| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 035146 | A. Building<br>B. Wing | 02/14/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Life Care Center of Paradise Valley | 4065 East Bell Road<br>Phoenix, AZ 85032 |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47910<br><br>Based on clinical record review, staff interviews and contract review, the facility failed to ensure one resident (#369) received treatment and care in accordance with professional standards of practice. The facility failed to ensure communication was provided to the family when the resident had a change of condition. This failure has the potential for confusion between resident's family and the facility.<br><br>Findings:<br><br>Resident (#369) was admitted to the facility on [DATE] with diagnosis that included, cardiac arrhythmia, unspecified; Parkinson's disease; bradycardia, unspecified; unspecified dementia with behavioral disturbance; anorexia; major depressive disorder, single episode unspecified.<br><br>Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) record revealed resident score was 03, indicating severe cognitive impairment. Further review of the MDS revealed resident was dependent or required extensive assist with activities of daily living.<br><br>Review of the physician's orders revealed orders for COVID-19 Nasopharyngeal Swab Test one time only for potential COVID exposure for 3 Days. Resident was diagnosed with COVID on July 2, 2020.<br><br>A review of the Care Plan dated September 2, 2020 revealed the following, resident (#369) has a behavior problem psychosis related to diagnoses of dementia, anxiety, bipolar disorder, has impaired cognitive ability/impaired thought processes related to) Dementia.<br><br>There was no evidence in the facility documentation and clinical record that the family or responsible party was notified of a change in the resident's condition.<br><br>On February 14, 2024 at 12:05 PM, an interview was conducted with Social Services Director Staff (#87) and Social Services Assistant Staff (#110). Staff #87 stated during COVID nursing was responsible for notifying families if a resident contracted COVID and it would be as soon as possible. She stated the physician makes the decision to have a conversation with the family if a resident's decision-making capabilities are compromised due to their cognitive status and will also utilize the Ombudsman. She further stated It was oversight on the facility's end that the spouse was not notified of the residents change of condition.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview was conducted with the Director of Nursing (DON/Staff #94) on February 15, 2024 at 2:08PM. She stated nursing is responsible for notifying families for change of condition and the expected timeframe for notification is dependent on the change of condition, but that it is completed within their shift if the nurse is initiating the change of condition. She stated evaluations for decision making abilities are based on the residents BIM score and will, if needed get the physician involved and the Psych provider. She further added if it is documented that the resident is confused, alert to self only they would not be considered as able to make informed decisions for self. The facility would also look at the history of the patient and type of family dynamics with responsible party.<br><br>Review of the facility policy titled Changes in Residents Condition or Status states this facility will notify the resident, his, her primary care provider, and resident's/resident representative of changes in the resident's condition or status. In the case of death of a resident, the resident's physician will be notified immediately by facility staff in accordance with State law. |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46606<br><br>Based on clinical record review, staff interviews, facility documentation, policies and procedures, the facility failed to ensure that one resident (#520) was free from abuse of another. The deficient practice could result in other residents being abused.<br><br>Findings include:<br><br>1.) Resident #520 (alleged victim) was admitted on [DATE] with diagnoses that included Alzheimer's disease, and dementia.<br><br>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that a Brief Interview for Mental Status (BIMS) was not conducted, however the resident was assessed as being severely cognitively impaired. The MDS also indicated that the resident had not exhibited psychosis, behavioral symptoms, or wandering during the assessment period.<br><br>A cognition care plan initiated on October 4, 2022 revealed that the resident has impaired cognitive ability and impaired thought process related to Alzheimer's disease and dementia. Interventions included to allow extra time for resident to respond to question and instructions.<br><br>A communication care plan initiated on October 18, 2022 indicated that the resident has difficulty communicating his needs since he only spoke Spanish. Interventions included to observe for physical/non-verbal indicators of discomfort or distress, and follow-up as needed.