STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035110	A. Building B. Wing	09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sun West Choice Healthcare & Rehab	14002 West Meeker Blvd Sun City West, AZ 85375

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49399 Based on clinical record reviews, staff interviews and reviews of facility policies and procedures, the facility failed to ensure care and services that adhere to accepted standards related to medications administration was provided to one resident (#125). The deficient practice could result in resident not receiving the necessary treatment needed. Findings include: Resident #125 was admitted on [DATE] with diagnoses of dementia, hypertension, atrial fibrillation, and depression. The care plan initiated on April 7, 2024 revealed the resident had altered cardiovascular status hypertension, atrial fibrillation, trans ischemic attack history. The goal was that the resident will remain free from signs and symptoms of hypertension. Interventions included give antihypertensive medications as ordered, monitor for side effects such as orthostatic hypotension and increased heart rate, and effectiveness, notify physician of any signs and symptoms of cardiovascular complications: nausea, vomiting, shortness of breath, decreased capillary refill, chest pain/discomfort, monitor for and document any edema, monitor/document abnormalities for urinary output and report significant changes to the physician. The physician order dated April 6, 2024 revealed the following orders: -Lisinopril (antihypertensive) 20 mg (milligram) give one tablet by mouth one time a day for hypertension; -Carvedilol (antihypertensive) 6.25 mg give 1 tablet by mouth 2 times a day for hypertension; and, -Midodrine (alpha adrenergic agonist) 5 mg give 1 tablet by mouth every 24 hours as needed for hypotension. Review of the admission MDS (minimum data set) assessment dated [DATE] revealed a BIMS (Brief Interview for Mental Status) score of 5 indicating the resident had severe cognitive impairment. The MDS also revealed that the resident had no health conditions or chronic diseases that result in a life expectancy of less than 6 months. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NP (nurse practitioner) progress note dated June 5, 2024 revealed that staff reported that the resident had not been eating. Assessments included dementia and hypertension. Plan was to monitor BP (blood pressure), HR (heart rate) and rhythm and laboratories in the morning were ordered. Per the documentation, the resident's BP was controlled. The late entry NP progress note dated June 7, 2024 included that the resident was not eating and drinking well; appeared tired; was not answering questions; and that, an order to was given to the nurse for one liter of IV (intravenous) fluids. It also included that staff were continue to encourage oral intake. The condition follow-up note dated June 8, 2024 revealed that the resident was s/p (status post) IV hydration, was more alert but remained somewhat lethargic; and, oral fluids were encouraged and accepted at 50%. The BP record for June 8, 2024 was 128/74 mmHg (millimeters mercury) at 6:51 a.m. and 133/77 mmHg at 8:27 p.m. The condition follow-up note dated June 10, 2024 included BP was 113/62 mmHg; and that, the IV hydration was completed. The BP record for June 10, 2024 were as follows: -128/72 mmHg at 4:31 p.m. -116/62 mmHg at 5:27 p.m.; and, -120/60 mmHg at 11:52 p.m. The BP record on June 11, 2024 included the following: -115/61 mmHg at 1:41 a.m.; -95/67 mmHg at 2:52 p.m.; and, -95/65 mmHg at 5:30 p.m. The medication administration record (MAR) for June 2024 revealed that June 11, 2024 at 2:52 p.m., Midodrine was administered to the resident. However, there was no documentation found in the clinical record that Midodrine was administered at 5:30 p. m. for a BP reading of 95/65 mmHg; and that, the physician was notified. The BP record on June 13, 2024 was 80/62 mmHg at 7:53 a.m. and was 65/33 mmHg at 10:08 a.m. and 10:23 a.m. Despite documentation of low BP at 7:53 a.m., 10:08 a.m. and 10:23 a.m. on June 13, 2024, there was no evidence found that Midodrine was administered to the resident. