STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035216	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caring House	510 South Ocotillo Road Sacaton, AZ 85147

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36814 Based on interview and record review, the facility failed to ensure a resident's rights are honored for one of 18 residents reviewed (Resident [R] 92) when facility provided an unwanted resuscitation attempt to R92 who had a Do Not Resuscitate (DNR, medical order that instructs healthcare providers to not perform life saving measures) expressed wishes. This failure resulted R92's healthcare and treatment decision not being honored. Findings: R92 was admitted to the facility on [DATE] with diagnoses including chronic kidney disease (CKD), atrial fibrillation (irregular heart rhythm), and hypertension. Review of R92's Living Will Instruction Form signed on [DATE] indicated, R92 wishes for Comfort Care Only a type of medical treatment that provides comfort and quality of life for patients who are near end of life. The living will also indicate that if R92 will have a terminal condition R92 do not want to received Cardiopulmonary resuscitation (CPR). Review of R92's Provider Progress Note dated [DATE], at 12 NN indicated, Was called into patient room for urgent care by wound RN (Registered Nurse), [name redacted] who found patient unresponsive. Gown and gloves donned. Patient assessed, no carotid pulses felt, no audible heartbeat or spontaneous breaths noted during auscultation with stethoscope. Called out for crash cart, 911 to be called. When asked patient code status, someone called out Full Code. Started compressions, [name redacted] RN took over after 2 rounds, breaths given through self-inflating bag-mask. 2 minutes of CPR completed. Called for AED when code cart arrived, was informed that patient was DNR. Patient pronounced dead at 1203. Ancillary staff, nursing and management at bedside when time of death called. EMS in house approximately 1205. Nursing/administration notified all necessary, family, medical examiner and funeral home. In an interview on [DATE], at 10:48 AM, Assistant Administrator (AA) reviewed R92's Living will and DNR form signed on [DATE]. AA stated, She (R92) does not want CPR and artificial nutrition. AA also reviewed R92's Provider Progress Note dated [DATE], at 12 NN where it was indicated that R92 was provided CPR. AA stated, It's a mistake. She's a DNR. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035216	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caring House	510 South Ocotillo Road Sacaton, AZ 85147

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled; Advance Directive last revised on ,d+[DATE] indicated, A Resident, or their designated representative, shall have the right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive . If a resident (directly or through an advance directive) declines treatment (such as refuses artificial nutrition or IV hydration, despite having lost considerable weight), the resident may not be treated against his or her wishes . The policy also indicated, Pre-Hospital Medical Care Directive (Do Not Resuscitate-DNR) refers to a document signed by the resident and their doctor that informs emergency medical services or hospital emergency personnel not to resuscitate the person who exercised the DNR. Arizona State law a DNR must be on letter sized paper or wallet sized paper on an orange background to be valid (aka-Orange Sheet) .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035216	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caring House	510 South Ocotillo Road Sacaton, AZ 85147

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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 11599 Based on observation, interviews, and record review, the facility failed to protect the resident's right to be free from physical abuse for one of two resident (Resident (R) 3) reviewed for resident-to-resident abuse. R65 abused R3 while in her room, which resulted in a scratch on R3's face. Findings include: Review of the facility's policy titled, Abuse Prohibition, Reporting, and Investigation, dated 08/2024, revealed, . Each resident has the right to be free from abuse, neglect, and corporal punishment of any type by anyone . Review of R3's Admission Record, located under the Profile tab in the electronic medical record (EMR), revealed the resident was admitted to the facility on [DATE] with diagnoses that included vascular dementia, hemiplegia, and hemiparesis following a cerebral infarction affecting the right dominant side. Review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/07/24, revealed the resident had a Brief Interview for Mental Status (BIMS) score of two out of 15, which indicated R3 was significantly cognitively impaired. It was recorded that the resident was dependent on staff for all cares and utilized a wheelchair for mobility. Review of R65's Admission Record, located under the Profile tab in the EMR, revealed the resident was admitted to the facility on [DATE] with diagnoses that included unspecified dementia with other behavioral disturbances. Review of R65's annual MDS, with an ARD of 10/18/24, revealed the resident had a BIMS score of three out of 15, which indicated R65 was significantly cognitively impaired. It was recorded that the resident was dependent on staff for all cares and utilized a wheelchair for mobility. Review of a Facility Reported Incident investigation, provided by the Administrator and dated 10/20/24, revealed R3 had been assisted to bed at 7:40 PM. After exiting R3's room, within two minutes, staff heard a scream from R3's room. R65 was observed exiting R3's room. R3 was assessed to have a one-inch scratch to the right side of her nose and stated, She came into my room and scratched my face. I am okay. R65 was interviewed and had no recall of the event. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035216	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caring House	510 South Ocotillo Road Sacaton, AZ 85147

