

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 03/22/2024
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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47911</p> <p>Based on resident and staff interviews, review of the clinical record, facility documentation and policy, the facility failed to ensure that code status was accurate and consistent in the medical record for one resident, #16. The deficient practice could result in resident not receiving care consistent with their signed advance directive.</p> <p>Findings include:</p> <p>Resident #16 was admitted on [DATE] with diagnosis including hypertensive heart disease with heart failure, bipolar disorder, schizophrenia, dementia, mood disturbance, anxiety, type 2 diabetes, depression, atherosclerotic heart disease of native coronary arteries, heart failure, Parkinson's disease, and psychotic disturbance.</p> <p>A review of the quarterly MDS (minimum data set) dated [DATE] revealed a BIMS (Brief interview of mental status) score of 14, suggesting the resident was cognitively intact.</p> <p>A review of the physician orders revealed an order dated [DATE] noting a DNR (do not resuscitate). A subsequent order in the electronic health record dated [DATE] revealed a full-code order, signifying that all resuscitation procedures will be provided to keep the resident alive.</p> <p>A review of the electronic health record revealed an advanced directive dated February 25, 2024, which noted that resident #16 is to be resuscitated and hospitalized . The advanced directive was signed and dated by the responsible party and the facility representative on February 26, 2024; however, the physician order was not updated until [DATE].</p> <p>A review of the care plan, revealed an entry for [DATE] noting NO CPR.</p> <p>An interview was conducted on [DATE] at 12:29 PM with staff #84 CNA (Certified Nursing Assistant). Staff #84 stated that she tries to make sure that she knows whether any of her patients have a DNR in place. Staff #84 reviewed the health record for resident #16 and stated that the resident was a DNR. Staff #84 stated that to her knowledge the DON (Director of Nursing) completes the advanced directives documentation with the residents.</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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on [DATE] at 12:43 PM with staff #86 RN (Registered Nurse). Staff #86 stated that that advanced directives are completed by the nurse on shift at admission. She further stated that an advanced directive is completed each time a resident gets sent out of the facility and returns. Staff #86 stated that if a resident is coding (cardiopulmonary arrest), staff would first check their code status (resuscitate or do not resuscitate) in the electronic health record. When asked where the code status is noted, staff #86 demonstrated where in the electronic health record she would look. She indicated the resident's profile page. She stated that once the code status was identified, staff would call the code, and notify the nurse practitioner or physician. Staff #86 stated that she knows which of her patients have a DNR in place, but generally does not work in this specific unit/area. Staff #86 pulled up the electronic health record for resident #16 and stated that the resident was a DNR signified on the profile page. When staff #86 was asked to pull up the advanced directive document in the electronic health record, she gasped and stated that this is not good, the resident is a full-code. She stated that the expectation is that the advanced directive documents match the code status on the profile page. She stated that the risk could include someone not being resuscitated when they are designated as a full-code, meaning that they are to receive all life saving measures.</p> <p>An interview was conducted on [DATE] at 12:50 PM with staff #34 DON (Director of Nursing). Staff #34 stated that any of the nurses can complete an advanced directive document with a resident. Staff #34 stated that if a resident is not of sound mind, then 2 physicians could make the necessary elections and sign the advanced directive/ DNR form on behalf of the resident. When staff #34 reviewed the electronic health record, he stated that the advanced directive selection did not match what was displayed on the resident's profile page. He further stated that this did not meet his expectations and that the code status displayed always needs to match the code status on the most current advanced directive form; however, the code status on the profile page for resident #16 did not match the code selection on the advanced directive form. He stated that the risk could include a full-code patient not being resuscitated.</p> <p>A review of the facility policy entitled Advanced Directives, with a revised date of [DATE], revealed that the resident has the right to formulate an advanced directive and that their advanced directives are honored in accordance with state law and facility policy. The policy further stated that resident's wishes are communicated to the resident's direct care staff and physician by placing the advanced directive documents in a prominent location; however, care staff on the unit for resident #16 were not familiar with the resident's wishes and looked up the code status on the resident's profile page, which did not correspond to the resident's elected wishes on the advanced directives form; moreover, the physician had not been notified of the residents current advanced directive election until [DATE], post interview with staff #86.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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** 47911</p> <p>Based on clinical record review, staff interviews, facility documentation, policies and procedures, the facility failed to ensure that one resident, #74 was free from staff abuse. The deficient practice could result in other residents being abused.</p> <p>Findings include:</p> <p>Resident #74 was admitted on [DATE] with diagnosis including chronic obstructive pulmonary disease, hypertension, paraplegia, muscle weakness and idiopathic neuropathy.</p> <p>A review of the quarterly MDS (minimum data set) dated July 20, 2023 revealed a BIMS (brief interview of mental status) score of 15, suggesting the resident was cognitively intact.</p> <p>A review of the care plan for resident #74 revealed no significant behaviors and or applicable findings.</p> <p>A review of the progress notes revealed that a skin assessment was conducted on September 15, 2023 revealing no skin injuries or wounds. The progress notes further revealed a change of condition documentation on September 17, 2023.</p> <p>A review of the facility's investigative report revealed that on September 17, 2023 staff #121 was cleaning the bathroom of resident #74. After staff #121 left the room, resident #74 was noted to have followed her into the hallway. The resident was then noted to have grabbed the broom from the housekeeping cart and began hitting staff #121. It was noted that staff #121 was observed blocking the blows and as a result made contact with the resident. The facility report further revealed that staff #121 was terminated on September 17, 2023 and is not eligible for rehire. The report further revealed that an in-service was conducted post incident.