| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 035205 | A. Building<br>B. Wing | 08/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Suncrest Healthcare Center | 2211 East Southern Avenue<br>Phoenix, AZ 85040 |

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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581<br><br>Based on documentation, staff interviews, and the facility policy and procedures, the facility failed to ensure that one resident (#3) was not neglected. The deficient practice could result in residents not receiving the care and services needed to improve and maintain health.<br><br>Findings include:<br><br>Resident #3 was admitted to the facility April 9, 2024 and readmitted on [DATE] with diagnoses that included acute respiratory disease, pneumonia due to corona virus disease, wheezing, and spinal stenosis.<br><br>The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 15 indicating the resident was cognitively intact.<br><br>Review of the order summary revealed an order dated May 17, 2024 for oxygen-apply O2 at 2 liters per nasal cannula as needed for O2 saturation below 90%. As needed: PRN 1, PRN 2, PRN 3.<br><br>Review of the order summary revealed an order May 17, 2024 for Amlodipine tablet 5 mg oral for hypertension once a day 7:00 a.m. to 10:00 a.m.<br><br>Review of the care plan did not reveal a plan for oxygen therapy.<br><br>Review of the vitals section in the clinical record did not reveal oxygen saturation rates on August 4, 2024.<br><br>A progress note dated August 4, 2024 at 12:30 p.m. revealed that the resident was complaining of chest pain, feeling short of breath, numbness on the right side, and severe anxiety. Blood sugar (BS)was 124, blood pressure (BP) 174/87, pulse 110, respiration 20, temperature 98.1, and oxygen was 87%. A small volume nebulizer (SVN) treatment was administered along with scheduled medications. Vital signs were retaken at 8:30 a.m.: BS 139, BP 171/89, pulse 115, respiration 20, temperature 98, and oxygen saturation 88%. The resident's significant other requested that the resident be seen at the emergency room . The nurse practitioner, and the Director of Nursing were notified and emergency medical services were called. The resident was transported at 11:30 a.m. Transfer form and bed hold form were completed. Report was given to the hospital nurse.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the hospital summary date August 4, 2024 revealed that the reason for the visit was shortness of breath and constipation.<br><br>A progress note dated August 5, 2024 revealed that the resident returned from the hospital emergency room at 7:30 p.m. on August 4, 2024 with no new medication orders. The resident was alert and oriented, and able to make her needs known. The resident is on continuous oxygen (O2) at 3 liters per minute via nasal cannula and tolerated well. The nurse practitioner and other responsible parties were notified. The resident is resting comfortably in bed with O2 in place and the call-light within reach. Vital signs this morning: BP 114/62, pulse 80, respiration 18. temperature 97.6, BS 152, and O2 saturation 96% on 3 L.<br><br>The medication administration record (MAR) dated August 2024 revealed that oxygen-apply O2 at 2 liters per nasal cannula as needed for O2 saturation less than 90% does not reveal that oxygen was administered.<br><br>The treatment administration record (TAR) dated August 2024 oxygen-apply O2 at 2 liters per nasal cannula as needed for O2 saturation less than 90% does not reveal that oxygen was administered.<br><br>An interview was conducted on August 21, at approximately 1:45 p.m. with the Director of Nursing (DON/staff #1), who stated that the licensed practical nurse (LPN/staff #7) no longer works for the facility. She stated that staff #7 stopped coming to work and she was not able to contact her.<br><br>An interview was conducted on August 21, 2024 at 1:55 p.m. with a certified nursing assistant/aide (CNA/staff #33), who stated that he takes the vitals of all the residents assigned to him every day at the beginning of his shift, which includes BP, temperature, O2, and respiratory rate. Then, he writes down the results and gives it to the nurse, and the nurse documents the results. He stated that if the O2 level is at 81-82%, it is a concern and he would tell the nurse right away.<br><br>An interview was conducted on August 21, 2024 at 2:22 p.m. with the (DON/staff #1), who stated that the nurses are required to take the vitals for the residents. Then the registered nurse/nurse supervisor (RN/staff #26) joined the interview and stated that when a resident is on certain medications, such as a hypertensive, the O2 levels should be taken daily. Staff #26 stated that the resident was being administered a hypertensive and the resident had an order for O2 PRN, so the O2 level should have been taken daily. During the interview, staff #26 provided documention of the O2 levels from April 10, 2024 through August 21, 2024, which were reviewed, and acknowledged that there was no documentation of O2 levels on multiple days. The (DON/staff #1) stated that if the resident had an order for oxygen-apply O2 at 2 liters per nasal cannula as needed for O2 saturation less than 90%, the O2 level should have been checked daily. Staff #1 also stated that the risks associated with not checking the O2 level daily include the O2 level being low and the resident becoming anxious.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview was conducted on August 22, 2024 at 8:30 a.m. with (LPN/staff #7), who stated that the resident was complaining of chest pain, she took the O2 level and it was not within normal limits because it was low. She stated that she was not able to find a concentrator, but did sit the resident up. She stated that they have a lot of people oxygen and she was not able to locate a concentrator that was not being used. She stated that she attempted to contact the physician by text and did not receive a response. Then she called the DON, who instructed her to send the resident to the emergency room . She stated that she did not tell the DON that she could not find a concentrator to administer oxygen to the resident. She stated that the resident didn't want to go to the hospital, but her spouse was present and able to talk the resident into going.<br><br>An interview conducted on August 22, 2024 at 8:49 a.m. with (DON/staff #1), who stated that she had read in the emergency room report that there wasn't a concentrator available. She stated that generally O2 is provided when the level is below 90%. She stated that there is a closet full of concentrators and she doesn't know or if (LPN/staff #7) provided oxygen to the resident and staff #7 should have documented in the progress note that she provided oxygen to the resident if it was done.<br><br>An interview was conducted on August 22, 2024 at 9:02 a.m. with resident #3 and the floor technician (staff #79). Resident #3 stated that staff #79 was her boyfriend and wanted him to stay for the interview. Staff #79 stated that he was present on August 4, 2024 and the (LPN/staff #7) told him that the resident's O2 level was low and he did not remember staff #7 giving the resident O2. When he and the resident agreed that the resident would go to the hospital, staff #7 called 911. Staff #79 thinks it took about 15 to 20 minutes for transport to arrive. Resident #3 stated that she did not receive O2 until she got to the hospital and she told (LPN/staff #7) that she was having a hard time breathing. Resident #3 stated that staff are not taking her O2 level daily, but will ask her if she needs oxygen. Staff #79 and resident #3 both agreed that there was concentrator in the room on August 4, 2024.<br><br>The facility policy, Respiratory Care and Oxygen Administration revised February 2018 states that the purpose of respiratory care and oxygen administration is to support respiratory function by providing respiratory care and supplemental oxygen to residents. Respiratory related care is based on doctor's orders. For emergency situations, all residents must have the care that is available and if the interventions do not work, residents must be transferred to the hospital immediately and inform the doctor. |