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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R65's Care Plan, located in the EMR under the RAI tab, revealed R65 was identified to have a Potential for conflict with other residents' d/t [due to] [R65] going into other resident's rooms and getting their property and hoards these objects in her room. [R65] roaming around the unit via wheelchair rummaging in other residents' rooms, drawers, and cabinets. [R65] has physical behavioral symptoms toward others: 10/1/24 [R65] had an episode of trying to approach another resident and attempting to strike another resident but was stopped by the staff right away and was separated right away. Interventions included, . all staff be aware of behavior, redirect, intervene, avoid overstimulation, maintain a calm environment and approach to the resident, psych consult as needed for medication evaluation and treatment. Following the resident-to-resident altercation on 10/20/24, R65 was placed on continuous one-to-one (1-1) supervision, 24 hours per day, seven days a week. R65 was observed to have a one-to-one monitor each day of the survey, from 11/04/24-11/08/24. During an interview on 11/06/24 at 3:47 PM, Certified Nursing Assistant (CNA28) stated, I'm with [R65] for my whole shift 6-6. Night shift is the same thing, 6-6. CNA28 confirmed that she has had to intervene in aggressive behavior by R65 and stated, It's less though with 1-1 right here. During an interview on 11/07/24 at 12:27 PM, Licensed Practical Nurse (LPN11) stated, [R65] is asleep, she didn't sleep last night, was agitated, that's why I'm here outside her door. During an interview on 11/07/24 at 3:14 PM, LPN2 stated, We have all received training on dementia care, no additional training was needed when the one-to-one was implemented. During an interview on 11/07/24 at 3:30 PM, R3's Responsible Person stated, I'm aware of the incident. They said she would have her own nurse. During an interview on 11/08/24 at 10:33 AM with the Director of Nurses (DON) and the Administrator, the Administrator stated, We are looking for alternative placement as the 24-hour one-to-one is not intended to be long term. We are working with [R65]'s Responsible Person who is to tour another possible placement.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035216	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caring House	510 South Ocotillo Road Sacaton, AZ 85147

