| 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 | 07/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 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 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>(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 |
|---|---|---|
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to ensure that one resident (#1000) was treated with dignity and respect by another resident.Based on documentation, staff and resident interviews, the facility policy and procedures, the facility failed to ensure that one resident (#1000) was treated with dignity and respect by another resident (#1001). The deficient practice could result in psychosocial harm. Findings included:Resident #1000 was admitted to the facility on [DATE] and discharged on October 3, 2022. The diagnoses included post traumatic disorder (PTSD), major depressive disorder, bipolar disorder, and anxiety disorder.The Minimum Data Set, dated [DATE] included a brief interview for mental status score of 15 indicating the resident was cognitively intact. It also included that the resident ambulated with a wheelchair.The care plan dated September 6, 2022 revealed that the will feel safe through the next review date. The resident reported being sexually assaulted by another resident that he touched and massaged her shoulder while she was sleeping. Interventions included to encourage the resident to stay away from the alleged perpetrator, encourage resident to notify the staff about any concerns that she may have, notify the police department and Adult Protective Services. (APS).A progress note dated September 5, 2022 revealed the resident came to nurse crying and wanting to talk in private. The nurse pulled her away from everyone to see what was wrong. The resident stated that another resident in room [ROOM NUMBER]A touched her arm and was massaging her shoulders while she was sleeping. The resident stated, I was outside in the smoking area last night and something made me wake up and when I did, the resident in room [ROOM NUMBER]A was massaging my shoulders and then ran his hands down my arm. The resident stated that she was scared to report it when it happened but she really didn't want it to happen to someone else and she felt she was ready to say something. This nurse called the Phoenix non-emergent line and sent and officer out to take her statement. AZDHS was called and message was left for them to call back. Awaiting that at this time. The resident is safe in her room and resting at this moment.A social services progress note dated September 6, 2022 revealed that an APS report was filed. A Five Day Report was sent to the Department of Health Services (DHS) and the Ombudsman will be faxed once the report is completed. A social services note dated September 7, 2022 revealed that an investigator from APS came to speak with Resident on this day.A social services note dated September 30, 2022 revealed that the Social Services Director called the police detective and he stated that the case was closed as shoulder rubbing was not a crime. The police officer watched the video and determined that there was no sexual abuse or motivation. -Resident #1001 was admitted to the facility on [DATE] and discharged on May 22, 2023. Diagnoses included schizoaffective disorder depressive type, dysphagia following cerebral infarction, and human immunodeficiency virus (HIV).The care plan dated September 6, 2022 revealed that the resident was accused by two other residents of sexually assaulting them. The resident will have appropriate behavior towards peers through the next review date. Interventions included to monitor the resident diligently of resident activities and behaviors, has high risk to repeat offending and resident is not allowed to come out of his room to go to another resident's room except for smoking, resident was redirected to leave the room, and addressing any behavior issues and notify the supervisor as indicated.The MDS dated [DATE] included a brief interview for mental status score of 8 indicating the resident had a moderate cognitive impairment. It also include that there were no changes in behaviors. A social services note dated September 6, 2022 revealed that the Social Services Director (SSD) spoke with the resident regarding allegations from other residents at the facility. The resident was told that he cannot go into other resident's rooms and to stay away from residents in 128B and 126C. The resident denied doing anything but agreed verbally and nodded his head that he would stay away from these residents.A Director of Nursing note dated September 6, 2022 revealed that the facility checked the security cameras, and resident (#1001) went outside to the smoking area. At the smoking area, resident (#1000) could be seen outside in her wheelchair on her own. Resident (#1001) could be seen to approach, watch her for a while and later, at about 10:30 p.m., he started touching her from the shoulders and going down her back. This was done against her will which the resident reported to staff. The police were alerted and an investigation was started. Now, the resident is not allowed to come out of his room and go into other residents' rooms at this time. The resident can go outside to smoke though. The Police have been furnished with the video