STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035176	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beatitudes Campus	1712 West Glendale Avenue Phoenix, AZ 85021

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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 51006

Based on clinical record review, interviews, facility documentation and a policy review, the facility failed to ensure that one sampled resident (#37) was notified prior to the room change. The deficient practice could result in residents and their representatives, not provided with the opportunity to exercise autonomy regarding their interests, preferences and desires, in regards to a room change.

Findings include:

Resident #37 was admitted on [DATE] with diagnoses of vascular dementia, moderate, with other behavioral disturbance; major depressive disorder, recurrent, moderate; and unspecified dementia, severe, with other behavioral disturbance.

Review of a quarterly Medicare Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 00 indicating resident had severe cognitive impairment.

A social service note dated July, 15, 2024, revealed that Power of Attorney (POA) had called the Social Worker (SW/staff #38); and that, the SW re-iterated information regarding the cancelled room change, that had been previously discussed during a scheduled quarterly care plan meeting. The note also revealed the resident enjoyed the 4th floor and the connections made on the 4th floor.

Review of the electronic health records (EHR) revealed no evidence that the resident or responsible party were provided a written notice prior to the re-initiation of the room change that occurred approximately between the dates of July 22, 2024 and August 3, 2024.

Further review of the EHR revealed that the resident or responsible party did not complete a consent form for a room of change that occurred approximately between July 22, 2024 and August 3, 2024.

An interview was conducted on August 26, 2024 at 11:29AM with the resident's POA, who stated that they had a concern with the resident moving rooms. The POA reported that to their knowledge, a room change took place while the social services coordinator was out of office. The POA stated that there had been a discussion previously to complete a room change, however, it was then discussed that the room change was cancelled. The POA reported that they were unaware of the room change, until they made a visit to the facility; and, was advised that the resident was no longer on the 4th floor, but now on the 3rd floor.

(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: 035176	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER Beatitudes Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 1712 West Glendale Avenue Phoenix, AZ 85021	

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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on August 29, 2024 at 11:20AM with the SW (staff # 38), who stated the room change process start with reaching out to the POA, and/or representative for the update in treatment; and then, a 30-day notice letter are to be sent out to the resident and/or representative. Regarding resident #37, the SW stated that a room change letter had been sent out in June; and that, the POA should have received it. The SW also said that following the letter, they had reached out to the POA and relayed to the POA that the room change had been cancelled. However, the SW admitted that the room change decision and implementation happened while she was out of town. Staff #38 stated that there was miscommunication regarding that room change for resident #37; and that, the room change happened without the proper room change notification expectations. Review of a facility policy titled, Notification of Room or Roommate Change, revealed that notification of room changes will be documented according to the facility's established practices, and to include completion of a Notification of Room or Roommate Changes form signed by the resident and/or resident's legal representative. The policy included that the resident has the right to notification of room or roommate changes and to agree prior to the change taking place.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035176	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER Beatitudes Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 1712 West Glendale Avenue Phoenix, AZ 85021	

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51124 Based on observation, record review, interviews, and facility policy review the facility failed to ensure one resident (#44) was assessed and care planned for the use of a power wheelchair seatbelt and bed rails/mobility bars. The deficient practice could lead to a resident experiencing decreased mobility, possible entrapment, and psychosocial and/or physical harm. Findings include: Resident #44 was admitted into the facility on [DATE] with diagnoses that included acute transverse myelitis, hemiplegia following cerebral infarction, major depressive disorder, and myocardial infarction. The care plan dated October 13, 2022 indicated that the resident required assist with completion of activities of daily living and with mobility due to transverse myelitis and hemiplegia. Another care plan dated October 13, 2022 revealed the resident had a functional decline related to CVa (cerebrovascular disease). Interventions included assistance with ADLs (activities of daily living) as needed) and use cushion in wheelchair. Further review of the care plan revealed no evidence that use of the power wheelchair seatbelt or bedrails/mobility bars on her bed were addressed with interventions implemented. Review of the physician orders revealed no evidence of any orders regarding use or assessment of seatbelt on her power wheelchair or bedrails/mobility bars on her bed. Further, there was no evidence in the clinical record that the resident was assessed for seatbelt use on her power wheelchair or bedrails/mobility bars on her bed. Review of the Treatment Administration Record (TAR) for July 2024 revealed no assessment, intervention, or monitoring, for Resident #44's seatbelt on her power wheelchair or bedrails/mobility bars on her bed. The quarterly Minimum Data Set (MDS) assessment dated [DATE] included a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident had intact cognition. The MDS also included that restraints and alarms, bed rail in bed and trunk restraint used in chair were coded as not used. An observation conducted on August 26, 2024 at 11:57 AM revealed Resident #44 in bed with mobility bars present on the sides of her bed and a power wheelchair with a seatbelt present positioned in front of the bed against the wall. Resident #44 confirmed that this was her personal wheelchair. In an interview conducted on August 29, 2024 at 08:06 AM, Resident #44 stated that the mobility bars sometimes get in her way, but that they were there for a reason. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035176	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER Beatitudes Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 1712 West Glendale Avenue Phoenix, AZ 85021	

