STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035154	A. Building B. Wing	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Place at Glencroft	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50116 Based on clinical record review, interviews, review of facility policies and the State Agency (SA) complaint tracking system, the facility failed to ensure residents do not sustain injuries with falls. Having mattresses that fit resident's beds properly will reduce the risk of possible slipping off the bed. Findings include: Resident #1 was admitted to the facility on [DATE], with diagnoses of pneumonia, hemiplegia and hemiparesis following a cerebral infarction affecting right dominant side, hypothyroidism, essential primary hypertension, osteoarthritis, weakness, and repeated falls. A review of the Minimum Data Set (MDS) revealed a staff assessment of the resident, for Brief Interview Mental Status (BIMS) of 14. Meaning the resident was cognitively intact. A review of the Comprehensive Care Plan revealed a focus on the resident's risk of falls due to the history of falls with dates of February 20, 2024, April 26, 2024, October 14, 2024. The problem start date was December 08, 2022. The date of admission. A new long term goal was updated on August 22, 2024. No major injuries from falls thru next review. New intervention was made on October 14, 2024. Replace with correct size mattress. A review of documentation in resident #1's electronic health record (EHR), by Licensed Practical Nurse/staff #5 (LPN) on October 14, 2024, 0520 AM, stated the resident slipped out of her bed, but the CNA assisted her to the floor. The nurse heard resident #1 make a noise as to be in pain, while outside of the room. The resident was assessed for injuries at that time and none were noted. How ever there was a complaint of pain in the feet. A review of documentation in resident's #1 EHR dated October 14, 2024 at 0234 PM by Director of Nursing (DON) Staff member #2, as per Interdisciplinary team (IDT), mattress was replaced to fit better. The provider gave an order for an xray of the left foot on October 15, 2024. The results were returned on October 16, 2024 with Acute to subacute impacted fracture necks of 2nd, 3rd, and 4th metatarsal bones. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On November 01, 2024 at 1039 AM, observed resident #1 sitting in a chair, in their room with the lights off while watching TV. Both legs elevated off the floor resting on a pillow on another chair. Noted for no brace/boot on resident's lower left leg/foot. Positive for wearing nonslip yellow socks. Attempted to ask resident questions regarding the injury. Resident looked over briefly then continued to watch TV. An interview was conducted with CNA/staff #1 on November 01, 2024, at 1043 AM. Was not working when the resident fell , but was aware of the incident. Knows that the residents are fall risks, by observing mats in the room, yellow socks. Fall risk and band on hand and label on chairs. The interventions that are working include putting the bed down, a safe place for the bedside table, an arranging the room to prevent falls. Keep the call light close. If a resident refuses interventions, you need to let them know that they could break bones and tell them in a way they will understand. If a resident falls, or if a resident is found on the floor, notify the nurse right away. An interview was conducted with Licensed Practical Nurse/Staff member #4 (LPN) on November 1, 2024 at 1046 AM. Was not working during the shift of the fall, but later that day. When a patient fall, you assess them first to make sure they are not hurt. Basically assess the situation, do you need to call 911? Call the family, the doctor, get any orders. Let the supervisors know. Attempted to interview DON/staff member #2, how ever was informed that they were off for the day, took a vacation day. Senior Director of Health Services/staff member #3 stated that they could answer questions. An interview was conducted with Senior Director of Health Services/staff member #3 on November 01, 2024 at 1117 AM. Staff have education to prevent falls, including the yearly Relias, education is provided if a specific event that takes place and rounding with staff two to three times per month. Was familiar with the resident's fall. Could not remember what was wrong with the mattress to the bed. It could be it does not fit right, could be too long, too short, worn, a dip in it or could be a tear in it. The resident did have an injury and was not aware of any prior injury to the same foot. They implement interventions to help prevent further falls. The IDT will meet and look at the entire scenario, with a focus on prevent the reason why, if safety is an issue, the CNA is educated immediately, making sure interventions are put in. What is the root cause of the fall and the people who were associated with the fall get educated immediately.