that showed the resident's encounter with resident (#1000). An interview was conducted on July 17, 2025 at 10:04 a.m. with the (DON/staff #71), who stated that there is a camera in the smoking area. She stated that he would have reviewed the video footage during the |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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** Based on clinical record review, facility documentation, and staff interviews, the facility failed to protect the rights of residents to be free from abuse by another resident (#777, #222, #444). The deficient practice could result in residents being harmed physically and emotionally. -Regarding Resident to Resident altercation between Resident #1001 and #777:<br><br>-Resident #1001 was admitted to the facility on [DATE] and discharged on May 22, 2023. Diagnoses included schizoaffective disorder depressive type, dysphagia following cerebral infarction, and human immunodeficiency virus (HIV).<br><br>The care plan dated April 10, 2023 revealed that the resident was involved in an altercation with another resident. He rammed his chair into the resident's feet. The resident will not be involved in another altercation with another resident through the next review date. Interventions included that the wheelchair was revoked as directed and to monitor the resident's behavior as indicated.<br><br>The MDS dated [DATE] included a brief a mental status assessment indicating the resident had a moderate cognitive impairment.<br><br>A progress note dated April 10, 2023 revealed that on April 9, 2023 nursing staff advised this writer that the resident was involved in an altercation with another resident. Loud voices were heard in the main lobby and the receptionist informed this nurse that her resident had been assaulted. Resident (#1001) was visibly upset and had gotten into it with another resident out on the patio. This writer and another nurse went out to the patio to determine what had occurred. The other nurse began to ask questions from the residents on the patio and all the residents stated the same facts, resident (#1001) rammed his chair into resident (#444's) feet several times and then took his good arm and back handed him in the face. Resident (# 444's) wound was immediately treated by his nurse.<br><br>-Resident (#777) was admitted to the facility on [DATE] with diagnoses that included paraplegia, acute respiratory disorder, and nonpsychotic mental disorder.<br><br>The MDS dated [DATE] included a brief interview for mental status score of 14 indicating the resident was cognitively intact.<br><br>The care plan dated April 10, 2023 revealed the resident’s feet were rammed several times by another resident and he was backhanded in the face. Interventions included to administer medication as ordered.<br><br>The progress note dated April 10, 2023 (late entry) revealed that on April 9, 2023 the resident was involved in an altercation with another resident. Loud voices were heard in the lobby and the receptionist informed this nurse that her resident had been assaulted. Resident (#1001) was visibly upset and had gotten into it with another resident out on the patio. This writer and another nurse went out to the patio to determine what had occurred. The other nurse began to ask questions from the residents on the patio and all the residents stated the same facts, resident (#1001) rammed his chair into resident (#777's) feet several times and then took his good arm and back handed him in the face. Resident (# 777's) wound was immediately treated by his nurse.<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 - Some | The five-day investigation dated April 13, 2023 revealed that the video of the patio area was reviewed and both residents were using their wheelchairs as weapons. It was determined that resident (#777) instigated the altercation and he also obtained an injury to his toe. It also revealed that the intial altercation began inside of the building as a verbal altercation and continued when both residents went out to the patio. There were multiple residents on the patio who witnessed the altercation.<br><br>An interview was conducted on July 17, 2025 at 9:35 a.m. with resident (#905), who stated residents can smoke on the patio any time without supervision. He remembered resident (#1001) got in a fight on the patio with resident (#777). He stated that both residents were throwing punches.<br><br>An interview was conducted on July 17, 2025 at 10:04 a.m. with the (DON/staff #71), who stated that there is a camera in the smoking area. She stated that he would have reviewed the video footage during the investigation and it should be noted in the 5-day investigation and would have been reviewed by the Business Office Manager. She stated that the residents are allowed to smoke at any time on the patio independently without supervision.<br><br>An interview was conducted on July 17, 2025 at 9:51 a.m. with a registered nurse (RN/staff #50) who stated that residents are allowed to smoke on the patio without supervision. She stated that if something goes wrong, a resident will usually come in and let the staff know something has happened. She stated that resident (#1001) was aggressive and got frustrated because he was not able to express himself. She stated that if resident (#1001) tried to hit someone with his wheelchair, it was abuse.