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview conducted on August 29, 2024 at approximately 8:10 AM, a licensed practical nurse (LPN/staff #76) stated that he was not aware of any process that the facility had for assessing and monitoring possible restraints. Staff #76 stated that a restraint was considered to be a full side rail on a bed; and, anything that keeps a resident from getting out of bed, chair alarms or straps that restrain a patient. He further stated there were no residents at the facility that had been assessed for possible restraints because the facility does not use restraints. In an interview on August 29, 2024 at 10:07 AM, the Director of Nursing (staff #12) stated that the facility does not restrain anybody; and that, restraints were anything that keeps the resident from getting up from the bed or chair. The DON said that a seatbelt was a restraint if the resident could not self-release; or, siderails were restraints if they cover the whole end of the bed. The DON said that if a resident had a seatbelt on their chair, then the facility conducts an assessment if the resident can self-release the seatbelt and this is documented in the electronic record. During the interview, a review of the clinical record was conducted with the DON who stated that resident #44 did not have any assessment for seatbelt use and bed rail/mobility bars and she could not find any documentation that the resident was assessed for ability to self-release seatbelt and/or use of bedrails/mobility bars. The DON said that if a resident was not assessed for a possible restraint, there was a risk of possible harm such as choking, if resident slide down in the chair, or contractures if they are restrained. Further, the DON said that the expectation was that staff would complete restraint assessment for residents who had a potential restraint and to document it on the TAR as per the facility policy. Review of the facility's policy on Restraint Free Environment revealed that restraints was defined as any physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Physical restraints may include but are not limited to: using bed rails that keep the resident from voluntarily getting out of bed and using devices in conjunction with a chair such as trays, bars, or belts, that the resident cannot remove and prevents the resident from rising. Before a resident is restrained, the facility will determine the specific medical symptom that warrants the use of the restraint, the type of direct monitoring and supervision that will be provided during the use of the restraint, how the resident will request staff assistance while the restraint is in place, and how to assist the resident in attaining or maintaining his or her highest practicable level of physical well-being. Finally, the care plan should be updated accordingly to include the development and implementation of interventions, to address any risks related to the use of the restraint.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035176	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER Beatitudes Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 1712 West Glendale Avenue Phoenix, AZ 85021	

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51103 Based on clinical record review, staff interview, and policies and procedures, the facility failed to ensure that a comprehensive person-centered care plan with interventions related to use of oxygen was developed for one resident (#38) and related to the use of a power wheelchair seatbelt and bed rails/mobility bars for one resident (#44). The deficient practice could result in the resident not receiving the necessary care and services according to their assessed needs. Findings include: Resident #38 was readmitted to facility March 28, 2024 with diagnoses of chronic obstructive pulmonary disease (COPD), acute and chronic respiratory failure. The physician note dated March 29, 2024 revealed that resident had an oxygen saturation of 90% on room air, had an oxygen flow rate of 2 liters, and a respiratory rate of 18 breaths per minute. The documentation included that resident was oxygen dependent without any shortness of breath or wheezing while on 2 liters of oxygen. Diagnoses included emphysema and chronic hypoxemic respiratory failure. Plan was to continue oxygen at 2 liters for chronic hypoxemic respiratory failure. A physician order dated March 30, 2024 included to change oxygen tubing weekly and to initial and date when the change was done. Another physician order dated March 30, 2024 included for supplemental oxygen at 1-4 liters via nasal cannula in order to keep resident oxygen level above 90%. Review of the Significant change in status Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 11 which indicated resident had cognitive impairment. The MDS also included that resident experienced shortness of breath while lying flat or with exertion and used oxygen. Review of hospice comprehensive assessment and plan of care dated July 15, 2024 revealed an order to initiate oxygen at 2-4 liters via nasal cannula continuously or as needed as indicated. The pain/palliative care consult notes dated July 24, 2024 revealed the resident was oxygen dependent. The physician visit note dated July 31, 2024 assessment statement stated resident was oxygen dependent due to COPD. Despite documentation that the resident was on oxygen therapy, the care plan related to oxygen use was not developed with interventions until August 28, 2024. The care plan with revision date of August 28, 2024 included the resident was expected to lose weight related to emphysema, angina at rest, paroxysmal atrial fibrillation and chronic hypoxemic respiratory failure. Intervention included to administer oxygen as ordered. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035176	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER Beatitudes Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 1712 West Glendale Avenue Phoenix, AZ 85021	

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with a licensed practical nurse (LPN/staff #60) on August 26, 2024 at 1:09 p.m. The LPN stated that resident #38 should have the oxygen via nasal cannula on. An interview with Assistant Director of Nursing (ADON/staff #68) conducted on August 27, 2024 at approximately 1:00 p.m. The ADON stated that care plans were created on admission, and updated as needed to meet the needs of the resident. ADON located the administrate oxygen intervention in Beatitudes care plan version. ADON believes the oxygen care planning portion was handled by Hospice of the Valley, and will obtain a copy for the surveyor. An interview with the ADON and the restorative nurse assistant (RNA/staff#78) was conducted on August 29, 2024 at 1:28 p.m. Both the ADON and the RNA said that the resident should have the oxygen on her. In an interview with the ADON conducted on August 30, 2024 at approximately 9:00 a.m., the ADON stated that resident #38 was often encouraged to wear oxygen as ordered on a regular basis to prevent shortness of breath and discomfort. The facility policy on Oxygen Therapy included that care planning for oxygen should include oxygen delivery type, time to administer, equipment settings, monitoring of oxygen saturation levels, and monitoring for complications. Review of the facility policy on Comprehensive Care Plan revealed that the care plan will include measurable objectives and timeframes to meet the resident's needs. The objectives will be utilized to monitor the resident's progress. 51124 -Resident #44 was admitted on [DATE] with diagnoses of included acute transverse myelitis, hemiplegia following cerebral infarction, major depressive disorder, and myocardial infarction. The care plan dated October 13, 2022 indicated that the resident required assist with completion of activities of daily living and with mobility due to transverse myelitis and hemiplegia. Another care plan dated October 13, 2022 revealed the resident had a functional decline related to CVa (cerebrovascular disease). Interventions included assistance with ADLs (activities of daily living) as needed) and use cushion in wheelchair. Further review of the care plan revealed no evidence that use of the power wheelchair seatbelt or bedrails/mobility bars on her bed were addressed with interventions implemented. The quarterly Minimum Data Set (MDS) assessment dated [DATE] included a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident had intact cognition. The MDS also included that restraints and alarms, bed rail in bed and trunk restraint used in chair were coded as not used. An observation conducted on August 26, 2024 at 11:57 AM revealed Resident #44 in bed with bed rails/mobility bars present on the sides of her bed; and, a power wheelchair with a seatbelt present positioned in front of the bed against the wall. Resident #44 stated that this was her personal wheelchair. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035176	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER Beatitudes Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 1712 West Glendale Avenue Phoenix, AZ 85021	

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview conducted on August 29, 2024 at 08:06 AM, Resident #44 stated that the mobility bars sometimes get in her way, but that they were there for a reason. Review of the facility's policy on Restraint Free Environment revealed that the care plan should be updated accordingly to include the development and implementation of interventions, to address any risks related to the use of the restraint.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035176	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beatitudes Campus	1712 West Glendale Avenue Phoenix, AZ 85021