<br><br>A progress note dated February 10, 2023 documented that a Certified Nursing Assistant (CNA) found resident #525 (roommate/alleged perpetrator) hitting resident #520 multiple times. Resident #520 was found in his bed curled up. The note indicated that resident #520 stated that I go him by him, I got him by him. The note also documented that resident #520 verbalized pain to his back, head, and right shoulder. Resident #520 was given pain medication. A skin assessment was completed and no visual injuries were noted at the time. The note indicated that the roommate/alleged perpetrator (resident #525) was removed from the room to ensure the residents' safety.<br><br>2.) Resident #525 (alleged perpetrator) was admitted to the facility on [DATE] with diagnoses that included unspecified dementia without behavioral disturbance, psychotic disturbance, and anxiety, and major depressive disorder.<br><br>Review of the cognition care plan initiated on November 18, 2019 revealed that the resident has cognitive deficits related to dementia and cerebral vascular accident (CVA). Interventions included to administer medications as ordered, allow time for resident to respond to questions and instructions.<br><br>A communication care plan initiated on November 18, 2019 indicated that the resident may have barriers to communication related to expressive aphasia secondary to CVA. Interventions included to anticipate and meet needs, allow adequate time to respond, repeat as necessary, do not rush, and request clarification to ensure understanding.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the quarterly MDS assessment dated [DATE] revealed that a BIMS score was not assessed. The MDS also indicated that the resident was negative for psychosis, behavior symptoms, rejection of care, and wandering.<br><br>A nursing note dated February 10, 2023 documented that a Certified Nursing Assistant (CNA) called a nurse to the resident's room after the CNA saw the resident punching his roommate multiple times on the body. The note stated that resident #525 said I fucking him up because he pissed on the floor again. The note indicated that skin assessments were completed on both residents. Resident was removed from the room.<br><br>Review of the clinical record reveals no documentation of the resident having physical altercations with staff or other residents. There were two entries for verbal altercations, one on June 6, 2021 with his roomate, a room change was made and the other was on November 15, 2022 with a staff member.<br><br>A nurse practitioner (NP) note dated February 10, 2023 documented that resident #525 stated that he became frustrated/agitated when his roommate urinated on the floor. The NP note indicated that resident struck his roommate and the NP was notified by nursing staff. The NP note documented that resident stated that he had aggressive behaviors in the past. NP indicated that psych will follow-up.<br><br>Review of the Event Report completed on February 10, 2023 indicated that nurse was notified by a CNA that resident #525 punched his roommate, resident #520 multiple times on the body. The report indicated that no injuries were observed at the time of the incident. The immediate action taken was the resident was removed from the room and placed in the dayroom and skin assessments were completed.<br><br>Review of the facility investigation report submitted February 15, 2023 indicated that a resident to resident altercation between residents #520 and #525 occurred on February 10, 2023 at approximately 5:10 AM. The report noted that a CNA saw resident #525 punching his roommate on the body multiple times. According to the report, resident #520 had urinated on the floor on February 9, 2023 which upset his roommate, resident #525 and resulted in the incident.<br><br>An interview was conducted with a Certified Nursing Assistant (CNA/staff #25) on February 25, 2024 at 12:58 PM. Staff #25 stated that incidents/allegations of abuse are reported immediately. The CNA said that they make sure the resident(s) are safe, then it is reported to the charge nurse and ED (Executive Director). Staff #25 stated that in instances of resident to resident altercation, the staff separates the residents from each other and then talk to them. She noted that incidents are investigated. The investigation entails interview of staff working that day or was working with the residents, and any witnesses.<br><br>In an interview with a Licensed Practical Nurse (LPN/staff #22) conducted on February 25, 2024 at 1:17 PM, Staff #22 stated that in incidents or allegations of abuse, staff makes sure that the resident(s) are safe. Then the administrator is notified immediately. In cases of resident to resident altercation, residents are separated then the administrator is notified. Staff #22 indicated that she was familiar with both residents #520 and #525. She said that she heard there was an incident between them but was not sure of the details since it did not occur during her shift. Staff #22 said that given that one of them is confused and the other was a wanderer, they were not a good fit to be roommates.