

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/01/2024
NAME OF PROVIDER OR SUPPLIER Sandridge Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 255 West Brown Road Mesa, AZ 85201	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581</p> <p>Based on documentation, staff interviews, and facility policy and procedures, the facility failed to ensure that one resident (#14) was free from abuse by other resident (#21). The deficient practice could result in residents being emotionally and physically harmed.</p> <p>Findings include:</p> <p>-Resident (#14) was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included quadriplegia, bipolar disorder, anxiety disorder, and post traumatic disorder.</p> <p>The minimum data set (MDS) dated [DATE] included a brief interview for mental status (BIMS) score of 15 indicating the resident was cognitively intact.</p> <p>A physician's progress note dated October 23, 2023 at 4:35 PM included that the patient is in bed and states that pain level is 2/10 to his face and nose. Resident had an altercation last night.</p> <p>Review of a 5-day written investigation revealed a statement dated October 23, 2023 by resident #14. He stated that he and resident #21 were both swinging at each other and resident #21 did not hit him first.</p> <p>A progress note dated October 25, 2023 at 4:10 PM revealed that the resident had a verbal/physical altercation with another male resident. A small abrasion remains on each side of residents nose. The resident denies any pain or discomfort to the area. No other injuries were noted.</p> <p>-Resident #21 was admitted to the facility on [DATE] with diagnoses that included osteomyelitis of vertebra, depression, hypertension, and other psychoactive substance abuse, but in remission.</p> <p>The minimum data set (MDS) dated [DATE] did not include a brief interview for mental status (BIMS) score.</p> <p>A physician's note dated October 22, 2023 at 10:01 PM revealed that the patient had a verbal/physical altercation with another resident. Both patients were inebriated. The patient tried to stand up from wheelchair and fell to ground. He did not hit head, so no change in level of consciousness, but did sustained a skin tear to right elbow, and multiple small abrasions to both lower extremities. The areas were cleansed and dressed.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of a 5-day written investigation revealed a statement dated October 23, 2023 by resident #21. He stated that he and resident #14 were verbally arguing and resident #14 drove by him in his wheelchair and hit him in the head. Resident #21 stated that he then stood up and hit resident #14 in the head with the back of his hand. Resident #14 ran into him with his wheelchair and he sat down and fell out of his wheelchair.</p> <p>-Resident #40 was admitted to the facility on [DATE], with diagnoses that included Type II diabetes, chronic kidney disease, and anxiety.</p> <p>The minimum data set (MDS) dated [DATE] included a brief interview for mental status (BIMS) score of 13 indicating the resident was cognitively intact.</p> <p>Review of a 5-day written investigation revealed a statement dated October 23, 2023 by resident #40. He stated that resident #21 was on the patio drinking alcohol and the other residents told him that he should not be drinking. Resident #40 stated that he witnessed resident #14 ramming his motorized wheelchair into resident #21 multiple times. Then, resident #21 got up and slapped resident #14 across the face really hard and fell to the ground and resident #14 pinned resident #21 to the ground. Resident #40 stated that both residents had been drinking.</p> <p>-Resident #6 was admitted to the facility on [DATE] with diagnoses that included human immunodeficiency virus, sepsis, and syncope and collapse.</p> <p>The minimum data set (MDS) dated [DATE] included a brief interview for mental status (BIMS) score of 14 indicating the resident was cognitively intact.</p> <p>Review of a 5-day written investigation revealed a statement dated October 23, 2023 by resident #6. He stated that resident #14 ran over resident #21 with his wheelchair. Then, resident #21 hit resident #14 with an open hand in the face. Resident #21 got up and resident #14 hit him; resident #21 lost his balance and fell back into his wheelchair sideways. Resident #6 stated that he went to get staff.</p> <p>During an interview was conducted on March 4, 2024 at 1:09 PM with the Director of Nursing (DON/staff #116) and the Administrator (staff #165). Staff #165 stated that both residents were cognitively intact and able to make their own decisions. She also stated that there was not a staff supervising the residents on the patio, but staff did go out to the patio area when they heard something happening and did intervene.</p> <p>The facility's policy, Abuse, Neglect, Exploitation and Misappropriation Prevention Program revised April 2021 states that residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual physical abuse, and physical or chemical restraint not required to treat the resident's symptoms.