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51103 Based on clinical record review, observations, interviews, and policy review; the facility failed to ensure oxygen was administered as ordered for one resident (#38); and, failed to ensure there was a physician order for the use of oxygen for one resident (#50). The deficient practice could result in resident complication and respiratory distress and hospitalization . Findings include: -Resident #38 was readmitted to facility March 28, 2024 with diagnoses of chronic obstructive pulmonary disease (COPD), acute and chronic respiratory failure. The physician note dated March 29, 2024 revealed that resident had an oxygen saturation of 90% on room air, had an oxygen flow rate of 2 liters, and a respiratory rate of 18 breaths per minute. The documentation included that resident was oxygen dependent without any shortness of breath or wheezing while on 2 liters of oxygen. Diagnoses included emphysema and chronic hypoxemic respiratory failure. Plan was to continue oxygen at 2 liters for chronic hypoxemic respiratory failure. A physician order dated March 30, 2024 included to change oxygen tubing weekly and to initial and date when the change was done. Another physician order dated March 30, 2024 included for supplemental oxygen at 1-4 liters via nasal cannula in order to keep resident oxygen level above 90%. The pain/palliative care consult notes dated April 26, May 1 and May 16, 2024 revealed the resident was oxygen dependent. Review of the Significant change in status Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 11 which indicated resident had cognitive impairment. The MDS also included that resident experienced shortness of breath while lying flat or with exertion and used oxygen. The pain/palliative care consult notes dated July 24, 2024 revealed the resident was oxygen dependent. The physician visit note dated July 31, 2024 assessment statement stated resident was oxygen dependent due to COPD. The care plan with revision date of August 28, 2024 included the resident was expected to lose weight related to emphysema, angina at rest, paroxysmal atrial fibrillation and chronic hypoxemic respiratory failure. Intervention included to administer oxygen as ordered. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035176	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER Beatitudes Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 1712 West Glendale Avenue Phoenix, AZ 85021	

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with a licensed practical nurse (LPN/staff #60) on August 26, 2024 at 1:09 p.m. The LPN stated that the oxygen concentrator was turned on at 1.5 liters but was not on the resident because the resident's nasal cannula was on the floor. She stated that the resident should have the oxygen via nasal cannula on; and that, the LPN encouraged the resident compliance with oxygen use and the importance of keeping the nasal cannula on. Further, the LPN instructed the resident to notify staff if the nasal cannula falls off or causes discomfort. On August 27, 2024 from 8:00 p.m. through 10:00 p.m., the facility had a power outage and was using their emergency power system. An observation was conducted on August 29, 2024 at 1:28 p.m. The resident was lying supine in bed and was pushing the buttons on the bed controls which were not working. The resident laid flat with three pillows on head of bed and tried to reposition herself in bed and attempted to sit up; and, did not have the oxygen via nasal cannula on. The resident attempted to reach the call light but was unable to because it was on the side table by her bed. The resident's wheelchair was close to bottom right of bed, with an oxygen tank attached to back of chair; and, the arrow on the oxygen tank pressure gauge pointed to distal end of red area. There was no nasal cannula or tubing attached to the tank. The oxygen concentrator was uncovered and unplugged to the left of resident's dresser with the nasal cannula wrapped around concentrator handle. The nasal cannula was labeled with date August 26, 2024 only and was uncovered while on concentrator. There was no red wall outlet found in the resident's room. The resident complained of not being able to get comfortable, was having difficulty in breathing and requested to have her oxygen brought over and to help elevate her head. The assistant director of nursing (ADON/staff #68) and the restorative nurse assistant (RNA/staff#78) were called to join in the observation. The ADON elevated the resident head using a pillow, and placed pulse oximeter on the resident's finger. The resident's oxygen saturation reading was 87% at 1:45 p.m. and 86% at 1:59 p.m. Both the ADON and RNA stated that the resident's portable oxygen tank on the wheelchair had a pressure gauge in red zone. Both staffs stated that the resident should have the oxygen on her. The RNA immediately left the resident room and came back with an oxygen tank replacement; and, the resident was transferred from bed to chair and was brought to the medication cart area by dining room. At 2:02 p.m., the resident's oxygen saturation was 89 % at 2 liters via nasal cannula. At 2:07 p.m., oxygen was increased to 4 liters; and at 2:09 p.m., resident's oxygen saturation was 92%. In an interview with the ADON conducted on August 30, 2024 at approximately 9:00 a.m., the ADON stated that resident #38 was often encouraged to wear oxygen as ordered on a regular basis to prevent shortness of breath and discomfort. Review of the facility policy entitled Oxygen Concentrator states to keep the oxygen concentrator set up turned off when not actively in use. Facility policy further instructs to keep oxygen delivery devices covered in a plastic bag when not in use. Policy also includes that it is the nurse responsibility to change oxygen tubing and cannula weekly, and as needed if it becomes soiled or contaminated. Review of the policy entitled Oxygen Therapy states the reason for the administration of oxygen is to treat or prevent the symptoms and manifestations of hypoxia. Policy further dictates that staff shall notify the physician of any changes in the resident's condition, including changes in vital signs, oxygen concentrations, or evidence of complications associated with the use of oxygen. 43863 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035176	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER Beatitudes Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 1712 West Glendale Avenue Phoenix, AZ 85021	

