

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  12/19/2024
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 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48932</p> <p>Based on clinical record review, interviews, review of Hoyer lift manual and facility policies, the facility failed to use a two-person transfer, as identified by the equipment manual, when transferring a resident. This resulted in resident #3 sustaining a major injury.</p> <p>Findings include:</p> <p>Resident #3 was admitted on [DATE] with diagnoses of chronic obstructive pulmonary disease (COPD), heart failure, closed fracture of the right lower leg with routine healing and stage 1 kidney disease.</p> <p>The activities of daily living (ADLs) care plan dated August 13, 2020 revealed that the resident required assistance with ADLs/mobility secondary to multiple chronic conditions, morbid obesity and history of foot/leg fractures. Interventions included extensive assistance of 1-2 staff for bed mobility, toileting and dressing; may use Hoyer lift for transfers; and total dependence for bathing.</p> <p>The care plan dated February 6, 2023 included that the resident was at risk for falls related to history of falls, impaired mobility and diagnosis of visual loss. Intervention included to assist resident/caregiver to organize belongings for a clutter free-environment in the resident's room and consistent furniture arrangement.</p> <p>The physician order dated February 28, 2022 included a Hoyer lift may be used for transfers.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 8 indicating resident #3 had moderate cognitive impairment. The MDS also revealed that the the helper does all of the effort with no effort from the resident or the assistance of 2 or more helpers was required for the resident to complete the activity. Further, the MDS included that the resident did not have a fracture and did not have any falls since the previous assessment.</p> <p>The comprehensive skin evaluation/assessment dated [DATE] included that the resident had moderate pain, had discoloration ecchymotic skin and bruise to the right side of the lower extremity.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A late entry eINTERACT Summary note dated August 7, 2024 included that there was a change in condition of the resident due to a fall. Per the documentation, the primary care provider recommended new pain medications and x-rays; and that, the resident had a fracture and the family decided not to treat the fracture.</p> <p>A nurse's note dated August 7, 2024 revealed the resident was alert and able to make needs known and was s/p (status post) fall in the morning shift. Per the documentation, the 2 views x-ray done to the right femur had an impression of acute displaced periprosthetic fracture in the distal femoral metaphysis. It also included that the nurse practitioner (NP) and the resident's family was notified of the results.</p> <p>The fall incident report dated August 7, 2024 included that a certified nursing assistant (CNA/staff #17) was transferring resident in the mechanical lift when the right bottom strap came off the lift hook then the resident slid out of the sling onto the floor. Per the documentation, the resident complained of right leg pain and her head was hurting; and that, the Hoyer lift taken out of commission. It also included that the resident was alert and oriented to person, place and situation and had a pain level of 3. Predisposing physiological factor included confusion. Injuries Report Post Incident included fracture of the distal femur. Further, the documentation included staff education on mechanical lift usage and the hoyer was taken out of commission; and that, there were no statements found. The report did not indicate whether there was another staff present in the resident's room during the transfer.</p> <p>The Rehab-Status Post-Fall Screen assessment dated [DATE] revealed that on August 7, 2024 at 11:00 a.m. , the resident had a witnessed fall in the resident's room during a hoyer lift transfer. Per the documentation, the strap of the sling of the Hoyer got unhooked and the resident slid out of the sling and onto the floor. Recommendations from therapy included to conduct staff in-service on Hoyer transfers. The documentation did not include whether there was another staff present in the resident's room during the transfer.</p> <p>The fall care plan was revised on August 10, 2024 to include that on August 7, 2024 the resident slid out of Hoyer sling during transfer. Intervention included to have a spotter in the room when Hoyer lift is in place.</p> <p>The eINTERACT transfer form dated August 11, 2024 included that the resident was sent to the hospital for femoral fracture and per family's request. Per the documentation, the resident had a recent fall on August 7, 2024 resulting in a fracture to the femur and that at that time the family did not want the resident to be sent to the hospital. However, the documentation did not include whether there was another staff present in the resident's room during the transfer.