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581</p> <p>Based on observations, documentation, staff interviews, and policy and procedures, the facility failed to ensure that one resident (#1) did not elope. The deficient practice could result in residents getting lost and/or harmed.</p> <p>Findings include:</p> <p>Resident #1 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder, alcohol abuse, and opioid abuse.</p> <p>The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 15 indicating the resident was cognitively intact.</p> <p>The elopement risk assessment dated [DATE] revealed a score of 18 indicating the resident was a high risk for elopement.</p> <p>Review of the care plan dated December 29, 2023 revealed the resident has a history of leaving against medical advise. Interventions included to administer medications as ordered, to assess for placement in a specifically designed therapeutic unit as indicated, and to assess living concerns and issues causing behavior.</p> <p>A progress note dated December 15, 2023 at 5:15 PM revealed that the resident has been pacing the unit most of the day and asking to go outside to smoke, resident was taken on smoking patio, and he is asking if he can leave the facility. Staff spoke with resident and reminded him that he is not to leave the building. The resident was in the dining room during lunch and was checked on around 3:55 PM, so he could smoke prior to dinner. The resident was not in his room. Staff searched the building and found there was a window open in a room on the unit. Staff went out of the building looking the resident and the police were notified.</p> <p>A progress note dated February 17, 2024 at 8:32 AM revealed that the resident has been pacing the unit most of the day asking to go outside to smoke and keeps asking this writer why he is here in this place stating he isn't sick and doesn't need to be in this facility and that he can go home. He states that he has a wife, house and kids he can go out to. Staff let the resident know that he lives here and they can talk to his parents about him moving. The resident checked at 3:30 AM and was resting his bed. When the CNA went to get him to come out to breakfast at 6:15 AM, the resident was not in bed, the sliding window lock was on the floor, and there was a chair against the wall on the patio.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with a certified nursing assistant (CNA/staff #16), who stated that the residents in their rooms are supposed to be checked every 15 minutes. He and the other CNA decide who is going to check the bedrooms, but they do not document when this occurs. He stated that resident #1 has escaped from the facility two times. The first time the resident escaped through a bedroom window that was left open by construction workers. He was missing for a few days and then his mom called to say that he was at her house. The second time, the resident went through another bedroom window and scaled the wall in the patio area. His mother called the next day to say he was at her house. Staff #16 stated that they had a meeting when the resident left the first time and they were instructed to pay more attention to the resident.</p> <p>An interview was conducted on March 4, 2024 at 2:21 PM with a Licensed Practical Nurse (LPN/staff #14), who stated that everyone on the unit is a wandering risk and they are supposed to check the residents rooms a minimum of every two hours. She stated that the staff decide who is going to monitor the hall and bedrooms and when she monitors, she checks the bedrooms every hour, but doesn't document when the bedrooms were checked. She stated that all the bedroom windows have a sliding window lock, so the windows can only open a little. She stated that the resident got out the first time because the contractors left the window open in one of the rooms and took the bus to his mother's house in Phoenix. The second time he went out another bedroom window and climbed over the patio wall. She stated that staff were supposed to try and keep the resident busy in the dining room with activities and music with the other residents.</p> <p>An interview was conducted on March 4, 2024 at 4:00 PM with the Director of Nursing (DON/staff #116), who stated that the resident was on a secured unit due to the alcohol induced persisting amnesic disorder. He stated that the construction workers left a bedroom window open and the resident got out. So they started using sliding window locks, and the second time the resident removed a bedroom window from the track and got out. He stated that the staff are supposed to check on the residents a minimum of every two hours. He stated that after the resident eloped the second time, it was determined that the facility could not monitor the resident appropriately for safety.</p> <p>The facility's policy, Safety and Supervision of Residents revised July 2017 states that resident safety supervision and assistance to prevent accidents are facility-wide priorities. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices.</p>		