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident #50 was admitted on [DATE] with diagnoses that included metabolic encephalopathy, Type 2 diabetes mellitus, and congestive heart failure. A physician order dated June 11, 2024 revealed an order for oxygen (O2) saturations (sat) every shift for O2 use. Review of the Medical Record Administration (MAR) for June through August 2024 revealed no evidence that oxygen was administered to the resident. The care plan dated June 23, 2024 included that resident was on for oxygen therapy. Interventions included to administer oxygen as ordered by the medical doctor, and safety per protocol. Review of a comprehensive Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 10 which indicated the resident had moderate cognitive impairment. The assessment also included that the resident was receiving oxygen therapy. An amended provider progress note dated July 11, 2024, revealed no evidence on the medication review list that Resident #50 was receiving oxygen. Per the documentation, the staff increases the oxygen to 5 liters. However, the documentation did not include any oxygen orders such as oxygen liters required and whether or not oxygen was to be administered continuously. A provider progress note dated August 24, 2024 revealed the resident had continued hypoxia and need for oxygen. Assessment of chest and lungs revealed the resident was on 4 liters via nasal cannula, continuous oxygen and a plan to continue oxygen supplementation. The medication review list section did not include the resident was receiving oxygen. Despite documentation that the resident was on oxygen, the clinical record revealed no evidence of a physician orders for administration of oxygen from January 1 through August 29, 2024 revealed An observation conducted on August 27, 2024 at 8:20 a.m. revealed resident #50 was lying in bed with oxygen being administered via a nasal cannula. In another observation conducted on August 28, 2024 at 9:30 a.m., the resident was lying in bed, awake and able to converse, with oxygen administered via nasal cannula. Another observation was conducted on August 29, 2024 at 9:31 a.m. and revealed that the resident was lying in bed with a certified nursing assistant (CNA) assisting him with breakfast. The resident had oxygen on via nasal cannula. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035176	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beatitudes Campus	1712 West Glendale Avenue Phoenix, AZ 85021

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on August 29, 2024 at 9:52 a.m. with a Licensed Practical Nurse (LPN/staff #29), who stated that resident #50 had been on the 4th floor for a couple of months, received oxygen continuously since then, and had been administered oxygen when he was on the other unit. The LPN stated that a physician order for oxygen would be required in order to administer oxygen to a a resident. A review of the clinical record was conducted by the LPN during the interview and the LPN stated that she found no physician order to administer oxygen to the resident; and that, there was also no documentation in the MAR and TAR that oxygen was administered to the resident. She further stated that the only physician order related to oxygen that in the clinical record was the order for oxygen saturations every shift for oxygen use; and this indicated that the resident was on oxygen. The LPN further stated that the clinical record revealed there was no evidence of discontinued or deleted orders for oxygen administration for resident #50. An observation of resident #50 in his room was conducted with the LPN who stated that the resident was receiving 4.5 liters of oxygen via nasal cannula. Further, the LPN said that there should have been a physician order for oxygen use for resident #50; however, there was none and this was an error. The LPN stated that resident #50 was administered oxygen without a physician order and this did not meet the facility policy. An interview with resident #50 was conducted on August 29, 2024 at 10:11 a.m. The resident stated that he had been receiving oxygen for about 3 months. During an interview with the Director of Nursing (DON/Staff #12) was conducted on August 29, 2024 at 10:20 a.m. The DON stated that the expectation was that there was physician order for oxygen use and monitoring of oxygen saturation for residents receiving oxygen. A review of the clinical record was conducted by the DON who stated that there was no evidence of a physician order for oxygen administration; and that, resident #50 was currently receiving oxygen. The DON further stated that this situation did not follow the facility policy, and the risk could result in residents receiving oxygen that they may not require. An interview was conducted with an LPN (staff #76) on August 29, 2024 at 10:31 a.m. The LPN stated that resident #50 was transferred to the unit about a month ago; and, the resident had been administered oxygen since June 2024. Further, the LPN stated that oxygen administration required a physician order. Review of a facility policy titled, Oxygen Administration, revealed that oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. Oxygen is administered under orders of a physician, except in the case of an emergency. Review of a facility policy titled, Medication Orders, revealed that medications should be administered only upon the signed order of a person lawfully authorized to prescribe. Verbal orders should be received only by licensed nurses, or pharmacists, and confirmed in writing by the physician, on the next visit to the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035176	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER Beatitudes Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 1712 West Glendale Avenue Phoenix, AZ 85021	

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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Post nurse staffing information every day. 51124 Based on observations and staff interviews, the facility failed to ensure daily staff posting was current and posted at the beginning of each shift. The deficient practice could result in the accurate daily staffing information not available to residents and visitors. Findings include: An observation in 4th floor was conducted on August 26, 2024 at 8:36 a.m. The daily staff posting was located on the wall by the elevators and across from the 4th floor nurse's station. The daily staff posting was dated January 3, 2024. On August 26, 2024, at 8:40 AM, an observation in the 3rd floor was conducted; and, the daily staff posting was found on the wall by the elevators and across from the 3rd floor nurse's station. The daily staff posting was dated August 6, 2024. An observation in the 4th floor was conducted on August 27, 2024 at 7:57 AM. There was no daily staff posting found on the 4th floor. An observation in the 4th floor was conducted on August 28, 2024 at 8:00 AM. There was no daily staff posting found on the 4th floor. In an interview with the director of nursing (DON/staff #12) conducted on August 29, 2024 at 12:25 PM, the DON stated that the daily staff posting was located on the 3rd floor by the nurse's station; and that, the residents on the 4th floor and their family can ask for the daily staffing information. The DON provided a copy of the daily staff posting dated August 26, 2024 and stated that this posting was previously posted on the 3rd floor on August 26, 2024. Review of the daily staff posting provided by the DON revealed that the date was altered from what appeared to be 8/06/24 and changed to 8/26/24. An interview with the administrator (staff #59) was conducted August 29, 2024 at approximately 12:27 PM. The Administrator stated that a lot of residents from the 4th floor frequently come to the 3rd floor for activities, resident council, or to meet with the Director of Nursing in her office, and would be able to see the daily staff posting. The administrator said that the residents from the 4th floor who do not participate in activities, resident council, or to meet with the Director of Nursing in her office can be brought to the 3rd floor any time or the resident can go to the 3rd floor themselves if they want. Further, the administrator said that staff had not educated residents and their families on the daily staff posting located on the 3rd floor. In an interview with a registered nurse (RN/staff #49) at the 4th floor conducted on August 30, 2024 at 6:56 AM. The RN stated that there usually was a daily staff posting on the 4th floor. The RN then pointed to the empty space on the wall by the elevator across from the nurse's station where there was a pushpin present in the wall. However, there was no daily staff posting posted on the wall; and, the RN stated that there was a daily staff posting found on the 3rd floor as well.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035176	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER Beatitudes Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 1712 West Glendale Avenue Phoenix, AZ 85021	

