STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035143	A. Building B. Wing	06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Scottsdale	9494 East Becker Lane Scottsdale, AZ 85260

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 - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42319 Based on clinical records, facility documents, staff interviews, and facility policy, the facility failed to ensure residents wounds were assessed and treated per professional standards for 3 residents. (#11, 4, 19). This deficient practice can result in significant increases in morbidity and mortality related to wounds. Findings include: Regarding Resident #11: -Resident #11 was admitted to the facility on [DATE] with diagnoses of osteomyelitis of the vertebra, sacral and sacrococcygeal region, paraplegia and encounter for surgical aftercare. A care plan initiated 7/2/2023 included that the resident has a break in skin integrity with interventions to provide treatment as ordered and a pressure reducing mattress. An admission Minimum Data Set (MDS) dated [DATE] included this resident is cognitively intact, has 1 stage 4 pressure ulcer and a surgical wound. A CAA(Care Area Assessment) Worksheet included (Resident #11) has a (history of pressure injury) which has now been treated surgically with flap closure. She is at risk for skin break down (related to) decreased mobility and incontinence. Staff will educate on causative factors for skin breakdown and how to prevent it. Staff will assist within continent care as needed. Staff will perform routine skin assessments to ensure skin integrity. Staff will encourage (patient) to change position at least every two hours to help reduce risk for breakdown (information obtained from hospital notes, clinical note, MARs (Medication Administration Records) /TARs (Treatment Administration Records), and therapy notes added to record in look back period 6/30/2023-7/4/2023). A hospital record dated 6/30/2023 included that the The patient may be discharged to (Skilled Nursing Facility) on a low air loss bed. Once transferred the patient is to remain in a lateral (side) or prone position. Follow up in wound clinic in 1 week for repeat exam and suture removal. An admission collection tool dated 6/30/2023 included that the resident had sutures to the back of left and right leg and notes that the resident has a surgical incision but did not contain measurements. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the physician's orders did not find an order for a low air loss bed. Review of the clinical record did not find that a low air loss bed had been implemented. A physician's order dated 7/1/2023 included Cleanse wound with normal saline. Apply Xeroform to wound and wrap with Kerlix every day shift for Wound Care which included that wound care was performed 5 times of 9 opportunities. A physician's order dated 7/1/2023 included to complete weekly skin and Braden assessment UDAs every night shift every Saturday, which included that a skin assessment was performed 1 of 2 assessments. A weekly skin integrity data collection dated 7/7/2023 included that this resident has a surgical incision, however no notes were made regarding the condition of the surgical incision. Review of the clinical record did not find that an assessment was completed of the surgical repair of the stage 4 ulcer with measurements during the resident's stay. An interview was conducted on 6/3/2024 at 3:11 P.M. with an RN (staff #7) who said that if there is nothing in the box on a Treatment Administration Record (TAR) it means it wasn't completed. This nurse said that the nurse that admits the resident is supposed to do measurements and descriptions of the wounds. An interview was conducted on 6/4/2024 at 11:46 A.M with a RN (staff #59) who said that who said that the wound team comes Tuesdays and Thursdays and the floor nurses do it when they are not here. She said that the first skin check is done by the floor nurses. This nurse said that we definitely note where the wound is at, try to get some measurements, and try to note that in the skin tab and write it in a summary in the end. If it's something that the wound team should see we put it in their book, also we look in their chart and go over the history and physical. She said that for a non-pressure wound, she measures it and write down if it has staples or sutures, and get orders to keep dressing on or to change the dressing, the appearance of the surrounding tissue, and the drainage. This nurse reviewed the clinical record and said she did not see an order for a low air loss mattress and that the facility always has an order for a low air loss mattress if one is used. She said that she did not see measurements for the surgical wound. Regarding Resident #4 -Resident #4 was admitted on [DATE] with diagnoses of encounter for surgical aftercare following surgery on the circulatory system. A 5 day MDS dated [DATE] included this resident is cognitively intact, has a surgical wound and requires partial/moderate assistance to roll left to right. A review of hospital records included this resident has 3 surgical wounds on the left shoulder, left medial elbow and left axilla, 2 which require dressings and the left axilla which is to be left open to air. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A wound observation tool with an effective date of 5/2/2024 included that a left arm surgical wound was well approximated, had no drainage and measured 1.7 x .5 x 0. However, no assessments of this wound were made from 4/25/24 until this assessment on 5/2/2024. No notes were found of the other surgical wounds. An interview was conducted on 6/4/2024 at 11:46 A.M with a RN (staff #59) who said that she reviewed the clinical record for resident #4 and said the wound observation tool on 5/2/2024 was the first record that the wound was measured. Regarding Resident #19: -Resident #19 was admitted on [DATE] with diagnoses of nondisplaced fracture of base of neck of right femur. An admission MDS dated [DATE] included this resident does not have memory issues and was independent for making decisions for daily life. This MDS was not completed in sections on M Skin Conditions or GG Functional Abilities and Goals A care plan dated 5/29/2024 included that this resident had a right hip fracture related to a fall and included that the resident would be observed for infection at the surgical site. Review of the clinical record did not find a wound assessment of the surgical site. An interview was conducted with a Registered Nurse (RN/staff #7) on 6/3/2024 at 3:11 P.M. who said that a blank spot on the Medication Administration Record (MAR) or Treatment Administration Record (TAR) meant that that was not completed. This nurse said that the nurse admitting the resident is supposed to assess the wounds which would include measuring them. An interview was conducted on 6/4/2024 at 11:46 A.M. with a RN (staff #59). This nurse reviewed the clinical record for resident #19 and said that she was unable to find measurements for the surgical site. An observation was conducted on 6/4/2024 at 9:27 A.M. with a RN (staff #7) who measured a surgical incision on the right hip which was 9 cm in length, fully epithelialized with clear tape over the incision which appeared to be the type applied during surgery. An interview was conducted during the observation with staff #7 who said that wound orders should be in the TAR. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 6/4/2024 at 1:40 P.M with the Director of Nursing (DON/staff #8) who said that she has not had a wound nurse in a few years. She said that the wound assessment tool triggers from the description of the wound and from there they put a treatment in place until a specialist comes in to assess and recommend treatment. She said that initially the staff were not assessing surgical wounds and that they have started recently. She said that her expectation is that the admission staff describe the wound and we have the wound team come in and assess and apply a treatment. She said that the wound team comes Tuesdays and Thursdays. This DON said that wound patients are reviewed during the NAR meeting to see if they are getting better or worse and that it would require measurements to assess if a wound was getting better or worse. She said that she was not able to find any other wound measurements for these residents. Regarding resident #11, She said that if a patient comes with orders, those orders have to be performed and that she did not see an order for or when a low air loss mattress was implemented. She said that the wound care was probably performed but that the nurse probably forgot to document and that resident #19's first wound assessment was 6/4/2024 that included a description and measurements. A policy titled Area of Focus: Wound Assessment & Wound Report revised 11/30/2023 included Wound Management is a daily event not a weekly plan and occurs 7 days a week and that new admissions and new wounds need timely assessment/documentation and treatments implemented preferably at time of admission or within 24 hours, this may require having additional nurses trained in HCA's CWC Certified Wound Champion Curriculum. A policy titled Documentation & Assessment of Wounds reviewed 03/31/2023 revealed that based on the comprehensive assessment of a resident, the facility must ensure that 1. A resident receives care consistent with professional standards of practice to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and 2. A resident with pressure ulcers receives necessary treatment and services consistent with professional standards of practice to promote healing, prevent infection and prevent new ulcers from developing. A policy titled Physician Orders revised 2/26/2024 revealed a physician, physician assistant or nurse practitioner must provide orders for the resident's immediate care and ongoing care of the resident. The facility is obligated to follow and carry out the orders of the prescriber in accordance with all applicable state and federal guidelines.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42319 Based on clinical records, facility documents, staff interviews, and facility policy, the facility failed to ensure residents pressure wounds were assessed and treated per professional standards for 1 residents. (#19). This deficient practice can result in significant increases in morbidity and mortality related to wounds. Findings include: -Resident #19 was admitted on [DATE] with diagnoses of nondisplaced fracture of base of neck of right femur. Review of hospital records dated 5/29/2024 did not include pressure ulcers. An admission MDS dated [DATE] included this resident does not have memory issues and was independent for making decisions for daily life. This MDS was not completed in sections on M Skin Conditions or GG Functional Abilities and Goals. A care