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MAR for June 2024 revealed that Lisinopril and Carvedilol were documented as administered to the resident at 8:00 a.m. on June 13, 2024 (approximately 7 minutes from the time BP reading of 80/62 mmHg). The clinical record revealed no documentation of any interventions put in place to address the resident's low BP readings at 7:53 a.m., 10:00 a.m. and 10:23 a.m.; and that, the physician was notified. The nursing note dated June 13, 2024 at 12:08 p.m. included that the resident was sent to the hospital due to low BP and per physician and family request. An interview was conducted on August 30, 2024 at 8:11 a.mm with a certified nursing assistant (CNA/staff #150) who stated that when she comes in for her shift, she would check the assignment book to see which residents she has and would do walk-in rounds during report. The CNA said that while waiting for the resident's breakfast, she would starts taking vital signs for her residents at around 6:30 a.m.; and this usually take around 30 minutes to an hour to finish taking vital signs for all residents assigned to her. She said that she would then document the resident's vital signs in the electronic record at around 7:30 a.m. The CNA said that abnormal BP reading would be a BP above 140/80 mmHg and under 100/60 mmHg; and that, she would notify the nurse immediately about the abnormal BP reading. An interview was conducted with another CNA (staff #135) on August 30, 2024 at 8:25 a.m. Staff #135 stated that when he arrives for his shift, he gets a report from the night shift, checks his assignment, and then start to get vital signs for residents assigned to him. He said that he starts taking resident vital signs from 6:00 a. m. through 7:00 a.m., documents the vital signs in the electronic record within same time frame up to 7:30 a. m. so the nurse has the vital signs results on hand and could do medication pass. Staff #135 stated after finishing taking resident vital signs, he will check the resident rooms, pass out breakfast which was served at 7:00 a.m. Staff #135 stated that an abnormal and high blood pressure would be150/80-90 mmHg and low blood pressure would be 100/60 mmHg; and that, he would report these abnormal vital signs to the nurse so the nurse can possibly administer medication if needed and to make sure that the resident was okay. In an interview with a registered nurse (RN)/staff #58) conducted on August 30, 2024 at 8:44 a.m., the RN stated that the 8:00 a.m. scheduled medications can be given at 7:00 a.m.; and that, documentation in the MAR revealed the use of the following codes: (a) check mark to indicate medication was administered; (b) Number 2 to indicate Hold/See Nurses Notes; (c) Number 10 to indicate hospitalization ; and, (d) Number 12 to indicate blood pressure parameters. The RN said that when giving blood pressure medications, she will look for the resident's current blood pressure, pulse and their physical state such as being alert. She stated that she will not administer an antihypertensive medication such as lisinopril if the systolic blood pressure was less than 90 mmHg, if pulse was anything less than 60 for pulse, and she will notify the provider of the resident vital signs. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with director of nursing (DON/staff #504) and the clinical resource (staff #505) conducted on September 3, 2024 at 10:25 a.m., the DON stated that for a change of condition, staff would first assess the resident then notify the provider. The DON said that they transfer resident to the hospital when the level of care cannot be provided in their facility; and that, when a resident is transferred, they would notify their family and complete the notice of transfer/discharge. Regarding resident #25, the DON stated the resident had lisinopril 20 mg by mouth every day for hypertension scheduled to be administered at 8:00 a.m. and carvedilol 6.25 mg twice a day scheduled to be administered at 8:00 a.m. and 5:00 p.m. The DON stated that on June 13, 2024 at 7:53 a.m. the resident's BP was 80/62; and, the actual time lisinopril and carvedilol were given to resident #25 on June 13, 2024 was at 8:26 a.m. She stated that staff were expected to call/notify the provider when the BP was low and to follow physician orders. Further, the DON stated that resident #125 was transferred out due to low blood pressure per family request. She stated that the resident's BP was 60/33 at 10:23 a.m.; and the resident was transferred out at 10:49 am on June 13, 2024 for low blood pressure. The facility policy on Administration of Drugs with revision date of February 2024 included that medications shall be administered as prescribed by the physician. Medications must be administered in accordance with the written orders of the attending physician.