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50862 Based on observations, staff interview, and policy review, the facility failed to ensure that the third-floor resident nourishment refrigerator food was stored in accordance with professional standards for food service safety. The deficient practice could result in food growing harmful bacteria that is a risk factor to cause foodborne illness. Findings include: During an observation of the third-floor nourishment refrigerator conducted on August 27, 2024 at 12:50 PM, revealed upon the refrigerator shelves, two fruit plates that were undated and partially uncovered. On half of the two paper-plates were green grapes and banana slices, and on the other half of paper plate were red color (strawberry color) liquid puddles with red stain soaked into the paper plate. The section of the plates with red color puddled juices had the clear plastic wrap pulled back leaving both plates partially uncovered with the banana slices and grapes exposed. An interview was conducted on August 27, 2024 at 12:57 PM with the registered dietician (RD/staff #35) near the third-floor secured nourishment refrigerator. Registered Dietician (#35) stated that the two fruit plates located within the nourishment refrigerator were from the night-shift staff, and that staff should have placed a use-by dated sticker on each plate and recovered the plates with saran wrap. The registered dietician opened the third-floor nourishment refrigerator and removed the two un-dated fruit plates and disposed. Review of the facility policy titled, Production, Purchasing, Storage; Food and Supply Storage revealed that the procedures are to cover, label and date unused portions and open packages with a completed orange-color label system. Products are good through the close of business on the date noted on the orange label and to discard food past the use-by or expiration date.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035176	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beatitudes Campus	1712 West Glendale Avenue Phoenix, AZ 85021

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program.

50887

Based on observations, staff interviews, and policy review the facility failed to ensure that infection control practices and standards were followed; failed to perform hand hygiene during provision of care; failed to ensure reusable resident equipment was cleaned and disinfected after its use. The deficient practice could result in the spread of disease and infections to residents. The facility census was 52 residents.

Findings include:

-Regarding wound care observation:

During a wound care observation for Resident (#7) conducted on August 28, 2024 at 8:17 AM, the licensed practical nurse (LPN/staff #29) took a multiuse wound wash solution and betadine container from the treatment cart and into the resident's room. During the course of treatment application, the LPN (staff #29) touched the wound wash and betadine container with gloves used to removed soiled dressing; and, following the application of the wound treatment, staff #7 removed her gown and gloves, and returned the betadine and wound wash bottles directly to the wound treatment cart without sanitizing the bottles.

An interview was conducted on August 28, 2024 at 8:17 AM with the LPN (staff #29) who stated that supplies used on residents during treatment down, staff would wipe them down with sanitizing/bleach wipes to ensure infection would not spread to other residents. Regarding the wound care observation, the LPN said that she should have sanitized or wiped down the wound wash solution and betadine containers that were brought into resident (#7)'s room before putting them back in the unit's treatment cart.

An interview with the Director of Nursing (DON/Staff #12) was conducted on August 29, 2024 at 1:49 PM. The DON stated that any item used on a resident should be cleaned when it leaves the resident's room; and that, it would not meet the facility's protocol if the items were not cleaned prior to putting them back into the treatment cart.

The facility policy titled, Wound Care revealed that after wound treatment is completed, reusable supplies are to be wiped with a sanitizing agent as indicated (outsides of containers that were touched by unclean hands, scissors, blades, etc.) prior to returning the supplies to the treatment cart.

-Regarding Enhanced Barrier Precautions:

During an observation on the 4th floor conducted on August 26, 2024 at approximately 8:45 a.m., there were residents on enhanced barrier precautions (EBP). However, there were no EBP signs posted in the walls of resident rooms in the hallway.

