

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035154	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/27/2024
NAME OF PROVIDER OR SUPPLIER Providence Place at Glencroft		STREET ADDRESS, CITY, STATE, ZIP CODE 8641 North 67th Ave Glendale, AZ 85302	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581</p> <p>Based on documentation, staff interviews, and the facility policy and process, the facility failed to ensure that resident (#1) was not abused by a staff (#42). The deficient practice could result in residents being abused by staff.</p> <p>Findings include:</p> <p>Resident #1 was admitted to the facility on [DATE] with diagnoses that included acute and chronic respiratory failure with hypoxia, alcohol cirrhosis of the liver, depression, and acute kidney failure.</p> <p>The minimum data set date July 10, 2024 included a brief interview for mental status score of 15 indicating the resident was cognitively intact. It also included that the resident ambulates in a wheelchair.</p> <p>The care plan dated July 16, 2024 revealed that the resident needs assistance at times with activities of daily living (ADLs) due to cirrhosis of the liver with ascites, asthma, diabetes mellitus, and fracture of the back. Interventions included to assist the resident with ADL care with toileting, and eating. The resident may fluctuate in the amount of care needed, assist or cue the resident to reposition frequently while seated or lying down, and monitor skin integrity during daily care, weekly rounds, and as needed.</p> <p>Review of a psych progress note dated August 14, 2024 revealed that the chief complaint is major recurrent depression severe severity without psychotic features. The resident seen for follow-up. Resident is seen in his room. He is smiling and relaxed. The resident is alert and oriented times four. He has had an improvement in mood and is reporting that he is hopeful for the future and has been making long-term plans. The resident was able to find multiple positives in a situation, this is an improvement from the patient's chronic negative thoughts.</p> <p>Review of a psych progress note dated August 19, 2024 revealed that the resident was seen for follow-up. The resident was seen in his room. Today the resident was resting in bed and was not participating as fully as normally. The resident reports that his mood is meh? today. Resident has had a breakup with his girlfriend and is wanting to rest and nap. The resident is alert and oriented times four. The resident has good eye contact, calm, and staff report baseline mood with some lability.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility training dated August 20, 2024 included Resident/Relationships and the curriculum included, Inappropriate Behavior - Employee to Resident which stated that inappropriate behavior from employee to resident includes, but is not limited to, verbal abuse, sexual harrassment/conduct, inappropriate touching, and aggressive behavior. If an employee engages in, or observes another employee engaging in, such behavior towards a resident, immediately report the incident(s) to human resources or a community support team member. The facility does not permit employees to enter into intimate relationships with residents. Inappropriate behavior can be grounds for discipline and/or termination of employment and removal of the person from the facility campus.</p> <p>Review of the 5-day written investigation dated August 22, 2024 revealed that on August 16, 2024 at 1:27 p. m. resident #1 reported that he had been having a relationship with a certified nursing assistant (CNA/staff #42) or three months. He stated that the relationship began in the shower room and they kissed. The resident stated that he gave staff #42 two gift cards, worth \$50.00, that he had won at the facility, and they were going to go out to eat. Resident #1 revealed that the he and staff #42 had spent the 4th of July together. He stated that the relationship became serious in July 2024 and they had discussed moving in together, getting married in Mexico, she had talked to his grandbabies. Resident #1 stated that he had been calling staff #42 for a few days without a response, until this morning, when staff #42 told him that they cannot be together, it is not good for the resident's health or hers, and she didn't want to deal with his baby mama. Resident #1 reported that he was devastated and his heart was broken. The resident reported that he doesn't want anything done, the relationship was concentual and he still loves staff #42. The resident had text messages and pictures of staff #42 on his phone and stated that they had been in constant contact for weeks. The resident reported being upset and stated that he would try to use a support network for emotional stablization; he cried during the interview. Staff #42 was suspended pending an investigation. Staff #42 left a message that she would not be returning to work because she quit. Facility staff were educated on the code of conduct: romatic/inappropriate relationships with residents is prohibited and can result in termination.</p> <p>An interview was conducted on August 30, 2024 at 1:53 p.m. with resident #1, who stated that four months ago, (CNA/staff #42) was assisting him with a shower and he pulled her towards him and kissed her. He stated that at first she pulled away and then she kissed him. He told staff #42 that he was starting to fall in love with her and she said that she should not do this because she works here. He stated that they never did anything more than kiss at the facility, but he went to her place and they had relations. He stated that she told him that no other man has ever done this to her, sex, the way that he has done it to her. He stated that staff heard him and another male resident (#13) talking about his relationship with staff #42. He was upset because he thought that she was breaking up with him and resident #13 was telling him to be careful because he could get hurt. He stated that the staff told him that if he didn't report it, she would have to report it to the Administrator, and this is why he reported it in the first place. He was not willing to identify the staff. He stated that staff #42 has returned to Arizona and they are back together, she told him that she loved him. They are still planning on getting married. He stated that they have been out to dinner and gone back to her place since she quit her job. He stated that he gave her two gift certificates that he got from the facility, but she has given him things when he was broke. He was not able to name anything that staff #42 had given to him.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility did not have a policy for Staff and Resident Relationships. The facility had documentation for employees Inappropriate Behavior - Employee to Resident which stated, Inappropriate behavior from employee to resident includes, but is not limited to, verbal abuse, sexual harassment/conduct, inappropriate touching, and aggressive behavior. If an employee engages in or observes another employee engaging in, such behavior towards a resident, immediately report the incident(s) to Glencroft Human Resources and or Community Support team member. Glencroft does not permit employees to enter into intimate relationships with residents. Inappropriate behavior can be grounds from discipline and/or termination of employment and removal of the person from the Glencroft campus. The document was dated December 2022.</p>		