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49399 Based on record reviews, staff interviews and reviews of facility policies and procedures, the facility failed to ensure basic life support including CPR (cardio-pulmonary resuscitation) according to the physician order and the advance directives was provided for one resident (#56) prior to the arrival of the emergency medical personnel. The deficient practice resulted in the resident's advance directives not followed and delay in initiation of basic life support including CPR and risk for serious injury and harm. As a result, a condition of Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) were identified. The census was 134. Findings include: On [DATE] at 12:41 p.m., a condition of IJ was identified. The administrator (staff #510) and director of nursing (DON/staff #504) were informed of the facility's failure to initiate basic life support including CPR prior to arrival of the emergency medical service (EMS). The DON stated staff would not start CPR if a resident still had vital signs. The administrator and DON presented the removal plan on [DATE] at 2:11 p.m. The administrator, DON and clinical resource (staff #508) were informed that the removal plan was not acceptable; and, must not be a copy of the regulation or guidance. It also failed to include steps or actions that taken to ensure no residents are or will likely be affected by the deficient practice; details on how they will keep the residents safe and free from harm, impairment or death caused by the non-compliance; date when in-service training was started and expected to be completed for all staff; identify the staff that would complete the in-service training; identify the topic of the in-service training they would provide to staff; and, actions the facility will take if a staff did not complete the required in-service training. In an interview conducted on [DATE] at 3:15 p.m., the DON stated that the facility did not have contract or registry staff; and, the facility did not require therapist to have CPR certification. A revised removal plan was received on [DATE] at 4:45 p.m. and was not accepted; and, failed to include how the facility identified the residents that may be affected; date all in-house review was started and expected to be completed; how in-house reviews will be conducted and where will these reviews be documented; how the facility would address residents with advance directives to include full code and DNR (do-not-resuscitate) in an in emergency situations; what is the therapists expected to do in the event of a code during a therapy session with a resident with full code status; and, date when in-service training was started and expected to be completed for all staff. Another revised removal plan was presented by the DON on [DATE] at 9:44a.m. The administrator was informed that the removal plan was not accepted because it failed to: address residents with DNR (Do Not Resuscitate) in emergency situations; change the plan of correction to removal plan; include therapy staff in the in-service training provided; and, include the start dates of random reviews to verify implementation of appropriate measures for acute changes of condition. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On [DATE] at 10:31 a.m., the administrator presented a revised removal plan and was accepted. The accepted removal plan included: -Full house review and random reviews of current residents for advance directives and code status; -Resident monitoring and evaluation for acute change of condition at leat every shift through routine delivery of care; -In-service training for all nursing staff on advance directives, full code status, basic life support and administering CPR when cardiac and/or respiratory arrest occur; -In-services training for all staff (therapy, dietary, housekeeping and laundry, maintenance, social service, etc.) on acute change in condition and notification of nursing staff immediately; and, -Completion of competency skills on CPR using the American Healthcare Association and AED manufacturer guidelines. On [DATE] at 12:21 p.m., the condition of IJ was removed after multiple observations were conducted of the facility implementing their removal plan which included resident and staff interviews, record review and in-service training of staff. -Resident #56 was admitted on [DATE] with diagnoses of hypertension, benign prostatic hyperplasia (BPH), non-Alzheimer's dementia, depression, and obstructive sleep apnea (OSA). The admission note dated [DATE] revealed that the resident was alert and oriented x ,d+[DATE] and was able to make needs known. Per the documentation, the resident was admitted for skilled PT (physical therapy)/OT (occupational therapy) following a ground level fall that resulted in right femur fracture. The advance directive form signed by resident representative (RR) and dated [DATE] revealed that should the resident wanted the following: -Cardiac resuscitation measures (CPR); -Artificial nutrition (tube feeding) if unable to accept nourishment by mouth; -Artificial hydration (IV hydration) if unable to accept hydration by mouth, unless IV hydration was used as comfort measure and will not prolong my death; -hospitalization (related to terminal condition); -Antibiotics therapy to be given to reduce or eliminate the infection, as long as the antibiotic will not prolong inevitable death; and, -Pain medication to be given to eliminate apparent pain, even if this poses a risk of depressing respiration and hastening my death. Review of a physician order dated [DATE] revealed the resident had a CPR/Full code status. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	The late entry history and physical note dated [DATE] included the resident was laying in bed resting with CPAP (continuous positive airway pressure) on. Assessments included sleep apnea with CPAP, hypertension and dementia. Plan included to monitor BP (blood pressure) and CPAP at bedtime and when napping during the day as needed. The physician orders dated [DATE] revealed the following orders: -CPAP at maximum IPAP (inspiratory positive airway pressure) 18 cm (centimeter)/H20 (water) and minimum EPAP (expiratory positive airway pressure) 8 cm/H20 with face mask at night and PRN while napping during the day and at bedtime for Sleep Apnea; and, -Oxygen titrate between ,d+[DATE] liters per minute (LPM) via nasal cannula (NC) as needed to maintain oxygen saturation over 90% every shift for hypoxia and SOB (shortness of breath). The care plan initiated on [DATE] revealed the resident used a CPAP related to OSA. The goal was to have no signs and symptoms of poor oxygen absorption. Interventions included to give medications as ordered; monitor for signs and symptoms of respiratory distress and report to the physician as needed: respirations, pulse oximetry, increased heart rate, restlessness, diaphoresis, headaches, lethargy, confusions, atelectasis, hemoptysis, cough, pleuritic pain, accessory muscle usage, skin color; and placing of CPAP with face mask at night and PRN (as needed) while napping during the day. The physician progress note dated [DATE] included the resident was alert and oriented x2. Assessments included dementia, psychosis, sleep apnea and hypertension. Plan was to monitor blood pressure closely. The skilled weekly review dated [DATE] revealed the resident required moderate assistance with bed mobility and transfers, stand-by assistance with upper body dressing; maximum assistance with lower body dressing, and, dependent on showers/bathing. Per the documentation, resident had OSA with CPAP at night and oxygen. A Minimum Data set (MDS) assessment dated [DATE] included the resident had a BIMS (Brief Interview for Mental Status) score of 6 indicating the resident had severe cognitive impairment. Active diagnoses included stroke, hypertension, benign prostatic hypertrophy (BPH), hyperlipidemia, non-Alzheimer's dementia, malnutrition, depression, obstructive sleep apnea, muscle weakness, cognitive communication deficit. The assessment also included that the resident did not have a condition or chronic disease that may result in a life expectancy of less than 6 months. A psychiatric note dated [DATE] included the resident was alert and oriented x 2 with appropriate responses and had diagnoses of obstructive sleep apnea and dementia. The daily skilled notes dated [DATE] through 14, 2024 revealed that the resident was alert and oriented x 3; had diagnoses of obstructive sleep apnea and dementia; and, was on CPAP at bedtime and as needed. The skilled weekly review dated [DATE] included the resident had OSA with CPAP at night and was on oxygen. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	The physician progress note dated [DATE] revealed the resident had sleep apnea with CPAP and hypertension. Plan was to monitor BP and heart rate (HR) and to continue with CPAP at bedtime and when napping during the day as needed. Review of physician's orders dated [DATE] at 08:52 revealed a discontinue order for the as needed Oxygen. A nursing note dated [DATE] revealed the resident sustained an unwitnessed fall with no injuries. Per the documentation, the resident was in the wheelchair and attempted to turn, pushed too far and fell . It also included that the resident reported that he did not realized that he pushed too far. The documentation that neuro checks were initiated; and, the provider and family were notified. Review of the physician progress note dated [DATE] included the resident was awake, alert, had intermittent confusion and reported falling and had some back pain. Plan was to monitor mental status for acute changes, monitor BP and HR and to continue with CPAP at bedtime and when napping during the day as needed. Per the documentation, code status was full code. The change in condition note dated [DATE] at 1:15 a.m. revealed that the resident had a fall. Vital signs were as follows: BP of ,d+[DATE], pulse of 76, respiration of 19 and oxygen saturation of 95% in room air. The vitals signs dated [DATE] at 2:41 a.m. included resident had BP of ,d+[DATE], regular pulse of 75 bpm (beats per minute), respiration of 18 breaths/minute and oxygen saturation of 98% room air. The nursing progress note dated [DATE] at 5:36 a.m. included that the resident was found sleeping on the floor in his room next to his wheelchair, was snoring and was laying on his left side with hands under his head. Per the documentation, staff attempted to assist the resident into the wheelchair and the resident became upset and indicated that he was asleep and did not want to get up. It also included that the nurse explained to the resident that he was asleep on the floor and staff was going to assist him back to bed; but, the resident insisted that he was not on the floor. Further, the documentation included that the resident had dementia and sun downs and denied falling from his bed. The documentation also included that neuro checks was initiated and the physician and RR were notified. The medication administration record (MAR) for [DATE] revealed documentation that at 6:00 a.m. the resident was administered with pain medication. The nursing progress note dated [DATE] at 6:55 a.m. revealed the resident was unresponsive to verbal and tactile stimuli at 6:30 a.m. Per the documentation, the head of bed was elevated, CPAP on, and vital signs of BP of ,d+[DATE], blood glucose of 249, pulse rate of 44 bpm, respiration of 24 breaths/minute and oxygen saturation of 98%. The documentation also included that there was emesis observed and the resident's fingertips to bilateral hands were cyanotic which was contradictory to the documented oxygen saturation of 98%. Further, it included that 911 was called and the physician, DON and ADON (assistant DON) were notified. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	The nursing home to hospital transfer form signed and dated [DATE] revealed the resident was alert, disoriented but can follow simple instructions; and, had CPR/full code for code status. Devices and treatments included CPAP. Per the documentation, the reason for transfer was that the resident was unresponsive. Vital signs at 6:40 a.m. included a BP of ,d+[DATE], HR (heart rate) of 44, respiratory rate of 24; and, at 6:41 a.m., oxygen saturation of 98%. Despite documentation that the resident had a low BP and was cyanotic from the fingertips to bilateral hands, there was no documentation of what the facility have done to address these issues while waiting for EMS (emergency medical services). The prehospital care report from EMS included impressions of difficulty of breathing, altered mental status, shortness of breath and respiratory distress. The documentation included that EMS arrived on scene at [DATE] at 6:36 a.m. and found the resident unresponsive with a GCS (Glasgow Coma Score) of 7 which indicated the resident was in coma. Per the documentation, the facility reported to EMS that the resident slept on the floor and staff had been checking the resident all night and the resident was fine; and that, staff did not know when the resident went unresponsive or if the resident actually fell . The documentation also included that the resident was pale, cyanotic and remained unresponsive, had palpable rapid irregular pulse, had agonal respirations, had room air oxygen saturation of less than 50%, had non-reactive pupil on the left eye and sluggish pupil on the right eye. It also included that the resident was unresponsive to IO (intraosseous) insertion, was cardioverted at 125 joules and ventilation with BVM (bag valve mask) and supplemental oxygen at 25 lpm (liters per minute) was performed and did not react to the [NAME] airway (non-inflatable cuff used in resuscitation) placement. The hospital admit-transfer-discharge information note dated [DATE] at 6:54 revealed the resident arrived via EMS and was unresponsive in atrial fibrillation with RVR (rapid ventricular response). The documentation included that upon arrival at the ED (emergency department) the Glasgow coma score was 3 indicating the resident was in coma and the oxygen saturation was 87% bag valve mask. Per the documentation, the resident was unresponsive, had tachycardic heart rate, no gag reflex, no corneal reflex, non-responsive, had nonreactive pupils 1 mm (millimeter) on the left and 4 mm on the right and skin was cold and dry. Coded diagnoses included accidental fall from bed, acute traumatic subdural hematoma with loss of consciousness status unknown. An interview was conducted on [DATE] at 1:10 p.m. with a certified nursing assistant (CNA)/staff #161) who stated that at the start of her shift, she checks the schedule book, gets a report from the outgoing staff and then checks her residents. The CNA stated that when resident was hard to wake up it was a change in condition. The CNA said she will then the nurse stat, check the resident's vital signs. She stated that if a resident was found on the floor, she would ask the resident if they were okay and will call the nurse. She said that she will not touch the resident and would wait for the nurse to do their assessment and give her instructions. