

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  035174	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/01/2024
NAME OF PROVIDER OR SUPPLIER  Park Avenue Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2001 North Park Avenue Tucson, AZ 85719	

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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42319</p> <p>Based on interviews, records review, policy review, and the SA Complaint Tracking System the facility failed to ensure adequate supervision was provided to one resident (#5) to prevent injury/accident. The deficient practice could result in harm and injury.</p> <p>Findings include:</p> <p>Resident # 5 was initially admitted to the facility on [DATE] with diagnoses of vascular dementia, restlessness and agitation, and senile degeneration of brain.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 5 indicating the resident had severe cognitive impairment. The assessment also included that the resident used a wheelchair and can independently wheel 150 feet in a corridor or similar spaces.</p> <p>The history and physical note dated July 6, 2024 included that the resident had assessments of Chronic Obstructive Pulmonary Disease (COPD), cachectia, mutism and dementia.</p> <p>A psychotherapy evaluation dated July 21, 2024 released the resident had major depressive disorder, insufficient sleep syndrome, and unspecified dementia. It also included that the resident had mild but diffuse memory loss with difficulty remembering recent events and periods of confusion about details, had periods of confusion with disorientation and memory problems, had poor insight into problems, judgement appeared fair and had signs of anxiety.</p> <p>A nursing note dated July 26, 2024 at 12:52 p.m. included that the resident was found sitting in his wheelchair out on the patio with his head bent down and was not verbally responding. Vital signs included blood sugar of 179, temperature of 100.7 degrees Fahrenheit, heart rate (HR) of 151, blood pressure (BP) of 47/23 and oxygen saturation (O2 sat) of 88%. Per the documentation, the family and provider were notified and the resident was transferred to the hospital.</p> <p>A nursing note dated July 26, 2024 at 1:10 p.m. revealed that the nurse spoke with a family member and explained that the resident was on the patio; and that, the family member reported telling the resident it was too hot to go outside.</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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The nursing note dated July 26, 2024 at 1:40 p.m. revealed the nurse was sitting at the nurses station when another floor nurse was rushing past the nurses station with a resident slumped over in wheelchair and stated that she needed help. The documentation included that the resident was rushed to the room at approximately 12:25 p.m.; and that, according to the floor nurse the resident who was slumped over was found outside in the courtyard under the trees with shade by the floor nurse. It also included that the resident was unresponsive while slumped over and had a rattled breathing; and that code blue/medical emergency and Emergency Medical Service (EMS) were called. Per the documentation, the resident was placed on the bed and vital signs were taken: BP was 52/30, HR at 151 beats/min, O2 sat was 88-89 % at room air, blood sugar was 179, and temperature via non-contact forehead was 100.7 degrees Fahrenheit. The note stated another nurse obtained a rectal temperature of patient at 106.6 degrees Fahrenheit, two nurses ran to get ice packs to put on patient at 12:28 p.m.; blood pressure was rechecked and noted at 47/23; and that, the resident was breathing. The documentation included that EMS arrived on site at 12:35 p.m. and obtained vitals: temperature via tympanic was 107.0 degrees Fahrenheit, heart rate at 162 beats/min, blood sugar 188; and, a highflow oxygen was placed via nonrebreather. According to the documentation, the resident was transported to the hospital at approximately 12:40 p.m.; and, the emergency contact, Director of Nursing (DON), and the physician were notified.</p> <p>Another nursing note dated July 26, 2024 at 2:36 p.m. included that the facility received a report from the hospital that the resident had a stable BP of 108/60 and was tachycardic in the 150s-160s.</p> <p>Review of documentation on tasks for wheeling 50 feet and 150 feet from July 3 through July 26, 2024, revealed that the resident could wheel 50 feet with two turns once resident was seated in wheelchair/scooter and was dependent on a helper for all of the efforts on more than 12 days.</p> <p>The documentation on task for chair/bed to-chair transfer from July 3, 2024 - July 26, 2024 revealed resident was dependent and that a helper did all of the effort for 12 days.</p> <p>The weather forecast for July 26, 2024 was a high temperature between 100-104 degrees Fahrenheit.</p> <p>The hospital record dated July 26, 2024 included a chief complaint of AMS (altered mental status)/shock. Per the documentation, the resident was found down in heat unconscious and unresponsive and EMS reported that on arrival, the resident's BP was 38/23 with a heart rate of 150, temporal temperature of 107 degrees Fahrenheit and O2 sat of 84% on room air. This record included that EMS had placed ice on the resident. It also included that the resident was sitting in a wheelchair in the parking lot of the facility and had been there for an unknown amount of time. Assessments included altered mental status, heatstroke and shock.</p> <p>The hospital physician progress note dated July 27, 2024 included that the resident was not responsive to verbal or painful stimuli and was in deep coma.