STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035126	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of North Glendale	13620 North 55th Avenue Glendale, AZ 85304

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47179 Based on observation, interviews, and records review the facility failed to ensure the physician was notified of a change of condition for one resident (#5). The deficient practice could result in delayed treatment. Findings include: Resident #5 was initially admitted to the facility on [DATE] with diagnoses of muscle weakness, anemia, chronic kidney disease and paroxysmal atrial fibrillation. The care plan initiated on July 12, 2021 revealed that resident #5 was on anticoagulant therapy. The goal was that the resident will be free from discomfort or adverse reactions related to anticoagulant use. Interventions included to administer anticoagulant medications as ordered by physician, monitor for side effects and effectiveness, observe for and report, as needed, adverse reactions of anticoagulant therapy including mental status and significant or sudden changes in vital signs. A progress note dated August 2, 2021 revealed the resident was sent to the hospital for a CT (Computerized Tomography) scan due to increase pain. The clinical record review revealed the resident was readmitted at the facility on August 9, 2021. A physician order dated August 10, 2021 included an order for warfarin sodium (anticoagulant) give 2.5 milligram (mg) by mouth at bedtime every Monday, Tuesday, Wednesday, Friday, and Sunday. The physician order summary for August 2021 revealed an order to monitor for signs and symptoms of bleeding including black tarry stools, bleeding gums, bruising/nose bleed related to anticoagulant use every shift, to document positive (+) if signs and symptoms were present and negative (-) if not present. A progress note dated August 10, 2021 at 11:44 A.M. revealed the resident was alert and oriented to situation and surrounding, was pleasant, and was not in acute distress. It was also noted that the resident was readmitted to the facility for coagulopathy and elevated INR. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress note dated August 10, 2021 at 5:18 P.M. revealed resident had a fall and was found sitting on the floor next to her bed. The documentation included that neuro checks were started per policy; and that, the physician and family member were notified. The progress note dated August 10, 2021 at 11:32 P.M. revealed resident was alert and oriented x 3 with confusion and was able to verbalize need. Further, it included neuro checks were continued status post of unwitnessed fall; and that, the resident was very confusing at night and weak while night. The Fall Risk Evaluation dated August 10, 2021 revealed that the resident had 1-2 falls and had no cognitive change in the last 90 days. There was no documented response for questions on resident behaviors such as easily distracted, periods of altered perception or awareness of surroundings, episodes of disorganized speech, periods of restlessness, periods of lethargy, mental function varies over the course of the day, wanders, abusive and resists care. However, in another Fall Risk Evaluation dated August 10, 2021 documented that the resident had no falls and had a cognitive change in the last 90 days. The documentation also included that the resident was easily distracted, had periods of altered perception or awareness of surroundings, had episodes of disorganized speech, had periods of restlessness, had periods of lethargy; had mental function that varied over the course of the day, wanders; was abusive and resisted care. Review of the clinical record revealed that Neurological Checks were completed; and the initial neurological check was August 10, 2021 at 4:45 P.M. Subsequent assessments were conducted on every 15-, 30-, and up to 60-minute intervals; and, the documentation revealed the resident had clear speech. The neurological check dated August 11, 2021 at 2:00 A.M. the speech evaluation section was left blank. At 8:00 A.M. and 2:00 P.M., the documentation included that the resident had slurred speech. Review of the Fall Risk Evaluation dated August 11, 2021 revealed that resident had 1-2 falls and had no cognitive change in the last 90 days. The documentation also included that the resident was not easily distracted, had no periods of altered perception or awareness of surroundings, had no episodes of disorganized speech, periods of restlessness, no periods of lethargy, had a mental function that varied over the course of the day, did not wander, was not abusive and did not resist care. The physician order with a start date August 12, 2021 included for warfarin 1.5 mg by mouth at bedtime every Thursday and Saturday. However, there was another physician order with a start date of August 12, 2021 to continue to hold coumadin (brand name for warfarin) and recheck INR in the morning one time only until August 12, 2021. The neurological check dated August 12, 2021 at 6:00 A.M. revealed the resident had clear speech. At 8:00 A.M, the resident was documented to have slurred speech. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a progress note dated August 12, 2021 at 3:14 P.M. revealed resident was laying in a recliner chair with eyes closed holding a cellphone to ear talking to the air and had slurred slow speech, nonsensical, and was not able to be redirected; and that, a family member was in the room with the resident. It also included that the resident was lethargic, confused, and was hitting, kicking, and pulling at oxygen tubing, screaming without cause in a high-pitched manner. The documentation also included that all narcotics had been discontinued due to the resident's mental status. Despite documentations that the resident had slurred speech on August 11 and August 12, 2021, there was no evidence found that the physician was notified. The physician orders for warfarin sodium was transcribed in the Medication Administration Record (MAR) for August 2021. The documentation in the MAR revealed that warfarin 2.5 mg was held on August 10, 2021 and given on the August 11, 2021. Despite the hold order for warfarin, the MAR documentation for August 12, 2021 revealed that warfarin was administered to the resident. Review of a progress note dated August 13, 2021 revealed that a registered nurse (RN) contacted the resident's family member regarding the resident's increasing confusion and the medication changes to include the discontinuation of all narcotics. Further, the documentation included that the family member requested to contact the doctor. A physician