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview with the licensed practical nurse (LPN/staff #31) conducted on [DATE] at 1:37 p.m., the LPN stated when she comes in for her shift, she and the outgoing nurse will do a nurse to nurse report and both nurses would discuss what happened with each resident during the previous shift. The LPN said that examples of change of condition would be a fall or abnormal vital signs such as an extremely low and high blood pressure that deviates from baseline. She stated that a high blood pressure was 190 systolic blood pressure and lower blood pressure was 60 systolic blood pressure; and that, if this occurs, she will double check the vital signs, inform the physician and wait for new orders. The LPN said that for a low blood pressure, she would also check for lethargy, feeling tired and/or resident not being hungry. She stated that if a resident for a fall, she will go in the patient's room and assess the patient. The LPN said that for an unwitnessed fall, she would do neuro checks and would inform the physician and family about the fall. Further, the LPN stated that residents on blood thinners with significant bleeding and non-responsive and had a fall, she would call 911. The LPN said for a non-responsive resident, she would try to intervene by having the crash cart; and, if the resident was not breathing, the facility has an AED (Automated External Defibrillator) to use. The LPN also stated that if a resident was cyanotic, she would call a code, check the vital signs, check the resident's pulse; and that, during the code, there would be staff running the resident's vital signs or assisting with anything; there would be one leading the code and another performing CPR. Further, the LPN stated that if a resident was cyanotic, extremely tired, slow to response but still breathing, she would call the physician, get the resident's vital signs, reposition the resident; and, if the oxygen saturation was low she would give the resident oxygen after clarifying with the physician. An interview was conducted on [DATE] at 9:49 a.m., with the LPN (staff #50) who worked on Monday, [DATE] when the incident with resident #56. Staff #50 said that she was getting a report from the outgoing nurse when the day shift CNA came to her and reported that the CNA was getting the vital signs of resident #56 who was not responding. Staff #50 stated she went to the resident's room immediately and found the resident looked like he was sleeping with the head of bed elevated and the CPAP on and functioning. Staff #50 said that the resident was taking deeper breaths than normal and she tried shaking him by the shoulder 2 to 3 times but had no answer from the resident. She also said that she squeezed the resident's fingertip and did a sternal rub but received no response from the resident. She stated that she then went out to get a Vitals kit to take vitals and recalled patient was prediabetic so she checked the blood sugar, and the CNA was doing vital signs. She stated she noticed the resident's fingertips were cyanotic so she took the CPAP off and check the resident's mouth, took the dentures out, and the mouth was clean; but, there was emesis in the resident's mouth that looked like a film in the upper palate so she put the CPAP back on to the resident. Staff #50 said that the CNA stayed with the resident while she and the night shift nurse notified the provider who gave an order to send the resident to the hospital. She stated they called 911 and the EMS came within 2 minutes. Staff #50 stated that the resident was breathing and had a pulse the whole time, the CPAP was on and the oxygen saturation was at 98 percent; but, the very tip of the resident's fingertips were bluish gray. Staff #50 stated that neuro checks was in process for resident #56 because the resident had a fall the previous day or night shift. She said that neuro checks are done every 15 minutes times 4, every 30 minutes times 2, and every hour times 6 and then every 4 hours times 4. Staff #50 said that resident #56 was alert and oriented with confusion at times, able to propel his wheelchair by propelling, and required assistance with transfers. (continued on next page)

