STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035207	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springdale Village Healthcare	7255 East Broadway Road Mesa, AZ 85208

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48932 Based on clinical record review, staff interviews, and the Resident Assessment Instrument (RAI) 3.0 User's manual, the facility failed to ensure the completion of comprehensive Minimum Data Set (MDS) assessments for three residents (#8, #10, #12) within the regulatory time frames. The deficient practice could result in inadequate assessment of resident needs. Findings include: Regarding Resident #8 Resident #8 was admitted to the facility on [DATE]. Review of the MDS revealed both an annual assessment dated [DATE] and a quarterly assessment dated [DATE] were still In Progress. The annual and quarterly assessments were not completed in the required timeframe for resident #8. Regarding Resident #10 Resident #10 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Review of the MDS revealed a quarterly assessment dated [DATE] was In Progress. The MDS assessment for resident #10 was not completed in the required timeframe. Regarding Resident #12 -Resident #12 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of the discharge assessment MDS dated [DATE] revealed it was In Progress. The discharge MDS for resident #8 was not completed in the required timeframe. (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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with the MDS coordinator/Licensed Practical Nurse (LPN/Staff #38) on April 2, 2024 at 9:49 AM. Staff #38 indicated he started his role as the MDS coordinated in mid-January and was aware there was a backlog. He also indicated that the MDS coordinator position had been vacant for a while prior to him taking the position so they were not being completed. Due to this, he and another contractor were doing 5 extra MDS assessments a week in an effort to get caught up. Staff #38 also indicated the facility was aware of the issue and there was a Quality Assurance and Performance Improvement (QAPI) plan in place to improve in this area. An interview was conducted with the Director of Nursing (DON/staff #33) and the facility Administrator (ADM/Staff #6) on April 2, 2024 at 10:02 AM. Both staff members acknowledged the facility was behind in the MDS assessments and indicated since they both took over in their roles, they had identified the issue of MDS assessments not being completed in a timely manner. Staff #6 indicated the person who was tasked with completing the MDS had quit and the facility did not have anyone who was qualified and knew how to do the MDS. Both staff members indicated they monitor the MDS completion progress each week during their weekly At Risk meetings and track the numbers of outstanding MDS assessments. Review of the RAI 3.0 User's manual, dated October 2023 revealed the Assessment Reference Date must be within 366 days after the previous Omnibus Budget Reconciliation Act (OBRA) assessment; the MDS completion must be no later than 14 calendar days after the above ARD; quarterly assessment must be completed with 92 days of the previous OBRA assessment; and discharge return not anticipated be within 14 days of the discharge date .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49399 Based on observations, interviews, review of records, documents and policy, the facility failed to develop and implement a care plan for one resident (#4). The deficient practice could result in the resident's care needs not being met. Findings included: Resident #4 was admitted to the facility on [DATE] with diagnoses of type 2 diabetes mellitus, atrial fibrillation, depression, anxiety disorder, and seizures. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed resident #4 had a Brief Interview for Mental Status (BIMS) score of 15 indicating cognitively intact; and, resident received antipsychotic and antidepressant medications. Review of the physician orders revealed the following orders: abilify oral tablet 10 milligrams (mg) one tablet by mouth one time a day for bipolar disorder dated November 27, 2023 and end date on November 30, 2023; abilify 10 mg one tablet by mouth at bedtime for bipolar disorder frequent mood changes dated December 29, 2023; anti-psychotic medication use: observe closely for significant side effects, sedation, drowsiness, dry mouth, constipation, blurred vision, extra pyramidal reaction, weight gain, edema, postural hypotension, sweating, loss of appetite, urinary retention date of November 27, 2023; anti-anxiety medication use: observe closely for significant side effects, sedation, drowsiness, ataxia (drunk walk), dizziness, nausea, vomiting, confusion, headache, blurred vision, skin rash dated November 27, 2023; paroxetine hydrochloride oral tablet 20 mg two tablets by mouth one time a day for depression dated November 30, 2023; anti-depressant medication use: monitor for significant side effects: drowsiness, dry mouth, blurred vision, urinary retention, tachycardia, muscle tremor, agitation, headache, skin rash, photosensitivity (skin), excess weight gain dated December 20, 2023. The care plan dated March 25, 2024 for the use of antidepressant medication revealed to, Specify medications related to (r/t). The goals included the resident will be free from discomfort or adverse reactions related to antidepressant therapy through the review date and the resident will show decreased episodes of signs and symptoms of depression through the review date; however, there were no specific interventions included in the care plan as well as the specific medication. The care plan dated March 25, 2024 related to the resident having depression. The goals included the resident will remain free of signs and symptoms of distress, symptoms of depression, anxiety or sad mood by/through review date; however, there were no specific interventions included in the care plan as well as the specific medication. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on April 3, 2024 at 10:24 AM with a licensed practical nurse (LPN/staff #50). The LPN stated that the care plan process began during admission and was based on the needs of the resident and the integration of resident's diagnoses and medication. The care plan also included any changes, progression or decline of the resident. Staff #50 stated that the care plan needed to be adjusted as needed to fit the resident's needs. For example, a care plan would include a resident with a foley catheter, an intravenous line on antibiotic, or be a two persons assist, or anything specific for that resident would be in the care plan. The care plan included an initial problem, set goals, and interventions to achieve the resident's goals. In addition, the LPN stated that the care plan was updated as needed, during weekly risk assessment, and for instance during a change in condition such as a fall. An interview was conducted on April 3, 2024 at 10:31 AM an LPN (staff #51). She stated that a care plan, baseline care plan was completed for each resident. The LPN (staff #51) added that the MDS used the information from the baseline care plan to complete a comprehensive care plan. Further, she stated that the care plan was updated as the resident's needs changed. Staff #51 explained that in the care plan staff put information such as depression, anti-anxiety medication, and also the use of non-pharmacological and pharmacological psychotropic medication. She stated that the care plan would be patient specific. The Interdisciplinary Team (IDT) met every three months for care plan updates. An interview was conducted On April 3, 2024 at 11:44 AM with the director of nursing (DON/staff #33) with the administrator (staff #6) present. The DON stated that the residents were assessed on admission using diagnoses, medication ordered, ancillary orders, and ancillary services to create a care plan for the resident. The care plan had a focus or problem, a measurable goal, and interventions to help facilitate the goal. The care plans were updated daily, quarterly, any change in the resident's condition, or other subjects where a care plan needed to be updated. In addition, the DON stated that care plans can be reviewed by any staff; however, there were no designated staff to complete the care plans. All members of the IDT added to the care plan. The DON further stated that the care plan should be complete--that all components of the care plan should be included such as the focus or problem, the goals, and the interventions. If there were no intervention, the goals of the care plan would not be met. Review of facility's policy on Care Plans, revised on March 2022 revealed that the baseline care plan included instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident including but not limited to the following such as, initial goals based on admission orders and discussion with the resident/representative; physician orders; dietary orders; therapy services; social services; and PASARR (Pre Admission Screening and Resident Review) recommendation, if applicable. The resident and /or representative are provided a written summary of the baseline care plan that includes, but is not limited to the following such as stated goals and objectives of the resident; a summary of the resident's medications and dietary instructions; any services and treatments to be administered by the facility and personnel acting on behalf of the facility; and any updated information based on the details of the comprehensive care plan, as necessary.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48932 Based on clinical record review, interviews, and review of facility policy and procedure, the facility failed to ensure a discharge summary was completed for a resident (#14) discharge. The deficient practice could result in an unsafe discharge for residents. Findings include: Resident #14 was admitted to the facility on [DATE] with diagnoses of dementia, kidney disease, and type 2 diabetes. The discharge Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 12 indicating moderate cognitive impairment. Review of a progress note indicated resident #14 received a notice of discharge on December 29, 2023 and transferred to a sister facility on January 2, 2024. The progress note did not indicate a full discharge summary was provided to the resident or the resident's representative at the time of discharge. An interview was conducted with the Director of Social Services (staff #72) on April 3, 2024 at 8:53 AM. Staff #72 indicated they were not sure what the facility's policy was related to required paperwork when discharging a resident. Staff #72 indicated they were not sure who was responsible to ensure the completion of the resident's discharge summary. Staff #72 also indicated that she was responsible to ensure that a resident was able to access resources upon discharge. When asked what the risks would be of a resident or their representative not obtaining a discharge summary upon discharge, staff indicated the residents would not be able to get outside services once they are discharged . Staff #72 stated, timeliness is important to their care and good communication,. An interview was conducted on April 3, 2024 with the Director of Nursing (DON/staff #33) at 9:10 AM. Staff #33 indicated they were still new in the role and was getting up to speed on the facility's policies and procedures. Staff #33 stated I don't know what the process is for discharge right now, but I know what I would like to see the process be. Staff #33 indicated they would like to see a transfer form which would include a recapitulation of the resident's stay which would also include progress notes and a communication of the discharge or transfer of the resident. Staff #33 also indicated that they have been having conversations with staff who participates in the discharge process about including residents' goals for discharge in their care plan regardless if the residents were actually discharge or not. When asked about the risks associated with not providing residents or their representative with a copy of a discharge summary, they indicated that it could lead to distress and/or psychosocial harm to the residents and/or their representative. A review of the facility policy titled, Discharge Planning Process, which was implemented in November 2017, indicated that the Discharge Summary was to be included in the discharging resident's discharge plan.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the activities program is directed by a qualified professional. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49399 Based on interviews, facility documents and employee record review, the facility failed to ensure that the activities program was directed by a qualified professional. The deficient practice could result in the activities program not being directed by a qualified professional Findings included: On [DATE] at 11:14 AM, a review of staff #21's file was conducted with the Human Resources (HR) Director and Business Office Director (staff #52). On [DATE] at 12:35 PM, an interview was conducted with Staff #52 and he stated that he oversaw the operation for the HR and business office, performed and provided standard operating procedure for HR which included full screening and scheduling interview, conducted onboarding, ensuring paper work and packets were up to date, and verified licenses, fingerprint cards, and references. He said he also updated employee files. Staff #52 stated that he did not know the policy on licenses and certifications. He added that staff would be removed from the schedule immediately if their license expired. He would notify the staff, Director of Nursing (DON), and the administrator when a license or certification was expired. On [DATE] at 9:00 am, the Administrator (staff #6) provided a document that revealed staff # 21's employment timeline. The document revealed that staff #21 was hired as an activity assistant on [DATE] and was promoted to the Director of Activity position in 2013. The document further revealed that per regulation, the activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who- (i): [left blank] (ii) Is: (A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after [DATE]; or (B) Has 2 years of experience in social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or (C) Is a qualified occupational therapist or occupational therapy assistant; or (D) Has completed a training course approved by the State. The document stated that staff #21 met the qualifications of a qualified professional under (ii)B; however, Staff # 21 did not meet the other qualification as required per regulation: (i) Is licensed or registered, if applicable, by the State in which practicing. (continued on next page)

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 8:40 AM, an interview was conducted with Activity Director (staff #21). Staff #21 stated that she has been in the Activity Director role for ten years and a total thirteen years with the company. Her role as an Activity Director included organizing monthly activity calendars with three to five activities and organizing staff calendars. She stated that there's activities seven days a week, on holidays and evenings, and also depending on resident's needs. She stated that she started as an activity assistant in 2011 for two years. During her role as an activity assistant, she assisted the activity director, doing documentation, everything what a director would do. She stated that the documentation involved what they do for residents daily, performing assessment for new admission, and developing care plans. For instance, for a resident assessment, the resident was assessed for skill level and preferences. If a resident wanted to be independent, they were provided leisure materials such as magazines, books, or face time with family members. Furthermore, she stated her experience included attending activity professional group meetings organized by the activity director. She added, the meetings she attended included going to other facilities and meeting with other activity directors. Staff #21 said the last time she attended a meeting with other activity directors was in 2019. She stated that she has not taken any courses or training approved by the State.