STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035125	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgecrest Post Acute	16640 North 38th Street Phoenix, AZ 85032

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51930 Based on clinical record review, staff interviews, and policy and procedures, the facility failed to ensure a discharge Minimum Data Set (MDS) assessment was accurate for one of three sampled residents (#139). The deficient practice could result in inaccurate discharge tracking information and data for quality monitoring. Findings include: Resident #139 was admitted on [DATE] with diagnoses that included altered mental status, catatonic disorder condition, anxiety disorder, and auditory hallucinations. A baseline care plan dated October 7, 2024 revealed that the resident's goal was to discharge to home. An order summary dated October 11, 2024, revealed that the resident's tentative discharge plan was to return home with family. A social services progress note dated October 16, 2024, revealed that the resident was discharged to home with her daughter and husband. The note further revealed that the home health was also arranged. A nursing progress note dated October 16, 2024, revealed that the resident was discharged home with home health. Despite this, a review of a discharge MDS assessment dated [DATE], revealed that the resident had been discharged to a short-term general hospital on October 16,2024. An interview was conducted on December 4, 2024 at 10:26 AM with a Registered Nurse (RN-Staff #218), who stated that a transfer form/e-interact transform form is completed when a resident is transferred to the hospital, along with Physician discharge notes. The RN reviewed the clinical record and stated that the resident had been discharged home. She further stated that a social worker's note revealed that the resident left by car with home health arrangements. (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on December 4, 2024 at 10:41 AM with the MDS Coordinator (Staff #55), who stated that MDS data should be accurate as per the standard of care. He reviewed the resident's clinical record and stated that there was a discrepancy between progress notes, which indicated a discharge home, and the MDS discharge assessment, which indicated the resident was discharged to the hospital. He stated that the potential risk could result in inaccurate MDS data. An interview was conducted on December 4, 2024 at 10:57 AM with the Director of Nursing (DON/Staff #141), who stated that she expected MDS assessments to accurately reflect a resident's status. The DON reviewed Resident #139's progress notes, and stated that the resident was discharged home. She then reviewed the discharge MDS assessment dated [DATE] and stated that the assessment indicated that the resident had been discharged to a hospital. She further stated that the MDS was inaccurate and would need to be corrected. The DON stated uncertainty regarding the resident's final destination (Home or Hospital) and stated that she would have to look into it. The DON also stated that an inaccurate MDS assessment could result in incorrect MDS data. Further interview was conducted on December 4, 2024 at 12:20 PM with the DON (Staff #141) who stated that the clinical record contained a physician order to discharge the resident home, and a social service note to send the resident home. A facility policy titled, Comprehensive Assessments, revealed that a discharge MDS assessment is completed whenever a resident is physically discharged from the facility and is completed per RAI manual guidelines. Review of Centers for Medicare and Medicaid Services Long Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, version 1.19.1, dated October 2024, revealed that the RAI process has multiple regulatory requirements including that the assessment accurately reflects the resident's status.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49399 Based on clinical record review, staff interviews, and review of facility policies and procedures, the facility failed to ensure one resident (#113) is assessed for self-administration of medication. The deficient practice could result in residents having access to medications not authorized or contraindicated for their use. Findings include: Resident #113 was admitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease, anxiety disorder, obstructive sleep apnea, and arthritis. Review of the admission MDS (Minimum Data Set) assessment dated [DATE], revealed the resident has a Brief Interview for Mental Status (BIMS) score of 15.0 indicating cognitively intact. The MDS also indicated that the resident uses a walker and wheelchair. The MDS assessment also revealed that the resident needs setup or clean up assistance with eating, partial/moderate assistance with oral hygiene, toileting hygiene, shower/bathe, upper and lower body dressing, and personal hygiene. During a medication administration observation with licensed practical nurse (LPN/Staff #176) on December 4, 2024 at 08:02 am, the following medications were observed prepared by Staff #176: - aspirin 81 mg (milligram), one tablet - duloxetine 30 mg, one capsule, - Eliquis 5 mg, one tablet - Lidocaine patch 4%, one patch - Protonix 40 mg, one tablet, - potassium 10 meq (milliequivalent), one tablet - oxycodone 10 mg, one tablet Upon entering the resident's room, an orange colored tube of medication labeled Neosporin and two packets labeled Calmoseptine was on top of resident #113's bed side table. Staff #176 identified the medication found on the table as Neosporin and Calmoseptine. Staff #176 stated that the resident is using the medication for itching around her groin area. Upon exiting the resident's room, a staff standing by resident#113 room door identified herself as the director of nursing (DON)/Staff #141, and stated that they are working on the self-administration. Review of the resident's clinical record did not contain any documentation stating that the resident has been assessed and cleared to self-administer medications. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Furthermore, review of the resident's care plan did not reveal anything about self-administration of medication. Review of the resident's order summary report revealed that there were no orders for self-administration of medications. Additionally, the order summary did not contain a physician's order for Neosporin and Calmoseptine. Furthermore, the resident's medication administration record for December 2024 revealed no orders for resident to self-administer medication and no orders found for Neosporin and Calmoseptine. However, a Self-Administration of Medication Observation form with an effective date of December 4, 2024 timestamped 8:30 am was added to the resident ' s clinical record. The Self-Administration of Medication Observation form indicated that the medications the resident would like to self-administer were Neosporin and house stock zinc oxide. The storage of medication section documented that the resident was in the process of self-administration training for 2 ointments and that the education was in process. Additionally, during a follow-up review of the resident ' s clinical record it was observed that the order for Neosporin and Calmoseptine were added with a start date of December 4, 2024. An interview with Resident #113 was conducted on December 4, 2024 at 8:51 am. Resident #113 stated that the medication has been there for months. The staff pulled the medication out and had it set on top of her table. Furthermore, the resident said that the medication has been on her table since yesterday afternoon. During an interview with the Director of Nursing (DON/staff #141) conducted on December 4, 2024 at 3:15 pm, the DON stated that their residents have the right to self-administer medication. Staff #141 said her IDT (interdisciplinary team) which includes a nurse provides training to make sure their residents are able to self-administer competently. The IDT conducts assessments and care plan. The DON stated that they do training simultaneously, obtain orders, and create the care plan. In addition, staff #141 stated that her unit manager was in the process of doing self-administration training with the resident, and the training started today. A follow up interview was conducted with the DON on December 5, 2024 at 8:16 am. The DON stated that medications are stored in the nurse's cart. If self-administering, it is stored in the resident's room. The medication is stored in resident's room on their side where they have easy access, and where ever they have easy access. The DON declared that this is her final answer. Review of the undated facility policy titled, Self-Administration of Medications, stated that residents have the right to self-administer medications if the IDT has determined that it is clinically appropriate and safe for the resident to do so. The policy indicated that part of the evaluation is that the IDT assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident. The policy also indicated that if deemed safe and appropriate for resident to self-administer medications, it is documented in the medical record and the care plan. The policy also noted that any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 51928 Based on record review, staff interviews and observations, the facility failed to ensure that electronic records for one of twenty-eight sampled residents (#64) were accurately documented. The deficient practice could result in the medical record not reflecting the resident ' s condition and the care and services provided across all disciplines. Findings include: Resident #64 was admitted on [DATE] with diagnoses of dementia, type 2 diabetes mellitus, major depressive disorder and anxiety disorder. Review of Resident #64's medical record revealed a New Admission Medication Review dated June 12, 2023 that was for another resident, regarding Prednisone 20 mg. Further review of the form revealed another resident ' s name, date of birth, and medications, and was no longer a resident at the facility. An additional New Admission Medication Review dated June 12, 2023 was also in Resident #64 ' s medical record with the same resident ' s name that included: Evaluate: Bupropion 150 mg Modify: Prednisone 20 mg Evaluate: Rosuvastatin 20 mg Evaluate: Leader Nicotine gum 2 mg An interview was conducted with the Health Information Director (HID/Staff #33) on December 4, 2024 at 1:44 p.m., who stated documents are checked before and after they are uploaded into the medical records system. She stated that if incorrect records are found, the issue would be immediately corrected. She reviewed Resident #64 ' s clinical records and stated that New Admission Medication Reviews dated June 12, 2023 were that of another resident. She also indicated that the records were inaccurately placed in Resident #64 ' s records. An interview was conducted with the Director of Nursing (DON/Staff #141) on December 4, 2024 at 2:00 p.m. , who stated that all resident records should be held privately in the online system. She reviewed Resident #64 ' s clinical record and stated that another resident ' s New Admission Medication Reviews were incorrectly placed in Resident #64 ' s clinical record. She also stated that this did not meet her expectations and should be corrected immediately, as this was private resident information. Review of a policy titled, Confidentiality of Information and Personal Privacy, document revealed that the facility will safeguard the personal privacy and confidentiality of all resident personal and medical records. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a policy titled, Resident Rights, revealed that Federal and State laws guarantee basic rights to all residents that include privacy and confidentiality. The policy further revealed that the unauthorized release and access to resident information is prohibited.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51159 Based on observation, documentation, staff interview, review of policy and procedures the facility failed to ensure that corrective actions plans were set in place for legionella. The deficient practice could result in residents to have respiratory complications. Findings include: A review of the final report from the water sampling company testing collected on June 6, 2024 revealed that 3 residents' rooms and one nursing station tested positive for Legionella. According to the report, room [ROOM NUMBER] had a Legionella pneumophila serotype 2-15 at a concentration of 6.3 CFU (colony forming units)/ml (Milliliter). Room # 102 was found to have Legionella pneumophila serotype 2-15 at a concentration of 0.6 CFU/ml. Additionally, room [ROOM NUMBER] detected the presence of Legionella pneumophila serotype 2-15 at a concentration of 7.7 CFU/ml. The 400 Nurse ' s Station was also positive for the presence of Legionella pneumophila serotype 2-15 at a concentration of 25 CFU/ml. Review of the Legionella program and Infection Prevention and Control program did not reveal any documentation pertaining to the detection of Legionella in the facility ' s water system. An interview was conducted on December 04, 2024 at 10:24 AM with the Maintenance Director (Staff # 45). Staff #45 stated that for the process for legionella testing the water safety company would send a testing kit for legionella and from there the maintenance director would send back those water samples to the water safety company for results. The Maintenance Director (Staff #45) stated that the testing results of legionella would determine how often the testing needs to be completed. Staff #45 stated that when water testing results are positive for legionella then more testing will occur to determine if the levels of legionella have decreased. The Maintenance Director (staff #45) stated that he would monitor for legionella by flushing out the water system. A review of an email sent from the water safety company regarding the legionella testing done on June 6, 2024 was conducted with Staff #45 on December 4, 2024 at approximately 10:24 a.m. The email revealed that 4 out of the 5 locations sampled in the facility tested positive for legionella. In an interview with the Maintenance Director (staff #45) conducted on December 4, 2024 at 10:24 a.m., he stated that with positive legionella results the water testing company would come to the facility to test the water 3 additional times to ensure that the levels have decreased. Staff #45 stated that there were no previous records from the previous maintenance director in regards to results for legionella. A telephonic interview was conducted December 04, 2024 at 12:52PM with a water company representative (staff #477) stating that 3 out of 4 locations that were tested for legionella was greater than 1.0 CFU/ml. Staff # 477 stated that the water sample testing were completed on June 6, 2024. The results indicated that the facility water was controlled poorly. The water company representative stated that there should have been a corrective action plan set in place to put things back into control. Staff # 477 stated that there is no record of a corrective action plan being made to address legionella. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A request for follow up documentation regarding the water sampling test was submitted on on December 04, 2024 at 1:07 PM. The request was returned with a signed statement from the administrator (staff #13) which stated no follow-up/not required. An interview was conducted on December 4, 2024 at 1:29PM with the Infection Control Preventionist (Staff # 27). Staff #27 stated that protocols for positive legionella testing consists of contacting the Center for Disease Control (CDC), State, and County. The Infection Control Preventionist stated that the Maintenance Director is the best person to explain the process since he would be the one to take the appropriate actions. During an interview with the Maintenance Director (Staff #45) conducted on December 4, 2024 at 1:51PM, he stated that he was not aware of the test results for legionella testing done on June 6, 2024 since he was not the Maintenance Director at that time. Staff # 45 stated that from his understanding there was no form of communication in regards to test results completed on June 6, 2024. The Maintenance Director (staff # 45) stated that with positive legionella test results, the Infection Control Preventionist , the Maintenance Director, and Administrator would be notified. An interview was conducted on December 4, 2024 at 2:34PM with Administrator (Staff #13). Staff #13 stated that regarding the testing done June 6, 2024 for legionella, there was no communication and no need for follow up in regards to those results. The Administrator stated the facility does not have routine testing for legionella and there is no policy set in place. Staff # 13 stated that the risk to residents when there is legionella in the facility is increased respiratory risk. The Administrator acknowledged that if a resident tested positive then it would be a big thing. During a follow up interview with the Infection Control Preventionist conducted on December 5, 2024 at 7:56AM, staff #27 stated that legionella is a communicable disease, and when legionella occurs that the County, State, and Center of Diseases Control (CDC) would be contacted.