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview with the Director of Nursing (DON/staff #94) conducted on February 15, 2024 at 2:08 PM, the DON stated that the expectation is that allegations of abuse is reported timely within guidelines and that staff know who to report it to, and what to report. Staff #94 said that the reporting process is initiated when staff reports it to their supervisor. In instances of resident to resident altercation the expectation is that they are separated and the incident reported immediately. Abuse investigations should have information from the individual who reported, interview of everyone directly involved or had the potential to be involved, interview of staff and residents, and review of documentation, care plan, and notification of parties involved.<br><br>Review of the facility policy titled Abuse-Protection of Residents issued October 4, 2022 stated that the facility will ensure that all residents are protected from physical and psychosocial harm during and after the investigation. The policy noted that if the accused abuser is another resident, the residents must be separated while investigating the incident. Interventions must be implemented to assure the safety of all residents.<br><br>The facility policy titled Abuse-Prevention issued October 4, 2022 stated that it is the policy of the facility to prevent and prohibit all types of abuse. It noted that they identify, assess, care plan for appropriate interventions, and monitor resident with needs and behaviors which might lead to conflict. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46606<br><br>Based on clinical record review, staff interviews and policy review, the facility failed to ensure that two resident's (#525, #535) care plans were updated and revised as needed.<br><br>Findings include:<br><br>1.) Regarding resident #525<br><br>Resident #525 was admitted to the facility on [DATE] with diagnoses that included unspecified dementia without behavioral disturbance, psychotic disturbance, and anxiety, and major depressive disorder.<br><br>Review of the quarterly MDS assessment dated [DATE] revealed that a BIMS score was not assessed. The MDS also indicated that the resident was negative for psychosis, behavior symptoms, rejection of care, and wandering.<br><br>A nursing note dated February 10, 2023 documented that a Certified Nursing Assistant (CNA) called a nurse to the resident's room after the CNA saw the resident punching his roommate multiple times on the body. The note stated that resident #525 said I fucking him up because he pissed on the floor again. The note indicated that skin assessments were completed on both residents. Resident was removed from the room.<br><br>Review of the clinical record did not reveal any documentation of physical aggression against staff or residents. There was documentation of a verbal altercation between the resident and his then roomater on June 6, 2020 resulting in a change of rooms and a second verbal altercation with a staff member on November 18, 2022 about moving his wheel chair from a doorway which was blocking access.<br><br>A nurse practitioner (NP) note dated February 10, 2023 documented that resident #525 stated that he became frustrated/agitated when his roommate urinated on the floor. The NP note indicated that resident struck his roommate and the NP was notified by nursing staff. The NP note documented that resident stated that he had aggressive behaviors in the past. NP indicated that psych will follow-up.<br><br>However, review of the care plan post incident revealed that the careplan was not updated to address the resident's behavior and risk for resident to resident altercation. No interventions were put in place to mitigate further resident to resident incidents.<br><br>2.) Regarding resident #535<br><br>Resident # 535 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder, and bipolar disorder, with current episode manic severe with psychotic features.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14 indicating that the resident is cognitively intact. The MDS also indicated that the resident had exhibited verbal behavior symptoms directed towards others which occurred 1-3 days during the assessment period.<br><br>A nursing note dated May 16, 2023 for resident #530, documented that resident #530 stated that her roommate, (resident #535) had threatened to kill her. Resident ##530 denied making any threats to harm her roomate.<br><br>A nursing note for resident #535 documented that resident #530 stated that resident #535 told her I want to smother you with a pillow, and save a knife from the dinner tray and stab you. The note indicated that resident #535 was interviewed and denied threatening her roommate.<br><br>A nurse practitioner (NP) note dated May 24, 2023 indicated that resident #535's chief complaint was that she wanted her own room. Note indicated that resident was moved due to behaviors that resulted in conflict. The note stated that per staff, resident manipulates and make false accusations when she does not get her way.<br><br>Review of the care plan for residnet #535 revealed that it was not updated to address the resident's behavior and risk for resident to resident altercation. No interventions were in place to mitigate potential resident to resident incidents.<br><br>During an interview with the Director of Nursing (DON/staff #94) conducted on February 15, 2024 at 2:08 PM, she stated that her expectation is that following a resident to resident altercation, resident should be put on change on condition to monitor for psychosocial needs, discuss interventions such as move rooms and ensure that staff are aware of how to intervene and provide psych services. Staff #94 said that there should be an update of interventions on the care plan following a resident to resident altercation.