<br><br>The facility policy, Abuse and Neglect states that the resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart.<br><br>- In regards to the altercation between Resident #111 and Resident #222<br><br>Resident #111<br><br>Resident #111 was admitted [DATE] with diagnoses that included type 2 diabetes mellitus with other specified complications and pain, unspecified.<br><br>An MDS (Minimum Data Set) assessment dated [DATE] revealed a BIMS (Brief Interview of Mental Status) score of 12, which indicates that the resident had intact cognition at the time of the incident.<br><br>A progress note dated February 17, 2023 revealed that Resident #222 reported an altercation with him and Resident #111 where both residents were located in the designated smoking area when Resident #222 observed Resident #111 throwing rocks at cats that roam the facility grounds. Resident #222 had told Resident #111 to stop the action. In response, Resident #111 hit Resident #222 in the face. The progress note also revealed that security footage had been reviewed and revealed that Resident #222 did attempt to stop Resident #111 from the action and in response Resident #111 was observed pulling the arm of Resident #222 and punched Resident #111 in the face and ripped his shirt. Indicating that an altercation between Resident #111 and Resident #222 did occur on February 17, 2023.<br><br>Resident #222<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 - Some | Resident #222 was admitted [DATE] with diagnoses that included unspecified abdominal pain, long term (current) use of anticoagulants, chronic pain syndrome, and bipolar disorder, unspecified.<br><br>An MDS (Minimum Data Set) assessment January 15, 2023 revealed a BIMS (Brief Interview of Mental Status) score of 14, which indicates the resident had intact cognition at the time of the incident.<br><br>A progress note dated February 17, 2023 revealed that Resident #222 reported that they were involved in an altercation with Resident #111. The progress note also revealed that Resident #222 had been observed with redness on their nose and the right side of their face, with a torn shirt. Resident #222 had also been observed with anxious behavior, evident by rocking back and forth in their wheelchair with shortness of breath. The progress note also revealed that Resident #222 had been administered pain medications following the incident.<br><br>Another progress note dated February 17, 2023 revealed that an altercation between Resident #222 and Resident #111 occurred in the designated smoking area where Resident #222 observed Resident #111 throwing rocks at cats that roam the facility grounds. Resident #222 had told Resident #111 to stop the action. In response, Resident #111 hit Resident #222 in the face. The progress note also revealed that security footage had been reviewed and revealed that Resident #222 did attempt to stop Resident #111 from the action and in response Resident #111 was observed pulling the arm of Resident #222 and punched Resident #111 in the face and ripped his shirt. Indicating that an altercation between Resident #111 and Resident #222 did occur on February 17, 2023.<br><br>An interview was conducted on July 15, 2025 at 9:46AM with a CNA (Certified Nursing Assistant/Staff #100) who stated that although they did not witness any altercations between Resident #111 and Resident #222, that a resident to resident altercation can be identified as abuse. Staff #100 also identified abuse as any action that make cause physical, emotional, financial, sexual, and psychological harm on a person.<br><br>A telephone interview was conducted on July 15, 2025 at 12:04PM with a CNA (Staff #87) who stated that although they did not witness the altercations between Resident #11 and Resident #222, that resident to resident interactions are defined as abuse if the interaction involved hitting, verbal threats, and utilizing objects to cause harm, per facility’s expectations.<br><br>An interview was conducted on July 15, 2025 at 2:55PM with a Social Services Director (Staff #33) who stated that although they did not witness the altercations between Resident #111 and Resident #222, that resident to resident interactions where a resident may throw an object to another resident, and as well as, a physical interaction in a common area, are identified as abuse within the facility’s definition and expectation regarding abuse allegations.<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 - Some | An interview with Licensed Practical Nurse (LPN/Staff #57) was conducted on July 17, 2025 at 11:30AM, who identified resident to resident physical altercations in a common area, such as an outdoor patio as abuse; and, identified a resident to resident verbal and physical altercation where profanities are exchanged and coffee is thrown from a resident to another resident, as abuse. Staff #57 re-called the altercation between Residents #111 and Residents #222 where the two residents got into a dispute regarding the cats located in the smoking patio of the facility, that escalated into a physical interaction between Resident #111 and Resident #222. Staff #57 also stated that their role as a Wound Nurse limited their interactions with Resident #111 and Resident #222, however, stated that pain and redness on the face of Resident #222 had been monitored and offered a cold compress as needed. Indicating that Resident #222 experienced a physical outcome following the incident that occurred on February 17, 2023.