On August 26, 2024 at 10:04 AM, the social services director (SSD/staff # 38) walked down the hallway on the 4th floor and placed the enhanced barrier precautions (EBP) signs next to resident's rooms. At 10:11 a.m. , multiple staff were placing EBP signs in the hallway next to resident's rooms.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035176	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER Beatitudes Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 1712 West Glendale Avenue Phoenix, AZ 85021	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with the Director of Nursing (DON/Staff #12) on August 27, 2024 at 1:01 PM. The DON stated that staff were expected to use gown, gloves, and a face shield (for splashing) when providing care to residents on EBP. She then stated the EBP policy included that staff would use personal protective equipment (PPE) for any resident care. The DON further stated that staff would know that the resident/s was on EBP because there would be a sign on the resident's door and staff had worked on the unit all the time. The DON stated that she saw staff putting EBP signs by the resident's rooms that morning the survey team arrived on the unit. She further stated that not having EBP signage posted was considered an issue and the risk to the residents would include spread of infection. In an interview with a Certified Nursing Assistant (CNA/Staff #87) conducted on August 28, 2024 at 10:15 AM, the CNA stated that she would have to wear a gown and gloves anytime she goes into the room of residents on EBP for any task that needed to be done. The CNA further stated that she would know which residents were on EBP by the EBP signage outside the resident's room or the nurse would let her know. She also stated that the EBP signs were posted in the hallways by the resident's room on her last shift on Friday, August 23, 2024; however, she was not aware the signs had been taken down before the survey team arrived on the unit. The facility's policy titled, Enhanced Barrier Precautions, revealed that the facility would have discretion on how to communicate to staff which residents required the use of EBP, as long as staff were aware of which residents required the use of EBP during high-contact care activities. -Regarding hand hygiene: An observation conducted on the fourth-floor unit on August 26, 2024 at 8:30 AM, revealed that hand sanitizer was not accessible inside or immediately outside of resident's rooms. During a facility observation conducted on August 26, 2024 at 8:47 AM, the Certified Nursing Assistant (CNA/Staff #22) performed hand hygiene and put on gloves before transferring a resident into bed from a wheelchair using a gait belt. After the transfer, the CNA (Staff #22) removed her gloves but did not perform hand hygiene upon leaving resident's room. Hand sanitizer was not observed outside of resident's room. Further observation conducted on August 26, 2024 at 9:36 AM, a CNA (Staff #16) transported resident (#28) back to her room via wheelchair. The CNA (Staff #16) walked over to another resident (#38) and lifted up her blanket. The CNA (Staff #16) then walked back over to resident (#28) and took the resident back out of the room via wheelchair. The CNA (Staff #16) did not perform hand hygiene between resident interactions or when leaving the room. An interview was conducted on August 26, 2024 at 8:30 AM with a Certified Nursing Assistant (CNA/Staff #16), who stated that the hand sanitizer was located on the unit's medication cart and at the nurse's station. She further stated if the staff did not have time to go the nurse's station or medication cart that they would wash their hands going in and out of the resident's room. An interview was conducted on August 28, 2024 at 10:15 AM with a CNA (Staff #87), who stated that hand hygiene would be performed using either soap and water in the resident's room or hand sanitizer. She further stated that hand hygiene would be performed before and after touching residents and upon entering and leaving the resident's rooms. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035176	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER Beatitudes Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 1712 West Glendale Avenue Phoenix, AZ 85021	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on August 29, 2024 at 10:24 AM with the Assistant Director of Nursing (ADON/Staff #68), who stated the policy for hand hygiene included the expectation that staff was to wash or use hand sanitizer between resident contact. She further stated that hand sanitizer was located at the nurse's station and on the medication cart. The ADON (Staff #68) was informed of the observations of CNA (Staff #16) from August 29, 2024. The ADON stated that she would speak with CNA (Staff #16) to correct the behavior. An interview was conducted on August 27, 2024 at 1:01 PM with the Director of Nursing (DON/Staff #12), who stated that hand hygiene would be performed before and after contact with a resident, and at meal times. She also stated that the fourth floor was previously a dementia unit so there were no hand sanitizers installed in the hallways. The DON (Staff #12) stated that she expected staff to wash their hands when going in or out of resident rooms. The facility policy titled, Hand Hygiene, revealed that hand hygiene is a general term for cleaning hands by either handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub. The policy indicated that staff would perform hand hygiene when indicated, and that the use of gloves did not replace hand hygiene. If the task required gloves, the staff would perform hand hygiene prior to putting on gloves and immediately after removing gloves. 51103 -Regarding resident equipment During an observation in the dining area conducted on August 28, 2024 at approximately 7:45 a.m., the licensed practical nurse (LPN/Staff #29) attempt wrist BP (blood pressure) check on resident and the wrist cuff reading was unsuccessful. The LPN returned the wrist cuff to the medication cart, obtained a manual arm cuff from cart and used it to get a BP from the same resident. The LPN then returned both the wrist and the arm BP cuffs into the medication cart without disinfecting or wiping them down. An interview with the with LPN (staff #29) was conducted on August 28, 2024 at approximately 7:50 a.m. The LPN said that it was necessary to wipe down equipment before locking it inside the medication cart to avoid spreading any type of infection. However, the LPN stated that she forgot for wipe down or disinfect the wrist and arm cuff she used on one resident before putting it back in the medication cart. An interview with the assistant director of nursing (ADON/staff #68) was conducted on August 28, 2024 at approximately 9:15 a.m. The ADON stated that dirty items should never be placed in the medication cart; and, all resident equipment should be wiped down with approved disinfectant wipes to avoid spreading of infection before and after each resident use. The DON (staff #12) joined the interview and stated that resident equipment such as BP cuffs were usually wiped down with disinfectant wipes; and that, staff were to use the alcohol prep pads located in the medication cart when disinfectant wipes were not available. A review of facility policy entitled Medication Administration included that medication cart/storage should be kept clean, organized, and stocked with adequate supplies in order to break the chain of infection. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035176	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beatitudes Campus	1712 West Glendale Avenue Phoenix, AZ 85021

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy on Cleaning and Disinfection of Resident Care Equipment revealed that blood pressure cuffs were classified as reusable multiple resident non-critical item. Multiple-resident use equipment was to be cleaned and disinfected after each use. The staff should follow established infection control principles for non-critical equipment. 51124 -Regarding Foley catheter bag An observation was conducted on August 28, 2024 at 7:51 AM. The resident (#19) was lying in bed with his indwelling catheter bag laying on the floor beside the resident's bed. Another observation was conducted on August 28, at 11:07 AM and revealed the resident (#19) was in bed with the indwelling catheter bag on the floor beside the resident's bed. In an interview on August 28, 2024, at 11:37 AM, a certified nursing assistant (CNA/staff #11) stated that the catheter bag should not be on the floor in order to stay clean. An interview with another CNA (staff #1) was conducted on August 28, 2024, at 11:42 AM. The CNA (staff #1) stated that the catheter bag should not be on the floor, and if it is on the floor, then there is a risk of infection. An observation of resident #19 was conducted with the CNA (staff #1) during the interview; and, the CNA stated that the resident's indwelling catheter bag was on the floor and it should not be. The CNA said that she would get a bag for it in order to hang it on the side of the bed. During an interview conducted on August 29, 2024, at 12:44 PM, the Director of Nursing (DON/staff #12) stated that a catheter bag should not be on the floor, and that there was risk of infection if it was on the floor. Review of the facility's policy titled Appropriate Use of Indwelling Catheters revealed that indwelling catheters (urethral or suprapubic) will be utilized with current standards of practice, with interventions to prevent complications to the extent possible. Possible complications include but are not limited to: urinary tract infection, blockage of catheter, pain, discomfort, and bleeding.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035176	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER: Beatitudes Campus		STREET ADDRESS, CITY, STATE, ZIP CODE: 1712 West Glendale Avenue Phoenix, AZ 85021	