</p> <p>An interview was conducted on March 19, 2024 at 12:32 PM with staff #84 CNA (certified nursing assistant). Staff #84 stated that she in a resident's room, heard commotion outside and went to investigate. She stated that she saw the resident #74 and staff #121 fighting. She stated that she ran over in an effort to protect the resident. She said that she had observed the staff member hitting the resident a few times. Another staff member arrived and assisted with separating the resident and staff #121. She stated that she then proceeded to move resident #74 outside and assess him for injuries as well as help calm him down and reassure him that he was safe. She stated that no injuries were observed.</p> <p>An interview was conducted on March 20, 2024 at 12:12 PM with staff #86 RN (registered nurse). The RN stated that training, regarding resident , is conducted at hire, annually and then as needed throughout the year.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on March 20, 2024 at 2:10 PM with staff #94 CNA (certified nursing assistant). Staff #94 stated that abuse includes not only physical abuse by anyone but also verbal abuse. The CNA stated that staff receive training regarding abuse at least annually but often times more frequently.</p> <p>An attempt was made to contact staff #121 CNA (alleged perpetrator) on March 21, 2024 at 8:38 AM. A message on the phone noted that the person called was unable to receive messages at the time.</p> <p>An interview was conducted on March 21, 2024 at 9:03 AM with staff #43 (licensed practical nurse). Staff #43 stated that she was around the corner when she heard yelling. She stated that when she came around the corner, she saw that resident #74 had a broom and was hitting staff #121. She stated that staff #121 yelled for the resident to stop. She stated that one of the CNA's grabbed the resident and she took the broom out of his hand. She stated that thereafter staff #121 went behind the resident, after he had already been restrained, and started hitting him from behind. She stated that she did not recall where or how often resident #74 was hit by staff #121. She stated that, to her knowledge, resident #74 did not incur any injuries. She stated that all staff received additional abuse training after the incident. Staff #43 stated that the expectation is that resident abuse does not occur; however, it was observed that staff #121 did hit resident #74 willfully.</p> <p>An attempt was made to interview resident #74 on March 21, 2024 at 9:36 AM; however, the resident declined the interview.</p> <p>A review of the Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy revised April 2021 revealed that the objective is to keep residents free from abuse by facility staff or others. A review of the facility policy entitled Resident Rights, revised December 2016, revealed that residents have a right to be free from abuse; however, staff #121 was observed, by other staff, hitting resident #74.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47911</p> <p>Based on observations, resident and staff interviews, clinical record review, and policies and procedures, the facility failed ensure that oxygen cylinders are not stored directly on the floor for one resident, # 364. The deficient practice could cause the cylinder to tip over, the valve to break off and or the cylinder to potentially explode.</p> <p>Findings include:</p> <p>Resident #364 was admitted on [DATE] with diagnosis including chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, acquired absence of left leg-below the knee, anxiety, and major depressive disorder-recurrent.</p> <p>A review of the MDS (minimum data set) dated March 19, 2024 revealed a BIMS (brief interview of mental status) score of 15, suggesting the resident was cognitively intact.</p> <p>A review of the physician orders revealed an order on March 8, 2024 for 2 liters per minute of oxygen via nasal cannula as needed, per concentrator/ tank for shortness of breath.</p> <p>An observation was conducted on March 20, 2024 at 11:49 AM in the room of resident #364. Resident #364 was observed to be resting in her bed and approximately 2 feet from the foot end of her bed, an oxygen cylinder was observed sitting directly on the floor without carrier/ caddy or other stabilizing support mechanism.</p> <p>An observation was conducted on March 20, 2024 at 2:04 PM. The oxygen cylinder was observed in the same location, situated directly on the floor.</p> <p>An observation was conducted on March 20, 2024 at 2:12 PM, post interview with nursing staff. The oxygen cylinder remained in the resident's room, directly on the floor.</p> <p>An interview was conducted on March 20, 2024 at 2:04 PM with staff #87 (licensed practical nurse). Staff #87 stated that portable oxygen is not stored in resident rooms. She stated that only concentrators were used in the rooms. When asked why oxygen cylinders could not be kept in the resident rooms, she stated that the cylinders could fall over and cause injury or even explode. She stated all cylinders must be kept in a carrier and can never sit directly on the floor.</p> <p>An interview was conducted on March 20, 2024 at 2:10 PM with staff #94 (certified nursing assistant). Staff #94 stated that portable oxygen is only utilized when residents are transported or leaving their room. She stated that oxygen cylinders must always be in a sleeve or caddy and can never sit directly on floor. She stated that the risk for not have a cylinder in a sleeve or caddy could include it falling over and exploding.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on March 20, 2024 at 2:15 PM with staff #81 RN. Staff #81 stated that oxygen containers/ cylinders should always be in a carrier when in a resident's room. Staff #81 was taken to the resident's room, and then observed the oxygen container on the floor. She immediately picked up the container and removed it from the room. She stated that the container shouldn't be there like that. Stating that it needed to be in a a carrier. She stated that the risk could include explosion.</p> <p>An interview was conducted on March 20, 2024 at 2:21 PM with staff #34 DON (director of nursing). Staff #34 stated that oxygen containers are usually stored in oxygen storage rooms, and at times may be located in bottle bags on the resident's wheelchair. Staff # stated that the cylinders/ containers should not be kept in the resident's rooms directly on the floor. Staff #34 stated that the risk could include explosion.</p> <p>A review of the facility policy entitled Oxygen Administration with a revised date of July 2017 revealed that portable oxygen cylinders area strapped to the stand; however, the oxygen cylinder in the room of resident #364 was placed directly on the floor without a stand.</p>		