<br><br>An interview was conducted on July 17, 2025 at 10:38AM with a LPN (Staff #63) who identified resident to resident physical altercations in a common area, such as an outdoor patio as abuse; and, identified a resident to resident verbal and physical altercation where profanities are exchanged and coffee is thrown from a resident to another resident, as abuse. Staff #63 also stated that although they did not witness the altercations between Resident #111 and Resident #222, that Resident #111 exhibited behaviors of verbal and physical aggression with staff and other residents. Staff #63 also stated that Resident #222 exhibited attention seeking behaviors with staff and other residents.<br><br>An interview was conducted on July 17, 2025 at 11:39AM with the DON (Director of Nursing/Staff# 71) who identified resident to resident physical altercations in a common area, such as an outdoor patio as abuse; and, identified a resident to resident verbal and physical altercation where profanities are exchanged and coffee is thrown from a resident to another resident, as abuse. Staff #71 also stated that the altercation between Resident #111 and Resident #222 on February 17, 2023 were identified as abuse per facility’s expectations.<br><br>A facility policy, Abuse and Neglect states that the resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The policy also defined abuse as the willful infliction of injury, unreasonable confinement, or punishment that can have the result of physical harm, pain or mental anguish or depravation.<br><br>- In regards to the altercation between Resident #222 and Resident #444<br><br>Resident #222<br><br>Resident #222 was admitted [DATE] with diagnoses that included unspecified abdominal pain, long term (current) use of anticoagulants, chronic pain syndrome, and bipolar disorder, unspecified.<br><br>An MDS (Minimum Data Set) assessment April 17, 2024 revealed a BIMS (Brief Interview of Mental Status) score of 12, which indicates the resident had moderate cognitive impairment at the time of the incident.<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 - Some | A progress note dated June 23, 2024 revealed that Resident #222 had approached nursing staff and stated their involvement in an altercation with Resident #444 where a verbal disagreement between Resident #222 and Resident #444, that had led to Resident #444 throwing coffee on Resident #222, and then proceeded to throw coffee on Resident #444. Resident #222 had been observed with a spill on their shift that staff identified as coffee. Resident #222 had also stated to the nursing staff that he was hit in the face with the mug that Resident #444 had in his possession. This progress note indicates that an altercation took place on June 23, 2024.<br><br>Resident #444<br><br>Resident #444 was admitted on [DATE] with the diagnosis that included encephalopathy, unspecified; epilepsy, unspecified, intractable with status epilepticus; bipolar disorder, in partial remission, most recent episode hypomanic.<br><br>An MDS (Minimum Data Set) assessment May 17,2024 revealed a BIMS (Brief Interview of Mental Status) score of 15, which indicates the resident had intact cognition at the time of the incident.<br><br>A progress note dated June 23, 2024 revealed that an altercation with Resident #444 where a verbal disagreement between Resident #222 and Resident #444, that had led to Resident #444 throwing coffee on Resident #222, and then proceeded to throw coffee on Resident #444. Resident #222 had also stated to the nursing staff that he was hit in the face with the mug that Resident #444 had in his possession. Resident #444 was noted to have no injuries following the incident. This progress note indicates that an altercation took place on June 23, 2024.<br><br>An interview was conducted on July 15, 2025 at 9:46AM with a CNA (Certified Nursing Assistant/Staff #100) who stated that although they did not witness any altercations between Resident #222 and Resident #444, that a resident to resident altercation can be identified as abuse. Staff #100 also identified abuse as any action that make cause physical, emotional, financial, sexual, and psychological harm on a person.<br><br>A telephone interview was conducted on July 15, 2025 at 12:04PM with a CNA (Staff #87) who stated that although they did not witness the altercations between Resident #222 and Resident #444, that resident to resident interactions are defined as abuse if the interaction involved hitting, verbal threats, and utilizing objects to cause harm, per facility’s expectations.<br><br>An interview was conducted on July 15, 2025 at 2:55PM with a Social Services Director (Staff #33) who stated that although they did not witness the altercations between Resident #222 and Resident #444, that resident to resident interactions where a resident may throw an object to another resident, and as well as, a physical interaction in a common area, are identified as abuse within the facility’s definition and expectation regarding abuse allegations.