plan dated 5/29/2024 did not include pressure ulcers or risk of developing pressure ulcers. An Admission/Readmission Collection Tool included that the resident had a right heel intact clear blister. This note included that the resident was to be seen by the wound team. A progress note dated 5/29/3024 5/29/2024 included that Patient has large intact blister on right heel that daughter is aware of. Heels floated while in bed and she is to be seen by wound team. A progress note dated 5/30/24 included wound team here to see and eval R heel blister with new orders for Tx, medicated as prescribed However, review of the clinical record did not find an assessment or a physician's order for the treatment of the resident's wounds from admission until 6/4/2024. No notes were found regarding a blister/pressure ulcer on the left heel from 5/29/2024 until 6/4/2024. This would indicate that the blister on the left heel was facility acquired. A physician's order dated 6/4/2024 for Saline Wound Wash Solution (Sodium Chloride) Apply to bilateral heel topically as needed for cleansing, then apply foam dressing and to apply protective dressing. This order included to change day shift every 3 days and for soiled or damaged dressing. An observation was conducted on 6/4/2024 at 9:27 A.M. with a RN (staff #7) who greeted resident #19, explained the procedure, then removed wrapped gauze, and a bordered dressing from both heels. This nurse stated that orders should be in the Treatment Administration Record (TAR). This nurse measured a blister on the left heel at 4cm x 2.5cm and stated that it was a closed blister. This nurse then measured the right heel blister as 9cm x 4.5cm with small serosanguinous drainage. This resident's family was in the room during the measurement and stated that the resident's heel was not looked at since admission, however said that they had booties on one night. This nurse looked for the booties found in room and placed on residents' feet. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with a Registered Nurse (RN/staff #7) on 6/3/2024 at 3:11 P.M. who said the nurse admitting the resident is supposed to assess the wounds which would include measuring them. An interview was conducted on 6/4/2024 at 11:46 A.M with a RN (staff #59) who said that who said that the wound team comes Tuesdays and Thursdays and the floor nurses do measurements when they are not here. She said that the first skin check is done by the floor nurses. This nurse said that we definitely note where the wound is at, try to get some measurements, and try to note that in the skin tab and write it in a summary in the end. If it's something that the wound team should see we put it in their book, also we look in their chart and go over the history and physical. An interview was conducted on 6/4/2024 at 11:46 A.M. with a RN (staff #59). This nurse reviewed the clinical record for resident #19 and said that she was unable to find any measurements, or any assessments. An interview was conducted on 6/4/2024 at 1:40 P.M with the Director of Nursing (DON/staff #8) who said that she has not had a wound nurse in a few years. She said that pressure ulcer assessments are to be done promptly and a blister is a stage 2 pressure ulcer. She said that the wound assessment tool triggers from the description of the wound and from there they put a treatment in place until a specialist comes in to assess and recommend treatment. She said that her expectation is that the admission staff describe the wound and we have the wound team come in and assess and apply a treatment. She said that the wound team comes Tuesdays and Thursdays. This DON said that wound patients are reviewed during the NAR meeting to see if they are getting better or worse and that it would require measurements to assess if a wound was getting better or worse. She said that resident #19's first wound assessment was 6/4/2024 that included a description and measurements. She said that her expectations are that the staff do the wound tool to assess the resident, provide a description and get weekly assessments of skin integrity and that the staff should contact the physician to get an order for treatment. A policy titled Area of Focus: Wound Assessment & Wound Report revised 11/30/2023 included Wound Management is a daily event not a weekly plan and occurs 7 days a week and that new admissions and new wounds need timely assessment/documentation and treatmentsnimplemented preferably at time of admission or within 24 hours, this may require havingmadditional nurses trained in HCA's CWC Certified Wound Champion Curriculum. A policy titled Documentation & Assessment of Wounds reviewed 03/31/2023 revealed that based on the comprehensive assessment of a resident, the facility must ensure that 1. A resident receives care consistent with professional standards of practice to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and 2. A resident with pressure ulcers receives necessary treatment and services consistent with professional standards of practice to promote healing, prevent infection and prevent new ulcers from developing. A policy titled Physician Orders revised 2/26/2024 revealed a physician, physician assistant or nurse practitioner must provide orders for the resident's immediate care and ongoing care of the resident. The facility is obligated to follow and carry out the orders of the prescriber in accordance with all applicable state and federal guidelines.