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	035110	A. Building B. Wing	09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sun West Choice Healthcare & Rehab	14002 West Meeker Blvd Sun City West, AZ 85375

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview with director of nursing (DON/staff #504) and the clinical resource (staff #505) conducted on [DATE] at 10:25 a.m., the DON stated that for a change of condition, staff would first assess the resident then notify the provider. The DON also said that stated that they transfer resident to the hospital when the level of care cannot be provided in their facility. Review of facility policy titled Advance Directives revised on [DATE] revealed that a resident's choice about advance directives will be recognized and respected. The facility policy on Cardiopulmonary Resuscitation (CPR) and First Aid last revised February 2024 included that it is their policy to administer CPR according to current national guidelines. Once CPR is initiated, it will be discontinued only by a physician's order and/or the arrival of rescue personnel who take over CPR efforts and/or transport the resident. The facility policy on Change of Condition Reporting with review date of February 2024 revealed for Life Threatening Change the licensed nurse will initiate appropriate first aid measures until emergency response personnel arrive on the scene and all nursing actions, physician contacts, resident representative and resident assessment information will be documented in the medical record.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50553 Based on record review, staff interviews, and policy review, the facility failed to ensure an abnormal lab results for one resident (#91) were promptly communicated to the provider. The deficient practice could result in complications and/or worsening of resident's health. Findings include: Resident #91 was admitted on [DATE] with diagnoses of dementia, dysphagia, type 2 diabetes mellitus, and psychotic disorder. The ADL (activities of daily living) care plan dated July 26, 2024 revealed the resident had ADL self-care performance deficit related to dementia, impaired mobility and UTI (urinary tract infection). Interventions included for staff to provide up to extensive assistance with bed mobility, dressing, toilet use, transfers, personal hygiene and locomotion on and off unit. Another care plan dated July 26, 2024 included that the resident had bowel/bladder incontinence related to dementia and impaired mobility. Intervention included to monitor/document for signs/symptoms of UTI. The late entry NP (nurse practitioner) progress note dated August 7, 2024 revealed the resident had been having nausea and vomiting, had IV (intravenous) fluid running and had a pending urine culture. Assessment included leukocytosis. Review of the Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment. The nutritional care plan revised on August 10, 2024 included the resident had potential nutritional problem and required diuretic treatment with fluid related weight changes and abnormal labs expected. Interventions included to obtain and monitor lab/diagnostic work as ordered, to report results to the physician and to follow-up as indicated. Review of physician order dated August 16, 2024 revealed an order for a urine culture and sensitivity for leukocytosis for 2 days. This order was transcribed onto the MAR for August 2024 and revealed documentation was coded as 1 indicating refusal on August 18, 2024 Review of the nursing progress note dated August 19, 2024 revealed that the urinalysis (UA) result was back; and that, the NP was notified. Per the documentation, there were no new orders and will wait for culture and sensitivity result. (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The UA result with collection date of August 19, 2024 revealed abnormal results: moderate leukocyte, trace protein and trace-intact blood. It also included a final urine culture result of >100,000 CFU/ml (colony-forming units per milliliter) of Klebsiella pneumoniae (bacteria) ESBL (Extended-spectrum beta-lactamases). Per the documentation, the lab result had a report date of August 22, 2024. Despite documentation of the laboratory result, the clinical record revealed no evidence that treatment was provided and started from August 22, 2024 to August 28, 2024. There was also no evidence found that the physician was notified of the urine culture result from August 22 through August 27, 2024. The physician progress notes on August 28, 2024 at 8:21 a.m. included that the physician was asked to see the resident due to concerns for change in mental status. Per the documentation, the resident's family had been requesting blood work because the family thought that the resident had UTI as the resident's mental