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 51158 Based on observations, staff and resident interviews, and the facility's documentation and policies, the facility failed to ensure a safe and comfortable environment for residents. The deficient practice could result resident not having a homelike environment and risk for injury and harm. Findings include: Review of the open work order report generated on July 15, 2024 did not reveal any work order pertaining to any of the issues identified during the walk-through observations. During the initial tour of the 4th floor unit conducted on August 28, 2024 at 12:17 PM., multiple rooms were found to have the following: -Water stains on the ceiling tile; -Door frame had a splatter of a brown substance; and, -Temperature probe above the dining area on the 4th floor had built up substance and appeared to be leaking. An interview with a Licensed Practical Nurse (LPN/ #29) was conducted on August 29, 2024 at 12:58 PM. The LPN (staff #29) stated that there was a work order website to put an order in and that staff can always call into the maintenance department. An interview with the Senior Maintenance Engineer (staff #205) was conducted on August 30, 2024 at 8:04 a. m. Staff #205 stated that he conducts a walkthrough of the facility unit/s at least once a week; and that, the maintenance technician for the building does daily walkthroughs to check in and speak with nursing staff to see if anything needs to be done that was not currently in their work orders. Staff #205 stated that staining on the walls/ceilings would be suspicious and the facility would try to get them changed out to find the source of the problem. Staff #205 stated that the staining could occur due to moisture coming from something. Staff #205 further stated that it may be aesthetically unpleasing and anytime there was a high moisture situation there was the chance of mildew. An interview with the Administrator (staff #110) was conducted on July 17, 2024 at 1:09 p.m. The administrator stated that the expectation was that the living area for residents was clean, free of obstruction, without significant odors and safe from hazards. The administrator said that repairs such as paint and upkeep should be maintained to have a homelike environment; and, this was important since the facility was the home for people living here and they deserve a good quality of life. The administrator also said that it has to be safe so that residents were not put at risk for accidents or injuries. Further, the administrator stated that if the facility was not homelike and not safe, the residents might feel discomfort, might reduce the homelike environment feel until things were repaired and could result in a risk for some type of injury i.e. if legs extend beyond the wheelchair there could be a risk of injury. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035176	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beatitudes Campus	1712 West Glendale Avenue Phoenix, AZ 85021

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled Preventive Maintenance Program revised January 11, 2023 and reviewed January 22, 2024 indicated that the facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. The facility policy titled Work Request System revised May 14, 2019 and reviewed January 15, 2024 indicated that the work order request system was designed to provide an established and effective means of requesting, coordinating, and completing maintenance of a corrective nature. A facility policy titled Resident Rights issued June 8, 2020 and reviewed September 25, 2023 indicated that residents have a right to a safe, clean, comfortable, and homelike environment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035176	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER Beatitudes Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 1712 West Glendale Avenue Phoenix, AZ 85021	

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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 51124 Based on personnel file review, staff interviews, and facility policy review, the facility failed to maintain an effective training program for two of 15 sampled staff (#70 and #19). The deficient practice could lead to a deficit in staff or volunteers' knowledge and/or skills which could affect resident care, leading to harm. Findings include: -Regarding the registered nurse (RN/staff #70) Review of personnel file for the RN (staff #70) revealed a hire date of November 07, 2022. The annual training transcript for the RN revealed that the most recent annually required training modules covering the topics of abuse, neglect, and exploitation, elder justice act, resident rights, dementia management, and infection control had been completed on November 08, 2022. There was no evidence found that the RN had taken any training modules after November 8, 2022. -Regarding the housekeeper (staff #19) The personnel file for the housekeeper (staff #19) included a hire date of August 21, 2023. Review of the housekeeper's annual training transcripts revealed that the most recent annually required training modules covering the topics of abuse, neglect, and exploitation, elder justice act, resident rights, dementia management, and infection control had been completed on August 21, 2023. There was no evidence found that the housekeeper had taken any training modules after August 21, 2023. An interview with the human resources assistant (HR assistant/staff #90) was conducted on August 28, 2024 at 9:57 AM. The HR assistant stated that she could not tell specifics regarding which annual training modules are required for all employees, contract staff, and volunteers. In an interview with the Administrator (Staff #59) conducted on August 29, 2024 at 11:15 AM, the administrator reviewed the provided annually required training module transcripts for Staff #70 and Staff #19. The administrator then stated that there were no annual training module transcripts on the topics of abuse, neglect, and exploitation, elder justice act, resident rights, dementia management, and infection control for the RN (staff #70) and the housekeeper (staff #19). The administrator also stated that annual training meant within the past 365 days. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035176	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER Beatitudes Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 1712 West Glendale Avenue Phoenix, AZ 85021	

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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the [NAME] President of Human Resources and Risk Management (VP of HR/staff #40) conducted on August 30, 2024 at 08:35 AM, she stated that when COVID hit, the facility did not update their training; and when the Administrator came on board, the administrator was not aware of that. The VP of HR also said that the facility was missing their old policy and was currently writing a new one. The VP of HR also said that their new written policy included what topics of training were required annually. Review of the facility's policy titled New Hire Training and Annual In-Service Policy revealed that orientation training for newly hired staff members and volunteers, as well as annual training for current staff and volunteers is to include training on the topics of nursing care institution policies and procedures, resident rights, infection control, hand washing, linen handling, prevention of communicable diseases, and disaster plans.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035176	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER: Beatitudes Campus		STREET ADDRESS, CITY, STATE, ZIP CODE: 1712 West Glendale Avenue Phoenix, AZ 85021	

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 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. 51124 Based on personnel file review, staff interviews, and facility policy review, the facility failed to ensure two of 15 sampled staff (#70 and #19) received ongoing education on residents rights . The deficient practice could lead to a deficit in staff or volunteers' knowledge and/or skills which could affect resident care, leading to harm. Findings include: -Regarding the registered nurse (RN/staff #70) Review of personnel file for the RN (staff #70) revealed a hire date of November 07, 2022. The annual training transcript for the RN revealed that the most recent annually required training modules covering the topics of abuse, neglect, and exploitation, elder justice act, resident rights, dementia management, and infection control had been completed on November 08, 2022. There was no evidence found that the RN had taken any training on resident rights after November 8, 2022. -Regarding the housekeeper (staff #19) The personnel file for the housekeeper (staff #19) included a hire date of August 21, 2023. Review of the housekeeper's annual training transcripts revealed that the most recent annually required training modules covering the topics of abuse, neglect, and exploitation, elder justice act, resident rights, dementia management, and infection control had been completed on August 21, 2023. There was no evidence found that the housekeeper had taken any training on resident rights after August 21, 2023. An interview with the human resources assistant (HR assistant/staff #90) was conducted on August 28, 2024 at 9:57 AM. The HR assistant stated that she could not tell specifics regarding which annual training modules are required for all employees, contract staff, and volunteers. In an interview with the Administrator (Staff #59) conducted on August 29, 2024 at 11:15 AM, the administrator reviewed the provided annually required training module transcripts for Staff #70 and Staff #19. The administrator then stated that there were no annual training module transcripts on the topics of abuse, neglect, and exploitation, elder justice act, resident rights, dementia management, and infection control for the RN (staff #70) and the housekeeper (staff #19). The administrator also stated that annual training meant within the past 365 days. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035176	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beatitudes Campus	1712 West Glendale Avenue Phoenix, AZ 85021