<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 - Some | An interview was conducted on July 15, 2025 at 3:12PM with Resident #444 who stated that he did feel safe in the facility, however, re-called an incident with Resident #222 has he stated that Resident #222 had antagonized and terrorized residents when upset. Resident #444 re-called the incident on June 23, 2024 where Resident #222 hit a dining table that Resident #444 had been sitting at and their own coffee cup spilled on themselves. Resident #444 also stated that the incident led to a verbal disagreement that escalated quickly. Resident #444 also stated that the facility had spoke to Resident #222 following the incident and then proceeded to remove themselves from any space that Resident #222 may be located in.<br><br>An interview was conducted on July 17, 2025 at 10:38AM with a LPN (Staff #63) who identified resident to resident physical altercations in a common area, such as an outdoor patio as abuse; and, identified a resident to resident verbal and physical altercation where profanities are exchanged and coffee is thrown from a resident to another resident, as abuse. Staff #63 also stated that although they did not witness the altercations between Resident #222 and Resident #444, Resident #222 exhibited attention seeking behaviors with staff and other residents. Staff #63 also stated that Resident #444 exhibited attention seeking behaviors and stringent with verbal requests.<br><br>An interview was conducted on July 17, 2025 at 11:39AM with the DON (Director of Nursing/Staff# 71) who identified resident to resident physical altercations in a common area, such as an outdoor patio as abuse; and, identified a resident to resident verbal and physical altercation where profanities are exchanged and coffee is thrown from a resident to another resident, as abuse. Staff #71 also stated that the altercation between Resident #222 and Resident #444 on June 23, 2024 were identified as abuse per facility’s expectations.<br><br>A facility policy, Abuse and Neglect states that the resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The policy also defined abuse as the willful infliction of injury, unreasonable confinement, or punishment that can have the result of physical harm, pain or mental anguish or depravation. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to update the fall care plan for one resident.Based on documentation, staff interviews, and the facility policy and procedures, the facility failed to update the fall care plan for one resident (#4). The deficient practice could result in residents not receiving the care needed to prevent further accidents.The findings included:The resident was admitted to the facility on [DATE] with diagnoses that included abnormality of gait, generalized muscle weakness, dorsalgia, usnspecified fall, and wedge compresision fracture of third lumbar vetebra, The resident expired on [DATE]. The MDS dated [DATE] included a brief interview for mental status score of 8 indicating the resident had a moderate cognitive impairment. It also included that the resident had a fall in the last month and had a fracture related fall in the last six months. The fall care plan dated [DATE] stated that the resident was at risk for falls. Review of the plan revealed that all the interventions on the care plan were implemented on [DATE]. There was no documentation to show that the care plan was updated after the resident fell on [DATE]. Review of a nurse's progress note dated [DATE] revealed that resident stated that he slid from his chair and onto the floor next to his bed. The resident was able to lift self back onto chair. The resident stated, I didn't call because I didn't know I needed to. A full body assessment found one bruise on left buttock 6 cm in diameter. The resident also stated also, It is the darn cushion that caused me to slide off the chair. I did not hit my head. The hospice nurse was notified and will continue to monitor the resident. A nurse's note dated [DATE] at 5:50 p.m. revealed that the resident complained of severe back pain a few hours following a fall and wanted to go to emergency room (ER) for evaluation. The hospice nurse was notified, and the okay was given for resident to go the ER. The doctor was notified. The resident was sent by non-emergency transportation to the ER around 5.00 pm. A nurse note dated [DATE] at 7:05 p.m. revealed that CNA notified nurse of patient being on the floor. On entering the room, patient observed sitting on the floor by the window, The resident said he was up walking towards the door but slipped off and fell hard on the floor on his butt. He denied a head strike. A nursing assessment was done and no apparent juries were noted. The vital signs (VSS), range of motion (ROM) to both uppper and lower extremities (BUE/BLE) were within normal limits (wnl). The resident denied pain at the time. Hospice was notified and a nurse came out and assessed the resident. Review of the hospital Discharge summary dated [DATE] revealed that the resident needed to be treated or managed emergently for a lumbar fracture. A progress note dated [DATE] 5:46 a.m. revealed that resident came back from the hospital around 1:00 a.m. with a lumbar spine fracture. No new orders. Resident is stable and vital are (WNL). An interview was conducted on [DATE] at 10:39 a.m. with the Director of Nursing (DON/staff #58), who reveiwed the clinical record and stated that there was no documentation regarding what interventions would be implemented in the care plan after the fall on [DATE]. She reveiwed the care plan for falls and stated that the care plan was not updated after [DATE], and the plan could have included interventions such as moving the resident closer to the nurse station and non-skid socks. She stated that the resident had moved rooms multiple times and was not located near the nursing station. An interview was conducted on [DATE] at 1:10 p.m. with the Assistant Director of Nursing (ADON/staff #74), who stated that when a resident falls, the interdisciplinary team (IDT) has a meeting to discuss whether new interventions are needed and the interventions are given to the MDS Coordinator and the care plan is updated. She reviewed the care plan and acknowledged that the plan was not updated after each fall. She stated that new interventions are added to keep the resident safe. She also stated that she usually moves a resident who falls closer to the nurse's station if a room is available and non-skid socks are standard. The facility policy, Care Plans, Comprehensive Person-Centered states that the comprehensive, person-centered care plan is developed within seven days of the completion of the MDS assessment (Admission, annual or significant change of status), and no more than 21 days after admission. |

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| | 035205 | A. Building<br>B. Wing | 07/18/2025 |

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| Suncrest Healthcare Center | 2211 East Southern Avenue<br>Phoenix, AZ 85040 |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to ensure that one resident's (#484) received services to meet professional standardsBased on documentation, staff interviews, and the facility policy and procedures, the facility failed to ensure that one resident (#4) received services that met professional standards. The deficient practice could result in residents not receiving the care needed in a timely manner.<br><br>Findings included:<br><br>Resident (#4) was admitted to the facility on [DATE] with diagnoses that included abnormality of gait, generalized muscle weakness, unspecified fall, and wedge compression fracture of third lumbar vertebra, The resident expired on [DATE].<br><br>The MDS dated [DATE] included a brief interview for mental status score of 8 indicating the resident had a moderate cognitive impairment. It also included that the resident had a fall in the last month and had a fracture related fall in the last six months.<br><br>Review of a nurse's progress note dated [DATE] revealed that resident stated that he slid from his chair and onto the floor next to his bed. The resident was able to lift self back onto chair. The resident stated, I didn't call because I didn't know I needed to. Full body assessment found one bruise on L buttock 6 cm in diameter. The resident also stated also, It is the darn cushion that caused me to slide off the chair. I did not hit my head. The hospice nurse was notified and will continue to monitor the resident.<br><br>A nurse's note dated [DATE] at 5:50 p.m. revealed that the resident complained of severe back pain a few hours following a fall and wanted to go to emergency room (ER) for evaluation. The hospice nurse was notified, and the okay was given for resident to go the ER. The doctor was notified. The resident was sent by non-emergency transportation to the ER around 5.00 pm.<br><br>A nurse note dated [DATE] at 7:05 p.m. revealed that CNA notified nurse of patient being on the floor. On entering the room, patient observed sitting on the floor by the window, The resident said he was up walking towards the door but slipped off and fell hard on the floor on his butt. He denied a head strike. A nursing assessment was done and no apparent juries were noted. The vital signs (VSS), range of motion (ROM) to both upper and lower extremities (BUE/BLE) were within normal limits (WNL). The resident denied pain at the time. Hospice was notified and a nurse came out and assessed the resident.<br><br>Review of the hospital Discharge summary dated [DATE] revealed that the resident needed to be treated or managed emergently for a lumbar fracture.<br><br>A progress note dated [DATE] 5:46 a.m. revealed that resident came back from the hospital around 1:00 a. m. with a lumbar spine fracture. No new orders. Resident is stable and vital are (WNL).<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview was conducted on [DATE] at 10:39 a.m. with the Director of Nursing (DON/staff #71), who stated that when a resident falls, the resident is assessed for injuries. She reviewed the emergency transfer form and stated that the facility called for transportation at 2:16 pm and transportation arrived at 4:19 pm. Then she reviewed the emergency transportation report and stated that the resident was picked up from the facility on [DATE] at 6:43 pm. She stated that the nurse makes the decision as to whether a call is emergent or non-emergent and this looked like it was non-emergent because the transportation didn't arrive immediately. She stated that if the resident fell and was complaining of back pain, he should have been transferred to the hospital emergent status.