STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035117	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Payson Care Center	107 East Lone Pine Drive Payson, AZ 85541

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51124 Based on observation, interviews, review of the clinical record, and review of facility policy and procedure, the facility failed to ensure a resident's (#72) skin was adequately assessed and treated according to professional standards. The deficient practice could lead to missed skin conditions, resulting in wounds, infection, or other physical harm to a resident. -Findings include: Resident #72 was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease, chronic kidney disease, obesity, radiculopathy, encounter for orthopedic aftercare, spinal stenosis, and rheumatoid arthritis. An admission minimum data set (MDS) assessment dated [DATE], revealed the resident had a brief interview for mental status (BIMS) score of 15, indicating intact cognition. A care plan dated February 27, 2025, indicated the resident was at risk for skin breakdown, with interventions to include weekly skin checks and treatment as ordered. There was no evidence of a physician's order for weekly skin checks. A physician's order dated February 26, 2025, indicated the resident must wear a corset brace when out of bed at all times. A physician order dated February 28, 2025, and discontinued March 5, 2025, indicated for lumbar surgical site: cleanse with wound wash and cover with dry dressing. There was no evidence of further orders for a lumbar dressing. A physician's order dated March 8, 2025, indicated a skin tear to the right elbow: cleaned and applied Steri-Strip. Observe and report to the physician with any changes. A physician's order dated April 11, 2025, indicated to cleanse the right arm with wound wash and cover with foam dressing. A physician's order dated April 15, 2025, indicated to send the resident to the emergency room for evaluation and treatment. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no evidence of a physician's order for a dressing for the sacral region. A Skin Monitoring: Comprehensive Certified Nursing Assistant (CNA) Shower Review (shower sheet) dated March 25, 2025, revealed the resident had no skin issues. A Braden Scale for Predicting Pressure Sore Risk assessment dated [DATE], revealed the resident was high risk for skin breakdown. A shower sheet dated March 29, 2025, also revealed the resident had no skin issues. A shower sheet dated April 1, 2025, revealed resident #72 had a popped blister on bottom on the right side of the sacral region. A Skin Integrity Update dated April 4, 2025, revealed the resident had a lumbar surgical incision with edges approximated, minimal redness, and no drainage. There was no description of a sacral skin condition. The clinical record was reviewed, and there was no evidence of any further skin assessments completed past April 4, 2025. A shower sheet dated April 5, 2025, indicated that Resident #72 had a dressing located on the sacral region and a dressing located on the lumbar region, and bruising to the front of the left forearm. A shower sheet dated April 9, 2025, indicated that Resident #72 had two locations of blisters on the chest, one red spot on the abdomen, and two red areas on the back of the right shoulder. A dressing was located on the sacral region as well as a dressing on the back of the right forearm. There was no evidence that a nurse completed a further skin assessment, or that notifications were made to the provider regarding new skin issues, or that any new treatment orders were received and implemented. A shower sheet dated April 12, 2025, revealed large and indiscernible circles on the body diagram that indicated Resident #72 had bruising to some location on the front of the left side of her arm, hand, and/or abdomen, and wounds on the sacral region and the back, and the back of the resident's right forearm. There was no evidence that a nurse completed a further skin assessment. A General Note from eRecord dated April 14, 2025, revealed Resident #72 has had a gradual decline in orientation and speech. Staff reports she has been mumbling more over the past few days. The family has requested a work-up and wants the patient to be sent to the hospital to receive imaging and labs. Patient sent to hospital via non-emergent transport. An interview was conducted with a Licensed Practical Nurse (LPN / Staff #4) on April 17, 2025, at 1:50 PM, who stated if a resident showed signs and symptoms of a possible change in condition, such as abnormal vital signs or a new skin condition, that the provider would be notified, the nurse would receive any orders, and the notification to the provider would be documented in the clinical record as well as any updates from the provider. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on April 17, 2025, at 2:16 PM with a CNA (Staff #21) who stated he had provided the resident with a shower during the week preceding April 8, 2025, and that the resident had a skin tear on her arm with a dressing, but no other skin issues. An interview was conducted with the Director of Nursing (DON / Staff #30), who stated that the facility's process for monitoring and assessing skin is that residents are supposed to have weekly skin checks and that CNAs also inspect the skin during showers, document on shower sheets, and notify the nurse with any new findings. The DON stated that if a CNA were to note a new skin finding during a shower, then the nurse should perform further assessment, notify the provider, and obtain treatment orders from the provider. The DON stated that weekly skin checks should be documented in an assessment or a progress note. The DON stated that if a nurse did not assess a resident's skin during weekly skin checks or if a new finding was noted on a shower sheet, then a skin condition or infection could be missed and lead to a worsening skin condition. The interview with the DON continued, and the DON stated that she was familiar with Resident #72. The clinical record was reviewed, and the DON stated that the resident was scheduled for a skin assessment on April 11, 2025, which was not done and should have been followed up on the next day. Regarding the shower sheet from April 9, 2025, the DON stated that the red areas and blisters noted on the resident's skin could have been from the back brace the resident was ordered to wear or from poor nutritional status as the resident had not been eating well, which could have led to skin breakdown. The DON stated that there were no further skin assessments or documentation on the skin issues from the nurse, and that it would not meet her expectations for adequately assessing the resident's skin. Review of the facility policy titled Skin Integrity & Pressure Ulcer/Injury Prevention and Management, revised July 9, 2024, revealed the policy provides associates and licensed nurses with procedures to manage skin integrity, prevent pressure ulcer/injury, complete wound assessment/documentation, and provide treatment and care of skin and wounds utilizing professional standards of the NPIAP (National Pressure Injury Advisory Panel) and WOCN (Wound, Ostomy, Continent Nurses Society). A comprehensive skin inspection/ assessment is completed on admission and re-admission to the facility. Per regulation, a standardized risk assessment tool should be completed upon admission/readmission, weekly for 4 weeks, quarterly, and as needed based upon each resident's specific needs. The standardized risk assessment tool being used is the Braden Scale (UDA tool). The score and additional risk factors are documented on the tool. A skin assessment/inspection should be performed weekly by a licensed nurse. Skin observations also occur throughout points of care provided by CNAs during ADL care (bathing, dressing, incontinent care, etc). Any changes or open areas are reported to the Nurse. CNAs will also report to the nurse if the topical dressing is identified as soiled, saturated, or dislodged. The nurse will complete further inspection/assessment and provide treatment if needed. When skin breakdown occurs, it requires attention, and a change in the plan of care may be indicated to treat the resident.