order with a start date of August 13, 2021 included to continue to hold coumadin and recheck INR in the morning one time only until August 13, 2021 at 10:59 A.M. Another progress note dated August 13, 2021 revealed that a nurse practitioner (NP) saw the resident and ordered for the resident to be sent the hospital for a CT scan of the head without contrast second to altered mentation. It was further noted that the resident was transported to the Emergency department at approximately 12:00 P.M. An interview was conducted on June 14, 2024 at 12:44 P.M. with a licensed practical nurse (LPN/staff #85) who stated that if a resident had an unwitnessed fall or was found on the floor and it was unknown whether the resident hit their head, the RN would perform a neurological assessment and notify the physician and family. The LPN stated that the doctor will also be notified that the resident was on a blood thinner; and, the doctor would give instructions. The LPN said it was the doctor's decision to send the resident who fell to the hospital for a CT scan. Further, the LPN stated that it was a change in condition and the doctor would be notified if a resident who had clear speech prior to a fall then developed slurred speech after the fall. The LPN said the resident who was on coumadin (anticoagulant) and had a fall would be at risk for a brain bleed; and that, not notifying the physician of any changes can put the resident at risk for internal bleeding. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with a RN (staff #61) was conducted on June 14, 2024 at 1:30 P.M., the RN stated that when a resident had an unwitnessed fall, she will assess the resident and the physician was notified; and that, a neurological check would be done to include vital signs, checking the resident's pupils, speech, orientation and upper and lower extremity movement. The RN said the neurological checks were completed at every 15 minutes x 4, then every 30 minutes x 4, then every 2 hours x 4, every 4 hours x 4, every 8 hours x 4, etc. The RN stated that neurological assessments allowed the nurses to see any changes and if there was a decline in the resident's status. The RN said that if there were changes from the resident's baseline during the neurological assessments then the physician was notified right away; and that, if the physician was not notified right away of any changes the resident may have had a stroke and the resident was not attended to right away. The RN further stated that residents on blood thinners like coumadin were at a higher risk for bleeding. The RN said that physicians relied on the neurological assessments to determine the next course of action, whether to hold coumadin or to continue giving it. A telephone interview was conducted on June 14, 2024 at 1:55 P.M. with a physician (staff #300) who said that staff notifies him for every resident that had a fall. The physician stated that the expectation was to indicate and let him know whether the resident hit their head or not; and the staff can volunteer to let him know if the resident was on a blood thinner. The physician stated that he does not hold medications for just any fall because of the risk versus benefits of the medications. The physician said some residents fall all the time but if they had atrial fibrillation he might not hold the medication. Further, the physician stated his expectation was that he was notified of any changes after a resident fell because the resident could have a subdural hematoma (brain bleed) that show up three days later; and, because subdural hematoma is slow it could take days to show signs/symptoms. He said that the resident would require a scan of the head. Further, the physician said that if a resident had clear speech then suddenly developed slurred speech after a fall, he would send the resident to the hospital and in his experience, any other doctor would do the same. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) conducted on June 24, 2024 at 2:13 P.M., the DON stated that if a resident had an unwitnessed fall and was on blood thinner, the staff would notify the RN right away so the resident could be assessed. The DON said that the RN would assess the resident paying close attention to the neurological assessment and any obvious bleeding, then notify the physician and family. The DON stated that the RN would let the physician know if the resident was on blood thinner like coumadin because of the risk of bleeding. The DON said that there could be slow and subtle bleeding which was why neurological assessments were done. The DON added that the neurological assessment included checking for pupil changes, drooping, headache, pain, and slurred speech; and that, if resident who was assessed to have clear speech and suddenly changed to a slurred speech, the physician would be notified. The DON said most doctors would want the resident to have a scan; and, it was important to notify the physician right away if there were changes in the neurological assessment because it was a critical situation to provide appropriate care. The DON stated that if the physician was notified by staff, it would be documented in the resident's clinical records. A review of the clinical record was conducted with the DON who stated that the physician was notified after the resident experienced a fall on August 10, 2021; and that, the neurological assessment on August 10, 2021 that resident had clear speech but on August 21, 2021 the resident had slurred speech. The DON stated that her assumption was that the physician was notified, which was why the narcotics were held. The DON stated that slurred speech would be concerning if it was new; and, based on what was documented in the clinical record, there was a change in the resident's condition. The DON said the expectation was that the physician was notified of the slurred speech; and that, she did not find any documentation in the clinical record that the physician was notified of the slurred speech of resident #5. The DON further stated that sometimes the signs of impairment were so subtle that it was hard to pick up, which was why neurological assessments were stretched out for a period of time. Review of the facility's policy titled, Neurological Assessment reviewed on August 10, 2023 revealed that neurological assessment shall be initiated by a written physician's order for neurological checks or when indicated by resident assessment (e.g. head injury, post fall, neurological decompensation). The noted procedure revealed that the nurse documents and reports any pertinent changes in the resident's neurological status immediately to the physician.