<br><br>The facility policy titled Comprehensive Care Plans and Revisions issued March 2, 2022 stated that the facility should monitor the resident over time to help identify changes in the resident condition that may warrant an update to the person-centered plan of care. When these changes occurs, the facility should review and update the plan of care to reflect the changes to care delivery to include additional interventions on existing problems.<br><br>Review of facility policy titled Abuse-Prevention issued October 4, 2022 stated that it is the policy of the facility to prevent and prohibit all types of abuse. It noted that they identify, assess, care plan for appropriate interventions, and monitor resident with needs and behaviors which might lead to conflict. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47910<br><br>Based on clinical record review, staff interviews and review of facility policy and procedure, the facility failed to ensure that one resident (#333) was provided with floor mat for fall prevention and implementation of the care plan. The deficient practice could result in preventable accidents such as falls.<br><br>Findings include:<br><br>Resident #333 was admitted with diagnoses of unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, Alzheimer's disease with late onset hypothyroidism, unspecified, muscle weakness (generalized), difficulty in walking, not elsewhere classified, unspecified lack of delirium due to known physiological condition coordination, cognitive communication deficit, repeated falls, pain in left knee<br><br>A quarterly Minimum Data Set (MDS) assessment dated [DATE], included a Brief interview for Mental Status (BIMS) score of 03 indicating the resident was cognitively impaired the assessment also included that the resident required substantial/max 1 person assist for transfers.<br><br>A care plan included the resident had an Activities of Daily Living (ADL) self-care performance deficit; and that, the resident had a risk for falls due to Alzheimer's Disease and had sustained multiple falls. The Care Plan with a date of 01/03/2024 states a floor mat x1 to extend bed perimeter when in bed.<br><br>An incident note dated January 8, 2024 included that IDT met and discussed event 1/3/24, resident was found on floor in dayroom, nurse performed assessment, small skin tear noted to Right Lower Extremity, able to move extremities on her own, neurological checks started, within normal limit's, resident has advanced dementia/Alzheimer's disease and delirium, unable to articulate desired activity, resident had shortly before event been in bed, appears resident crawled from bed to dayroom, floor mat x 1 placed next to bed to extend bed perimeter when in bed.<br><br>Review of the Fall Risk assessment dated [DATE] revealed resident had falls on 11/27/23, 12/4/23, 12/6/23, 12/19/23, 12/24/23, 01/03/24, 01/06/24<br><br>An observation was made on February 15, 2024 of resident #333 room, no visible floor mat was present.<br><br>An interview was conducted on February 15, 2024, at 12:04 PM with a Certified Nursing Assistant (CNA/staff #79) who stated that she is informed by her nursing supervisor before every shift of residents who are considered a high risk for falls. She stated some of the preventative measures used for fall prevention are non-slip wear, additional supervision, lower beds and floor mats. She further stated most residents who are fall risks have a band on their arms indicating so. CNA Staff # 79 stated she receives report every morning and gives report every afternoon, but has not received any information that resident #333 is supposed to use a floor mat and has never used one on her.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview was conducted on February 15, 2024, at 12:11 PM with a Licensed Practical Nurse (staff #88) who was assigned to the resident for that day. He stated nursing in general is responsible for implementing preventative measures for residents with fall risks and those measures usually involve low beds and floor mats. He further stated the CNA's are informed of the residents with fall risks and what measures are in place and that there is also a meeting at the beginning of day shift of any changes or a resident risk for falls. He stated this information is also found on the Kardex. LPN/Staff #88 stated resident #333 is considered a fall risk and has preventative measures in place by having a low bed and a mat on the floor when resident is in bed. An observation was made by the LPN who noted there was no mat in the resident's room, stating she should have one and he would get one for her.<br><br>An observation was made of LPN/Staff #88 on February 15, 2024, at 12:38 PM carrying a mat in the hallway. He stated it was for resident #333 and was taking it to her room<br><br>Review of the facility policy titled Fall Management, revised 04/07/2022 and reviewed 09/22/2023 states the facility will assess the resident upon admission / readmission, quarterly, with change in condition, and with any fall event for any falls and will identify appropriate interventions to minimize the risk of injury related to falls. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49325<br><br>Based on review of clinical records and policy, observations, and staff interviews the facility failed to ensure transmission-based precautions, particularly enhanced barrier precautions, signage and personal protective equipment were in-place to help prevent development or transmission of infections. The deficient practice could result in development or transmission of infections within the facility.<br><br>Findings include:<br><br>Resident #408 was admitted on [DATE] with diagnoses of surgical aftercare following surgery on the skin, sepsis (unspecified organism), and encounter for attention to gastrostomy. The most recent Admission Minimum Data Set (MDS) assessment revealed a Brief Interview for Mental Status (BIMS) score of 14 which indicated the resident was cognitively intact.<br><br>Review of medical records for Resident #408 revealed the presence of a feeding tube, wound, and a catheter. However, during an observation of care for Resident #408 February 13, 2024 at 10:05 AM, in room [ROOM NUMBER] revealed no transmission-based precaution Centers for Disease Control (CDC) Prevention signage or personal protective equipment (PPE) outside or near the room entrance.<br><br>An interview was conducted on February 13, 2024 at 11:10 AM with Assistant Director of Nursing/Infection Preventionist (ADON/IP/Staff # 43), who stated that the facility does not use enhanced barrier precautions in the facility, and therefore no enhanced barrier precautions signage is outside any room. Staff # 43 stated it was a decision made by everyone because sometimes it is confusing for the staff. Staff # 43 stated the isolation precaution signage that the facility utilizes are only droplet and airborne. Staff # 43 stated the risks of not using appropriate PPE, or displaying transmission-based precaution signage recommended by the CDC, including for enhanced barrier precautions when it is initiated, may result in widespread infection for resident and staff.<br><br>An interview was conducted on February 13, 2024 at 11:22 AM with the Director of Nursing (DON/Staff # 94), who confirmed that enhanced barrier signage was not used in the facility. Staff # 94 stated that the facility follows CDC recommendations in regards to infection control as well as their facility policy, however due to verbiage regarding enhanced barrier by CDC it is up to the discretion of the facility whether to be implemented as well as recommendations made by advisors. Staff # 94 stated the risks of transmission-based precaution signage not being followed is possibly carrying infections to other residents.<br><br>On February 14, 2024 at 8:30 AM a list of resident names with G-tube, J-Tube, wounds, colostomy, nephrostomy, catheters, multi-drug-resistant organisms (MDRO) was requested which revealed the following number of residents in the facility within each category: G Tubes/J Tubes: 5 residents; Wounds: 8 residents; Colostomy, Nephrostomy, Catheter: 11 residents; MDRO: 2 residents.<br><br>On February 14, 2024 at 9:00-9:30 AM an observation of entire facility consisting of the 1st and 2nd floor hallway rooms revealed no PPE or enhanced barrier signage present at any resident room with G Tubes/J Tubes, Wounds, Colostomy, Nephrostomy, Catheter, or MDRO.<br><br>(continued on next page) |

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| Life Care Center of Paradise Valley | 4065 East Bell Road<br>Phoenix, AZ 85032 |

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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | An interview was conducted on February 15, 2024 at 11:45 AM with the Executive Administrator (EA/Staff # 450), who confirmed that the entire management team have access to facility policies. Staff # 450 stated she expects policies to be followed and it would not meet facility expectations if staff did not follow enhanced barrier precaution facility policy.<br><br>The facility's policy and procedure document titled, Transmission-based Precautions and Isolation Procedures (revised September 15, 2023), revealed:<br><br>Standard and transmission-based precautions to be followed to prevent spread of infections.<br><br>Enhanced Barrier Precautions expand the use of PPE beyond situations in which exposure to blood and body fluids is anticipated and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing.<br><br>Enhanced Barrier Precautions can be applied (when Contact Precautions do not otherwise apply) to residents with any of the following:<br><br>Wounds or indwelling medical devices, regardless of MDRO colonization status<br><br>Infection or colonization with an MDRO<br><br>Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include:<br><br>Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator<br><br>Wound care: any skin opening requiring a dressing<br><br>When a resident is placed on transmission-based precautions, the staff should implement the following:<br><br>Place type precaution signage to be initiated on the outside of the resident room in a conspicuous place such as door or on the wall next to the doorway identifying the CDC category or categories of transmission-based precautions (e.g. contact, droplet, airborne, or enhanced), instructions for use of PPE, and/or instructions to see the nurse before entering.<br><br>Make PPE readily available near the entrance to the resident's room. |