STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035146	A. Building B. Wing	01/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Paradise Valley	4065 East Bell Road 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 48812 Based on staff interviews and review of facility documentation, policy, and procedures, the state regulation on record retention, and the State Agency (SA) complaint tracking system, the facility failed to ensure that medical record for one resident (#1) was retained as required by State law. The deficient pratice could result in pertinent clinical information not accessible. Findings include: Review of the SA complaint tracking system revealed that a complaint was submitted by resident #1 on September 30, 2018 at 5:50 p.m. The federal regulation stated that medical records must be retained for the period of time required by State law. The State law in section 36-401 on record retention stated that patient records must be retained for six years after the date of the patient's discharge. The facility letter dated January 18, 2024 and signed by the administrator revealed that the facility was using an offsite storage for medical records. It also included that according to State law, any records older than 6 years are then destroyed; and that, the oldest facility documentation retained off-site would be from 2019. Based on the facility letter, the records for resident #1 had been destroyed before the 6 year time frame. On January 18, 2024, at 12:00 p.m., an interview was conducted with the administrator (staff #120) who stated the facility transitioned to Electronic Medical Records in 2019; and that, the facility did not store any of the records onsite before the transition. The facility policy on Document Management revised on March 31, 2023 included that each facility will provide its own records management in accordance with the company record retention schedule. The policy also included that the facility is responsible for monitoring retention of documents maintained by the facility. An inventory review of all retained records should be conducted to identify records due for destruction.

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