<br><br>An interview was conducted on [DATE] at 11:29 a.m. with the nurse who assessed the resident after he fell on the floor (staff #207). She stated that the ambulance was called non-emergent, but if the resident had bad back pain, she would consider it an emergency call because it would mean that something is broken and needed to be fixed.<br><br>An interview was conducted on [DATE] at 1:10 p.m. with the Assistant Director of Nursing (ADON/staff #74), who stated that there is a risk of waiting a couple of hours a couple of hours to send a resident to hospital with serious back pain because the pain could worsen and if the resident had a previous fracture, it could worsen as well. She reviewed the clinical record and stated that the resident was sent non-emergent to the hospital. She also stated that the resident was experiencing severe back pain after a fall and would usually be sent out emergency status.<br><br>The facility policy, Fall Accident and Incident Reports states that if the incident involves a fall, check for limited range of motion, bruises, pain, lacerations, swelling, and vital signs. Notify the attending physician. Follow (his or her) orders. Emergency personnel orders must be followed.<br><br>Based on documentation, staff interviews, and the facility policy and procedures, the facility failed to ensure that two residents (#4, #484) received services that met professional standards. The deficient practice could result in residents not receiving the care needed in a timely manner, and could result in a plan of care that did not meet the resident’s needs and prevent falls.<br><br>-Regarding Resident #484<br><br>Resident #484 was admitted to the facility [DATE] with diagnosis including Cardiomyopathy, unspecified, Cerebral infarction, unspecified, Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side.<br><br>Review of the care plan dated revealed a focus for fall risk with actual fall on [DATE] with bleeding from mid head and right wrist and a fall on [DATE] with skin laceration to the right arm. The approaches included Increased staff supervision with intensity based on resident need and sent to emergency room as ordered.<br><br>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating cognition intact and extensive assistance with one person for bed mobility and transfers. There were no indicators for mood or behaviors. Further review of the MDS revealed resident occasionally incontinent of urine, always incontinent of bowel AND resident was prescribed anticoagulants and a diuretic.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the admission Fall Risk assessment dated [DATE] revealed a total fall risk score of 15.00, identifying the resident as a high fall risk.<br><br>Review of the fall event report dated [DATE] revealed resident sustained an unwitnessed fall, Th report states prior to the fall the resident was in his wheelchair exercising his arms. The report further states the resident sustained multiple lacerations to his right arm with no reported pain. The report states the resident fell while attempting to place himself to bed and di not wait for assistance from the certified nursing assistant. Further review of the post fall assessment revealed no updated fall risk score.<br><br>Review of the residents fall risk assessments revealed no further fall risk assessments completed following the admission assessment and the post fall assessment completed [DATE].<br><br>Review of the physician orders dated [DATE] revealed an order for Eliquis (apixaban)tablet; 5 mg; amt: 1 tab; oral twice a day.<br><br>Further review of the physician orders dated [DATE] revealed an order for fall risk assessments to be completed every 3 months.<br><br>Review of the progress note dated [DATE] revealed “At lunch time this resident decided to put himself to bed and fell on the floor. He has several skin lacerations on his right arm. unable to assess them properly. because they were bleeding sprayed antiseptic on abdominal (abd) pad & wrapped them with cling. took several of personal to life him on the bed.”<br><br>An interview was conducted on [DATE] at 12:55pm with certified nursing assistant (CNA/Staff #38) , who stated he has been employed with the facility for approximately four weeks. CNA #38 Stated he was assigned fourteen residents and of the fourteen residents he was assigned to could not identify or been informed if any of the residents were a fall risk or had preventative measures in place. The CNA stated he will “just assume everyone is a fall risk.” The CNA also stated the resident’s fall risk information should be in the documentation, but is not and has not received any information during report regarding a resident’s fall risk. The CNA further stated “when I ask the nurses they always say they don't know even if they have been here for a while.” CNA #38 further stated he was unaware of how the residents he is assigned to are supposed to be transferred and “I just use the Hoyer with most of them with another CNA or transfer them myself, they don’t have gait belts here so you have to look for one to transfer someone that’s why I will use the Hoyer. CNA #38 was unable to identify if resident #484 is a fall risk, stating “I don't know, no one has said anything to me otherwise, but like I said I assume everyone is a fall risk.” The CNA #38 stated that residents who are a fall risk should not have their beds in the high position. An observation was made of resident #484 bed position, noting the bed was raised in the high position. The CNA also stated the risks of having a resident bed in the high position and identified at risk for falls “can fall and hurt themselves or break something.”