status changed. Per the documentation, urinalysis was reviewed and showed positive for UTI; and that, the resident was not at her baseline during the visit. Assessments included leukocytosis and UTI - Klebsiella. Plans were to start on oral antibiotics for underlying UTI; and if the clinical picture changes will start IV antibiotics; and, consider starting IV fluids for volume contraction. The nursing note dated August 28, 2024 revealed that the resident's family was notified of the UA results and the starting of the oral antibiotics. The physician order dated August 28, 2024 revealed an order for Amoxicillin-Pot Clavulanate (antibiotic) 875-125 mg (milligram) give 1 tablet by mouth every 12 hours for bacterial infection for 10 days. This order was transcribed onto the MAR but was also marked as pending confirmation. There is no evidence found in the clinical record that the antibiotic was administered to the resident. A nursing progress note dated August 29, 2024 at 4:25 a.m. revealed that Resident #91 had UTI and was ordered amoxicillin; and that, the resident became unresponsive, was spasming, had fluctuating vitals and could not swallow her antibiotics. Per the documentation, physician requested for the resident to be sent out to the hospital. An interview was conducted on August 29, 2024 at 1:38 p.m. with a licensed practical nurse (LPN/staff #31) who stated that it was the responsibility of the nurse to tell oncoming staff about pending labs during nurse to nurse report; and that, the nurses should check the lab book to be aware of pending labs for residents under their care. The LPN said that in order to check the status of lab results, a nurse can call and ask the lab or check in the electronic health record (EHR) under the results tab. She also stated that urine cultures typically take 2-3 days before a result is received; and, once results were received, staff should immediately notify the physician and put a nursing note into the clinical record. (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the DON conducted on August 30, 2024 at 10:27 a.m., the DON stated that lab results should be reported to the physician once the result is received. She said that the expectation was for nursing staff to look at any lab results throughout their shift and notify the physician of any changes or new results. Regarding resident #91, the DON stated that the most recent urine culture result was received on August 22, 2024; but stated that the result did not seem right and would call in the Infection Preventionist to address this lab result. An interview with the DON and the Infection Preventionist (IP/staff #97) was conducted on August 30, 2024 at 10:44 a.m. The IP stated that sometimes the lab results do not reflect correctly in the EHR; and that, the urine culture result for resident #91 was received on August 28, 2024 and not on August 22, 2024 as noted in the EHR. Further, the DON stated that it was important to address things when made aware; however, she does not believe that the resident's lab result was reported to the facility until August 28, 2024. A telephone interview was conducted on August 30, 2024 at 10:50 a.m. with a representative from the laboratory where the urinalysis and urine culture of resident #91 was processed. The lab representative stated that the laboratory order for a urine culture for resident #91 was received by the lab on August 19, 2024; and, the results were reported to the facility on [DATE] at 11:44 a.m. The lab representative further stated that any results sent to the facility would be available in their EHR within a few minutes. On August 30, 2024 at 12:46 p.m., the DON presented an email correspondence from the laboratory's Director of Sales and Marketing who wrote that laboratory was investigating the laboratory results for requisition for resident #91. The email also included that the laboratory had received the lab request on August 19, 2024 with the final report being reported on August 22, 2024 at 11:44 a.m. In a telephone interview with the laboratory customer service representative conducted on September 3, 2024 at 10:16 a.m., he stated that urine cultures normally take 3-4 days but that results are instantly reported to the facility. Further, the lab customer service representative stated that the urine culture result for resident #91 was reported to the facility on [DATE]. Review of the facility policy titled Change of Condition Reporting revealed that all changes in resident condition should be communicated to the physician and documented. This policy further specifies that changes such as changes in behavior and abnormal laboratory results should be communicated to the provider promptly, and the notification should be documented.