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 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the [NAME] President of Human Resources and Risk Management (VP of HR/staff #40) conducted on August 30, 2024 at 08:35 AM, she stated that when COVID hit, the facility did not update their training; and when the Administrator came on board, the administrator was not aware of that. The VP of HR also said that the facility was missing their old policy and was currently writing a new one. The VP of HR also said that their new written policy included what topics of training were required annually. Review of the facility's policy titled New Hire Training and Annual In-Service Policy revealed that orientation training for newly hired staff members and volunteers, as well as annual training for current staff and volunteers is to include training on the topics of nursing care institution policies and procedures, resident rights, infection control, hand washing, linen handling, prevention of communicable diseases, and disaster plans.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035176	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER Beatitudes Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 1712 West Glendale Avenue Phoenix, AZ 85021	

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 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 51124 Based on personnel file review, staff interviews, and facility policy review, the facility failed to ensure two of 15 sampled staff (#70 and #19) received training on abuse, neglect and exploitation. The deficient practice could lead to a deficit in staff or volunteers' knowledge and/or skills which could affect resident care, leading to harm. Findings include: -Regarding the registered nurse (RN/staff #70) Review of personnel file for the RN (staff #70) revealed a hire date of November 07, 2022. The annual training transcript for the RN revealed that the most recent annually required training modules covering the topics of abuse, neglect, and exploitation, elder justice act, resident rights, dementia management, and infection control had been completed on November 08, 2022. There was no evidence found that the RN had taken any training on abuse, neglect and exploitation after November 8, 2022. -Regarding the housekeeper (staff #19) The personnel file for the housekeeper (staff #19) included a hire date of August 21, 2023. Review of the housekeeper's annual training transcripts revealed that the most recent annually required training modules covering the topics of abuse, neglect, and exploitation, elder justice act, resident rights, dementia management, and infection control had been completed on August 21, 2023. There was no evidence found that the housekeeper had taken any training on abuse, neglect and exploitation after August 21, 2023. An interview with the human resources assistant (HR assistant/staff #90) was conducted on August 28, 2024 at 9:57 AM. The HR assistant stated that she could not tell specifics regarding which annual training modules are required for all employees, contract staff, and volunteers. In an interview with the Administrator (Staff #59) conducted on August 29, 2024 at 11:15 AM, the administrator reviewed the provided annually required training module transcripts for Staff #70 and Staff #19. The administrator then stated that there were no annual training module transcripts on the topics of abuse, neglect, and exploitation, elder justice act, resident rights, dementia management, and infection control for the RN (staff #70) and the housekeeper (staff #19). The administrator also stated that annual training meant within the past 365 days. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035176	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beatitudes Campus	1712 West Glendale Avenue Phoenix, AZ 85021

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 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the [NAME] President of Human Resources and Risk Management (VP of HR/staff #40) conducted on August 30, 2024 at 08:35 AM, she stated that when COVID hit, the facility did not update their training; and when the Administrator came on board, the administrator was not aware of that. The VP of HR also said that the facility was missing their old policy and was currently writing a new one. The VP of HR also said that their new written policy included what topics of training were required annually. Review of the facility's policy titled New Hire Training and Annual In-Service Policy revealed that orientation training for newly hired staff members and volunteers, as well as annual training for current staff and volunteers is to include training on the topics of nursing care institution policies and procedures, resident rights, infection control, hand washing, linen handling, prevention of communicable diseases, and disaster plans.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035176	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beatitudes Campus	1712 West Glendale Avenue Phoenix, AZ 85021

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 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. 51124 Based on personnel file review, staff interviews, and facility policy review, the facility failed to ensure two of 15 sampled staff (#70 and #19) received training on infection control. The deficient practice could lead to a deficit in staff or volunteers' knowledge and/or skills which could affect resident care, leading to harm. Findings include: -Regarding the registered nurse (RN/staff #70) Review of personnel file for the RN (staff #70) revealed a hire date of November 07, 2022. The annual training transcript for the RN revealed that the most recent annually required training modules covering the topics of abuse, neglect, and exploitation, elder justice act, resident rights, dementia management, and infection control had been completed on November 08, 2022. There was no evidence found that the RN had taken any training on infection control after November 8, 2022. -Regarding the housekeeper (staff #19) The personnel file for the housekeeper (staff #19) included a hire date of August 21, 2023. Review of the housekeeper's annual training transcripts revealed that the most recent annually required training modules covering the topics of abuse, neglect, and exploitation, elder justice act, resident rights, dementia management, and infection control had been completed on August 21, 2023. There was no evidence found that the housekeeper had taken any training on infection control after August 21, 2023. An interview with the human resources assistant (HR assistant/staff #90) was conducted on August 28, 2024 at 9:57 AM. The HR assistant stated that she could not tell specifics regarding which annual training modules are required for all employees, contract staff, and volunteers. In an interview with the Administrator (Staff #59) conducted on August 29, 2024 at 11:15 AM, the administrator reviewed the provided annually required training module transcripts for Staff #70 and Staff #19. The administrator then stated that there were no annual training module transcripts on the topics of abuse, neglect, and exploitation, elder justice act, resident rights, dementia management, and infection control for the RN (staff #70) and the housekeeper (staff #19). The administrator also stated that annual training meant within the past 365 days. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035176	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beatitudes Campus	1712 West Glendale Avenue Phoenix, AZ 85021

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 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the [NAME] President of Human Resources and Risk Management (VP of HR/staff #40) conducted on August 30, 2024 at 08:35 AM, she stated that when COVID hit, the facility did not update their training; and when the Administrator came on board, the administrator was not aware of that. The VP of HR also said that the facility was missing their old policy and was currently writing a new one. The VP of HR also said that their new written policy included what topics of training were required annually. Review of the facility's policy titled New Hire Training and Annual In-Service Policy revealed that orientation training for newly hired staff members and volunteers, as well as annual training for current staff and volunteers is to include training on the topics of nursing care institution policies and procedures, resident rights, infection control, hand washing, linen handling, prevention of communicable diseases, and disaster plans.