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	02/20/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581 Based on documentation, staff interviews, and the facility policy and reviews, the facility failed to revise the care plan after one resident (#33) fell and had a change of condition. The deficient practice could result in residents not being provided the sufficient level of care needed for safety. Findings include: Review of resident #33's care plan with problem start date of August 31, 2022 revealed that the resident was a low to moderate fall risk due to muscle weakness. The care plan was last edited on February 12, 2025. Interventions included to use a sit-to-stand for transfers going forward. Resident #33's clinical record stated that she was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses that included unspecified fracture of left femur, Hemiplegia and hemiparesis following infarction affecting the left dominant side, and chronic kidney disease. The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 15 indicating the resident was cognitively intact. Review of the Resident Transfer form dated January 27, 2025 revealed that resident #33 was transferred to the hospital due to a fall while being transferred from the toilet to a shower chair. Review of the meeting notes for falls dated January 29, 2025 revealed that the resident was to use stand/lift for transfers. Review of the incontinence care plan dated February 12, 2025 revealed that the resident is incontinent and needs assistance from staff with toileting. Interventions included to encourage the resident to use the restroom on routine rounds and as needed, and to use a sit-to-stand for transfers going forward. Review of the fall risk care plan date February 12, 2025 revealed that the resident has a left side deficit due to status post cerebrovascular accident (CVA) and fall on January 27. Interventions included to use a sit-to-stand for all transfers going forward. (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on February 20, 2025 at 9:26 a.m. with MDS Coordinator (MDS/staff #4) and (MDS/staff #9) who stated that once the MDS id completed, the triggered areas are added to the care plan and if the resident has a change of condition (COC), the care plan is updated. She stated that if a fall occurs, she adds it to the care plan. She reviewed the clinical record and stated that the resident fell on [DATE], so they would have discussed it during the morning meeting on January 28, 2025. She stated that the fall was discussed, but the team didn't know what changes should occur to the resident's care plan because staff didn't have a chance to talk to the resident prior to being transferred to the hospital, so it was decided that they would retrain the staff. She stated that the resident was originally a one-person assist with transfers because she was able to stand by herself for a short period of time. She stated that the fall care plan would be updated after the resident fell because she had a fracture as a result of the fall. Staff #9 referred to the clinical record and stated that the resident was currently a two-person mechanical lift. Staff #4 stated that the purpose of the care plan is so that everyone taking care of the resident knows what to do. During a second interview conducted on February 20, 2025 at approximately 10:55 a.m. with the MDS Coordinator (MDS/staff #4), she reviewed the resident's care plan and stated that there were no new interventions added to the resident's care plan after she fell on [DATE]. An interview was conducted on February 20, 2025 at 2:43 p.m. with the Director of Nursing (DON/staff # 2), who stated that when a residents fall, the team discusses every Wednesday and when the resident fell , the team discussed the possibility of using a lift for transfers. When the resident came back from the hospital on February 6, 2025, the care plan should have been updated to include the use of a lift for transfers. She stated that the purpose of the care plan is so staff have a plan of care to follow and there is a risk to not updating the plan to include the use of a lift. The facility policy, Comprehensive Care Plans states that the comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented as needed.