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49399 Based on interviews, record review, facility document review, and facility policy review, the facility failed to ensure that three staff members (#35, staff #15, and staff #17) had current cardiopulmonary resuscitation (CPR) certification training on file. The deficient practice could put the resident's safety at risk and could result in needs not being met. Findings included: On [DATE] at 11:14 AM, a review of employees' files was conducted along with the Human Resources (HR) Director and Business Office Director (staff #52). During the employees' files review the following were identified: - License Practical Nurse (LPN/staff #35) CPR certification expiration date [DATE]. - Certified Nursing Assistant (CNA/staff #15) CPR certification expiration date [DATE]. - Certified Nursing Assistant (CNA)/staff #17) CPR certification expiration date [DATE]. On [DATE] at 12:35 PM, an interview was conducted with Staff #52 and he stated that he oversaw the operation for the HR and business office, performed and provided standard operating procedure for HR which included full screening and scheduling interview, conducted onboarding, ensuring paper work and packets were up to date, and verified licenses, fingerprint cards, and references. He said he also updated employee files. Staff #52 stated that he did not know the policy on licenses and certifications. He added that staff would be removed from the schedule immediately if their license expired. He would notify the staff, Director of Nursing (DON), and the administrator when a license or certification was expired. An interview was conducted on [DATE] at 8:29 AM with the Director of Nursing (DON)/Staff #33 and the Administrator/Staff #6. They stated that the hiring process included obtaining the staff's CPR certification. A follow up interview was conducted on [DATE] at 8:56 AM with the DON and he stated that it was the responsibility of the staff member to keep up and stay current with their CPR and that staff were given time to complete their CPR certification. Staff with an expired CPR certification were not allowed to assist in any CPR activity. Review of a punch detail record revealed that LPN (staff # 35) worked approximately 860 from [DATE] through [DATE] with an expired CPR certification on file. Review of a punch detail record revealed that CNA (staff # 15) worked approximately 175 hours from February 18, 2024 through [DATE] with an expired CPR certification on file. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a punch detail record revealed that CNA (staff #17) worked approximately 140 hours from February 18, 2024 through [DATE] with an expired CPR certification on file. The facility's policy related to CPR Procedure dated [DATE] revealed that CPR certification was a mandatory requirement for all clinical positions. In addition, the policy specified that in the event of a medical emergency within the workplace, employees who are CPR certified were expected to respond according to their training. Further, the policy stated that by adhering to this CPR procedure, the facility aims to maintain a safe and prepared workforce capable of responding effectively to medical emergencies.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49399 Based on interviews, record review, facility document review, and facility policy review, the facility failed to ensure that one resident (#4) was administered pneumococcal vaccine. The deficient practice could result in residents not receiving vaccines. Findings included: Resident #4 was admitted on [DATE] with diagnoses of type 2 diabetes mellitus, atrial fibrillation, asthma, chronic obstructive pulmonary disease, and seizures. The admission Minimal Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating cognitively intact. Review of a document titled, Consent/Pneumonia Vaccine revealed a signed consent to receive the pneumonia vaccine on her initial admitted in August 23, 2023 and on November 26, 2023 readmitted . Her record revealed that an immunization of Pneumococcal PCV13 vaccine was required and there was no evidence that the resident received the vaccine. An interview was conducted on April 4, 2024 at 8:56 AM with the Infection Preventionist (IP) (staff #53) and Director of Nursing (DON/staff #33). The DON stated that immunization of residents required consent and then the consent was uploaded into the system. They further added that immunization was offered upon admission and during the flu season. During the interview the DON verified the resident #4 's record and confirmed the resident consented to receiving the vaccination but the resident did not receive the pneumonia vaccine.