</p> <p>The IDT (interdisciplinary team) functional abilities collaboration evaluation dated August 13, 2024 included that the resident had a fall on August 7, 2024 with major injury.</p> <p>The facility's Total Mechanical Lift Competency Checklist and Sit/Stand Mechanical Lift Competency Checklist for their staff with revision date of April 2008 revealed that under section two titled, Mechanical Lift Operation subsection A included to ensure two caregivers are present; and visually inspects sling for signs of wear and tear and not to use any sling that is visually damaged.</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>The Hoyer Lift User Instruction Manual provided to the survey team revealed safety precautions such as not lifting the patient unless trained and competent to do so, always check the sling is suitable for the particular patient and is of the correct size and capacity, always carry out lifting operations according to the instruction in the user manual. Operating instructions included to have someone assist when attempting to transfer a patient.</p> <p>An interview was conducted on December 18, 2024 at 2:10 p.m. with a certified nursing assistant (CNA/staff #100) who stated that she typically do not use a Hoyer lift often because she mostly works in the behavioral unit; and that, today she was providing coverage in the general unit. She stated that when using the Hoyer lift to transfer a resident, she would put the sling on the resident, hook it up to the Hoyer and then lift the resident out of their wheelchair. Further, the CNA said that 2 staff members were required to be present and both staff had to be involved in the actual transfer. The CNA said that a dietary staff cannot be the 2nd staff member when operating the Hoyer because that dietary staff does not know the resident's care.</p> <p>An interview was conducted on December 18, 2024 at 2:19 p.m. with the CNA (staff #17) who was the CNA who assisted the resident with transfer using the Hoyer in August 2024. Staff #17 said that she received training on how to use the Hoyer lift when she was hired and a few months ago. She said that prior to using the Hoyer lift, she tests out the lift by moving it up and down to ensure that it was functioning correctly. She stated that when transferring a resident using the Hoyer lift, she uses a sling and connects them to the handles, then gets the chair ready and safely puts the resident in the chair. Further, staff #17 said that she also ensures that she has someone with her to help. Regarding the incident with resident #3, she stated that she was helping resident #3 get up and get dressed for the day; and, resident #3 fell when she was using the Hoyer lift. Staff #17 said that the resident fell because one of the sides of the sling was not connected and it came off. She said that the dietary director (DD/staff #127) was helping her by being the spotter that day of the incident. Staff #17 further stated that she was not sure how the sling came off; and that, maybe she did not put the strap/sling all the way and it slid off the hook.</p> <p>In an interview with the Director of Nursing (DON/staff #50) conducted on December 18, 2024 at 2:43 p.m., the DON stated that he was not sure how the strap came off the Hoyer lift as the CNA (staff #17) working with the resident swore she put the strap on. He said that he had tried to replicate the scenario and he could not figure out how the strap came off. The DON stated that the dietary director (staff #127) just happened to walk by when the transfer was in progress and he had assisted as the spotter for the CNA (staff #17) with the Hoyer transfer of resident #3. The DON further stated that anyone can spot the Hoyer transfer but the person operating the Hoyer lift had to be a clinical staff; and, it was not the standard of care that it was required that the second person was the a clinical person to assist with Hoyer transfers. Further, the DON stated that if staff did not received training on Hoyer, it does not mean that they do not know how to operate the Hoyer. The DON also compared using a Hoyer to changing a tire on a car; and that, he did not get training on how to change a tire on a car but he knows how to do it regardless.</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 on December 18, 2024 at 3:11 p.m. with the dietary director (DD/staff #127) who stated that in his [AGE] years working at the facility he had assisted with Hoyer lift transfers several times. He stated that when assisting with Hoyer transfers, he would get rid of the tables, clear out items in the way or even move wheelchairs around. However, he stated that he does not assist with the actual transfer using the Hoyer lift because he has not been trained on how to do the actual transfer. Regarding the incident with resident #3, the DD said that he was walking down the hallway when the CNA (staff #17) waved him down for assistance; he did but he did not enter the resident's room. He said that he spotted from the hallway. He said that the CNA had elevated the resident using the Hoyer and was starting to bring her off the bed when one of the straps came down and the resident started to slide out of the sling. The DD said that the CNA stopped what she was doing and lowered the resident on the Hoyer. He further stated that he could not recall if the straps were in place; and, admitted to not knowing the process of how the straps of the Hoyer should look or work. Further, the DD said that if he was trained on the Hoyer lift transfer, he might have been able to tell if the resident was strapped in correctly.