outside until the laundry staff arrives between 7:30 a.m. and 8:00 a.m. and then the laundry staff bring in the bins in one at a time. An interview was conducted on May 28, 2024 at 10:03 a.m. with the Housekeeping Supervisor (staff #76), who stated that starts work at 7:00 a.m. She stated that when she arrives to work, she gets the bins of soiled laundry and linens from the soiled utility room to wash them. She stated that the bins of soiled laundry and linens are not supposed to be left in the hallway because they are dirty, smell, and the residents could touch the soiled laundry, which could spread infection. She stated that she saw the bins of soiled laundry and linens in the hallway this morning and doesn't know who left the bins in hallway. She stated that the soiled laundry is left in the hall sometimes. An interview was conducted on May 28, 2024 at approximately 10:40 a.m. with the Director of Nursing (DON/staff #1), who stated that staff are trained on the removal of soiled linens, towels, laundry. It is her expectation that they are bagged up and tied, to prevent odors and the spread of infection. She stated that when the staff are doing rounds, the staff keep the bins in the hallway, so they don't have to walk back and forth and the bins are supposed to have a lid on them to prevent the spread of odors and items from falling out. She stated that there is a risk to residents having access to the soiled items. (continued on next page)

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F 0880 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 May 28, 2024 at 1:59 p.m. with a licensed practical nurse (LPN/staff #72), she stated that about a month ago, they started putting the soiled linens, towels, laundry, and soiled adult briefs in the bins in the hallway. The bins are supposed to be covered with lids and soiled items are supposed to be in bags that are tied. She stated that the change occurred because there were complaints about the soiled adult briefs. The facility policy, Laundry, Linen, Soiled dated October 2023 states that when collecting soiled linens, keep soiled linen containers properly covered at all times, return soiled linen to the laundry in the designated in the non-permeable containers, and the containers are to be covered at all times, lined with plastic bags and cleaned daily. When the containers are three-fourths full, linen containers should be transported to the laundry sorting room by laundry personnel or nurse assistant.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 40581 Based on observations, staff interviews, and the facility policy and procedures, the facility failed to ensure that soiled linens and laundry were not stored in public areas and were covered to prevent odor and ensure a comfortable environment. The deficient practice could impact the residents' safe, sanitary, and homelike environment. Findings include: On May 28, 2024 at approximately 8:01 a.m., a yellow round bin and one gray square bin full of soiled sheets and other laundry items were observed to be overflowing in the hallway on Hall 200 by the laundry room. There was also a smaller silver container full of dirty towels and the lid was not completely covering the bin. The hallway smelled of urine. On May 28, 2024 at approximately 8:05 a.m. a female staff was observed pushing the yellow round bin and gray square bin full of soiled laundry through the exit door near the laundry room and left them outside. The smaller silver container with dirty towels was left in the hallway. On May 28, 2024 at the Housekeeping Supervisor (staff #76) was observed entering the Hall 200 through the exit door when the soiled sheets and laundry were left outside and went into the laundry room. She did not remove the smaller silver container with dirty towels, so it was left in the hallway. On May 28, 2024 at 9:42 a.m. an interview was conducted with a certified nursing assistant (CNA/staff #53), who stated that soiled sheets, towels, and laundry are suppose to go into a bag, the bag is tied, and taken directly to the soiled utility room. She stated that the purpose of tying the bags is to reduce the smell and prevent contaminiation. There is a risk of odor and possible contamination to the residents if the binds are left in common areas. She stated that she thinks the night shift is supposed to take the bins of soiled sheets, towels, and laundry outside until the laundry staff arrives between 7:30 a.m. and 8:00 a.m. and then the laundry staff bring in the bins one at a time. An interview was conducted on May 28, 2024 at 10:03 a.m. with the Housekeeping Supervisor (staff #76), who stated that starts work at 7:00 a.m. She stated that when she arrives to work, she gets the bins of soiled laundry and linens from the soiled utility room to wash them. She stated that the bins of soiled laundry and linens are not supposed to be left in the hallway because they are dirty, smell, and the residents could touch the soiled laundry, which could spread infection. She stated that she saw the bins of soiled laundry and linens in the hallway this morning and doesn't know who left the bins in hallway. She stated that the soiled laundry is left in the hall sometimes. An interview was conducted on May 28, 2024 at 1:59 p.m. with a licensed practical nurse (LPN/staff #72), she stated that about a month ago, they started putting the soiled linens, towels, laundry, and soiled adult briefs in the bins in the hallway. The bins are supposed to be covered with lids and soiled items are supposed to be in bags that are tied. She stated that the change occurred because there were complaints about the smell of the soiled adult briefs. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	The facility policy, Laundry, Linen, Soiled dated October 2023 states that when collecting soiled linens, keep soiled linen containers properly covered at all times, return soiled linen to the laundry in the designated in the non-permable containers, and the containers are to be covered at all times, lined with plastic bags and cleaned daily. When the containers are three-fourths full, linen containers should be transported to the laundry sorting room by laundry personnel or nurse assistant.