</p> <p>The care plan dated July 27, 2024 revealed resident had COPD. Interventions included monitor for difficulty breathing (dyspnea) on exertion and remind resident not to push beyond endurance.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The care plan dated July 27, 2024 revealed resident was at risk for impaired cognitive function related to diagnosis of dementia. Interventions included monitor/document/report to physician any changes in cognitive function, specifically changes in decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, and mental status.</p> <p>A care plan initiated on July 27, 2024 revealed resident had potential alteration in diversion activities related to preferring to initiate activities of choice independently with goals including encourage to choose and participate in his preferred leisure activities while in the facility. Interventions revealed it is important to resident to go outside for fresh air when the weather is good, resident can wheelchair independently, and to encourage resident to go outside for fresh air when weather is good.</p> <p>The nursing note dated July 27, 2024 revealed that the facility received a report from the hospital nurse that the resident was actively dying with a systolic BP of 40-50.</p> <p>The nursing note dated July 28, 2024 revealed the resident returned from the hospital with hospice and comfort measures in place.</p> <p>An interview was conducted on August 1, 2024 with Licensed Practical Nurse (LPN/staff #168) who stated that when she walked outside at 10:30 a.m. after her medication pass, resident #5 was not out at that time. The LPN stated that the certified nurse assistant (CNA) did pericare to the resident at 10:00 a.m. and 11:00 a.m. The LPN stated that 12:30 p.m. she went out to smoke and found resident #5 sitting where the little brick raised area was and had his head bent down. The LPN also said that she asked the resident if he ate lunch but the resident did not respond so she wheeled him inside for treatment. The LPN said that there was another resident in area where resident #5 was found; and that the other resident reported to the LPN that he had been out in the area for 20 minutes with resident #5 who was already outside even before the other resident came out of the patio. The LPN said that resident #5 just liked sitting outside and was never seen smoking. Further the LPN said that residents who are outside in the smoking area had to be checked every 30 minutes. A follow up interview included that the resident was found in the middle of the courtyard.</p> <p>In an interview with a CNA (staff #101) conducted on August 1, 2024 at 11:47 a.m., the CNA stated that staff gets resident #5 into his wheelchair and once in the wheelchair, resident #5 could get around on his own. He stated that he was the CNA assigned to the resident on the day of the incident. He stated that he saw the resident when he was passing breakfast, when he changed him in the morning; and, before lunch the resident was trying to get to his wheelchair and he told the resident not to do so until he change the resident. The CNA stated that after he changed the resident he put the resident in his wheelchair; and that, he did not see the resident in the dining room when he was passing lunch. The CNA further stated that the resident never goes outside and would always be in the dining room hanging out with his roommate.</p> <p>An interview was conducted on August 1, 2024 at 12:08 p.m. with a resident's family member who said that the facility staff told her that they check on the resident's every 30 minutes while they are outside and that the resident has dementia and has good moments and bad moments.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>An interview conducted August 1, 2024 at 12:52 p.m. with resident #60 included that the facility used to restrict time outside but that since the electric cigarette lighter was installed the residents can go out into the courtyard whenever they like.</p> <p>An interview conducted on August 1, 2024 at 1:09 p.m. with resident #5's roommate (#112), who said that residents can go outside whenever they want; and that, resident #5 liked to go outside and sleep in the sun.</p> <p>An interview was conducted on August 1, 2024 at 3:09 p.m. with another LPN (staff #52) who said that an LPN (staff #168) was heading outside for a smoke break, then came in wheeling resident #5 across the nurses station and that together they treated the resident including performing a rectal temperature which read 106.6 degrees Fahrenheit.</p> <p>An interview was conducted August 1, 2024 at 4:45 p.m. with the Director of Nursing, (DON/staff #161) who said that she felt that the rectal temperature must have been in error, which was why the facility did not report the incident to the relevant authorities. She said that patients were rounded on every 2 hours; and, they have staff that go outside. However, the DON stated that they do not have a policy for residents monitoring while outside. She said that residents were allowed in the courtyard but that immobile residents were not left outside. The DON also said that the residents have access to shade and water; and that, resident #5 was able to move himself and was considered able to make his own decisions.</p> <p>A policy titled Resident Safety revised 5/2021 included that it is the policy of this facility to create a safe environment for the resident and that during the summer months, access to the patio/courtyard will be restricted from 10:00 a.m. to 5:00 p.m. and is subject to change as necessary.</p> <p>A policy titled Incidents and Accidents revised 8/2023 included that it is the policy of this facility to implement and maintain measures to avoid hazards and accidents.</p>