</p> <p>During an interview with a Registered Nurse (RN/Staff #124) conducted on December 18, 2024 at 3:58 p.m., the RN stated that she had helped CNAs when they are transferring residents using the Hoyer lift; and that, two persons were needed to operate a Hoyer lift. The RN said that prior to the incident with resident #3, the CNAs were using the Hoyer lift by themselves; and that, after the incident, facility management sent out a text message to staff that CNAs cannot operate the Hoyer by themselves. Further, the RN stated that a dietary staff could not be the second person operating the Hoyer Lift because they do not know how the Hoyer work and what information was needed to operate it; and that, the second person could either a CNA or another nurse. The RN said that she was not sure if rehab staff could help with the Hoyer transfer; and that, if staff were not trained on the use of Hoyer lift, there was a risk of resident falling. Further, the RN stated that it could also result in resident becoming fearful of the Hoyer and would not trust staff.</p> <p>In an interview conducted with another CNA (staff #161) conducted on December 18, 2024 at 3:47 p.m., the CNA stated that when using a Hoyer, there should be 2 persons doing it. She stated that one person would work the control and the other will be with the resident. She also said that one person will be standing by the Hoyer and the other person will be with the patient on the bed and guide the resident. The CNA also said that moving the machine always required 2 persons and this could be the CNA and another nurse or CNA or therapy. Further, the CNA said that she would get their help before moving the resident.</p> <p>An interview was conducted on December 18, 2024 at 4:12 PM with another RN (staff #158) who stated that she recently received training on using the Hoyer lift because of the incident with resident #3. The RN said that prior to the incident with resident #3, there was not a requirement to have two people in the room when using the Hoyer lift. However, The RN said that this was now a requirement; and that, dietary staff were not able to help with Hoyer transfers. The RN said that when using the Hoyer for resident transfers, there had to be two CNAs or a CNA and a nurse or two nurses in the room. Further, the RN said that untrained staff using the Hoyer or having only one staff qualified to use the Hoyer could result in a fall of the resident being transferred because the transfer might not be done correctly, or the staff person might not know how to operate the Hoyer lift.</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>During an interview with the administrator conducted on December 18, 2024 at 5:15 p.m., the administrator stated that the dietary manager (staff #127) did not have training on use of Hoyer; and that the dietary manager does not operate the Hoyer but would be the spotter during the transfer. Further, the administrator stated that the facility allowed staff such as housekeeping and dietary to spot the Hoyer while it is being used.</p> <p>In another interview with the DON conducted on December 19, 2024 at 8:19 a.m., the DON stated that when transferring a resident using the Hoyer lift, first person would hook up the sling to the Hoyer while the second person watches the transfer. The first person would operate the transfer only when they were trained to do so; and, the second person would be able to move things out of the way. The DON stated that the second person did not need to be trained on the Hoyer; but, should be inside the resident room during the transfer. The DON said that the User Manual for the Hoyer lift, did not say that the person using the Hoyer must be a licensed or qualified. Further, the DON said on August 7, 2024, the CNA (staff #17) and the dietary director (DD/staff #127) were transferring resident #3 using the Hoyer; and that, this was in line with the manufacturer's instructions of having two people to transfer a resident. The DON further stated that he was not sure how the strap came off the Hoyer during the transfer process and how the incident happened; but, resident #3 sustained a fracture as a result of the fall from the Hoyer.</p> <p>Review of facility policy titled Safe Lifting and Movement of Residents with last revision date of July 2017 included that in order to protect the safety and well-being of staff and residents, and to promote quality care, the facility uses appropriate techniques and devices to lift and move residents. The policy also included that staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts, lateral boards) and mechanical lifting devices. The policy did not include how many staff members are required for the transfer of a resident using a Hoyer lift.</p>		