<br><br>An interview was conducted on [DATE] at 1:01pm with Resident #484, who stated that he will push the call light if he needs assistance press the button and has had no recent falls, but did have a couple of falls in the past. Observation of resident’s bed in the highest position- The Resident stated “ my bed is always this high.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview was conducted on [DATE] at 1:01pm Licensed Practical Nurse (LPN/Staff #5). LPN/Staff #5 stated she has worked for the facility for two-plus years and her duties include medication pass, check vital signs, occasional wound care and quarterly and weekly assessments. The LPN stated that skin assessments are conducted weekly, elopement and AIMS are conducted quarterly. The LPN also stated fall risk assessments are done quarterly and as needed if there is an event such as a resident fall. The LPN further stated direct care staff such as the certified nursing assistants are informed of a resident’s fall risk and/or any preventative measures for those residents are given report, but “most of the staff have worked for the facility for a long time and they basically know the residents.” Staff #5 stated that new staff are provided with a verbal report regarding a resident fall risk status, but “there is nothing written for them, mostly verbal, we don’t have anything on the doors or in the residents rooms and I think the CNA's have a sheet that explains the residents basic needs. I do think I saw this sheet a long time ago-months ago, but I haven't seen it for a long time or seen any of the CNA's use it.”<br><br>An interview was conducted on [DATE] at 1:01pm with CNA (Staff #175), who stated that it was her fourth day working for the facility and was assigned ten residents for her shift. The CNA stated she was not made aware of her assigned residents if any of the residents were a fall risk or if any preventative measures were in place for fall prevention. The CNA stated “I always ask for my own safety, but it’s not something they just gave to me.” Further stating “I just go by what the CNA’s will tell me about a resident, but it’s something I had to ask for.” The CNA also stated that she had not been informed if the information provided to her by the other CNA’s is correct or if there is a change of condition for a resident. Staff #175 stated “we are supposed to be informed and we are not. They give us no information I just either ask or go by what the other CNA’s tell me because they have been here longer and if I see a blue mat in the resident's room, then it lets me know that they are at risk, but other than that I really don't know who is a fall risk or what they need to not fall. I make sure they have their call lights and get help with transfers if I can’t do it by myself.”<br><br>An interview was conducted on [DATE] at 9:58am with Director of Nursing (DON/Staff#71), who stated that the process for residents who are assessed at risk for falls is to refer them to therapy, provide the resident with appropriate equipment, increased supervision, make sure they are in the right bed, have a safe distance to the bathroom and proper bed placement. DON/Staff#71 stated residents are residents assessed for falls on admission and every three months. The DON also stated preventive measures used for those residents identified at risk for falls are low beds, floor mats, call lights within reach. The DON stated that the residents fall risk and preventative measures are communicated to staff verbally through reports from the nurses and the facility has a CNA sheet that has all of the resident’s information and that the nurses are responsible in ensuring the CNA’s are provided with the information needed for the residents they care for. The DON stated that the nurses are responsible in providing the CNA’s with the CNA sheet including the resident’s information, and that the facility ensures staff have the correct information to ensure residents safety. The DON stated that is part of the new hire orientation process and that new staff are supposed to be provided with the residents needs with their assignment. The DON further stated “I talk to the CNAs and remind them during rounds. The DON reported the facility does not have a formal fall management program. “Actually, I don’t know if we have a formal fall management program or not and I should probably know that answer.”<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the facility policy titled, Falls and Fall Risk Managing, revised [DATE] revealed that based on previous evaluations and current data, the staff will identify interventions related to the resident’s specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling. Environmental risk factors that contribute to the risks of falls included incorrect bed height or width. Further review of the policy states the facility practice is to complete fall risk assessments on the resident upon admission to the facility and every three months thereafter. |