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36814 Based on interview and record review, the facility failed to ensure a Significant Change in Status (SCSA) Minimum Data Set (MDS) assessment was completed for one of one resident reviewed (Resident [R] 66) who had change of capacity in carrying out activities of daily living (ADL). This deficient practice could affect the provision of appropriate care to meet residents need. Findings: R66 was admitted to the facility on [DATE] with diagnoses including hypertension, diabetes mellitus (high blood glucose), and dementia (loss of memory and thinking abilities). During an observation, on 11/05/24, at 11:23 AM and on 11/06/24, at 09:04 AM, R66 was sleeping in her room. In an interview, on 11/05/24, at 12:18 PM, Certified Nursing Assistant (CNA) 3 stated, R66 required Total care which required two staff to assist before she (R66) is only supervision. One staff can assist her. CNA3 added, R66 was Not able to express her need, not so much anymore like before. In an interview on 11/07/24, at 09:29 AM, Licensed Practical Nurse (LPN) 4 stated, When she (R66) had COVID May of 2024 she declined that time. She was sick for few days then I noticed that she's a bit weak. Now she needed more help. The confusion also is another thing. She used to be able to get up at the table, here outside. Seems that since then she declined to a point that she stayed in bed and it's hard to get her up. She's spending more time in bed. We have to encourage her more frequently. She is incontinent now. She changed a lot. Before she still can have understandable conversation but now not anymore. She's not the same (name of R66) anymore. Review of R66's electronic medical records (EMR) indicated the following assessment: The Monthly Summary dated 5/10/24, 06/10/24, 07/10/24, 08/10/24 revealed that R66 required limited assistance with one person assist for bed mobility, transfer, dressing, toilet use and bathing. An increased in the level of assistance indicated in the Monthly Summary dated 09/09/24 and 10/09/24 wherein R66 received an extensive assist that required two [2] person assist for bed mobility, toilet use and bathing. In an interview on 11/07/24, at 09:40 AM, MDS Registered Nurse (MDSRN) 2 confirmed that an MDS SCSA was not completed for R66's and she was not aware of R66's changes in level of assistance with the ADL. MDSRN explained that coordinators completing MDS assessment coordinate with the staff and we are doing IDT (Interdiciplinary Team) and discussed the condition of the resident. In a follow up interview on 11/07/24, at 02:11 PM, the MDSRN stated, There was a gap with the communication. I opened a significant change of status assessment for her. The change seems to start last May [2024] charted by CNA in the ADL Survey Report. MDSRN also added, I also updated her (R66) care plan (for ADL). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035216	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caring House	510 South Ocotillo Road Sacaton, AZ 85147

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy titled, Resident Assessment revised in October 2023 indicated, .1.OBRA-Required Assessments are federally mandated, and therefore, must be performed for all residents of Medicare and/or Medicaid certified nursing homes. OBRA assessments include: .d. Significant Change in Status Assessment (SCSA) .12. Information in the MDs assessment will consistently reflect information in the progress notes, plans of care and resident observations/interviews .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035216	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caring House	510 South Ocotillo Road Sacaton, AZ 85147

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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42306 Based on interview and record review, the facility failed to accurately assess one (1) of 19 sampled residents (Resident [R]16) reviewed for Minimum Data Set (MDS) Assessments. Specifically, the facility failed to code insulin accurately for R16. The deficient practice could result in care plans without resident specific care needs addressed. Findings include: Review of the Admission Record located under the Profile tab in the Electronic Medical Record (EMR) revealed that R16 was admitted on [DATE] with diagnoses that included type 2 diabetes mellitus with hyperglycemia, diabetes mellitus due to underlying condition with diabetic autonomic (poly)neuropathy, and metabolic encephalopathy. Review of physician's order dated 08/07/24 revealed R16 was receiving Ozempic 4mg/3ML (milligram/milliliter), inject 1 mg subcutaneously in the morning every Wednesday related to Type 2 Diabetes Mellitus with Hyperglycemia. Review of a Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/23/24 revealed R16 had no cognitive deficits with a Brief Interview for Mental Status (BIMS) score of 15. The assessment include that R16 had received Insulin one day during the lookback period. On 11/07/24 at 12:38 PM an interview with concurrent record review was conducted with Minimum Data Set Nurse MDS 3. MDS3 stated that they had completed the quarterly MDS assessment with ARD 08/23/24. When asked if Ozempic was an insulin, MDS3 said, yes. When asked what drug reference manual she used, MDS3 said, Google. During the interview, MDS3 Googled Ozempic and said, it says right there, used to treat diabetes. During an interview on 11/07/24 at 12:50 PM, the Director of Nursing (DON) reviewed the MDS and medical record for R16. When asked what insulin R16 was on during the Quarterly MDS with an ARD of 08/23/24, the DON said, Ozempic. When asked if Ozempic was a long acting or short acting insulin, the DON stated she would need to go and get the drug book to get that information. The DON left the office and returned with a Wolters Drug Guide dated 2023. The DON stated, I misspoke, it is not insulin. When asked if the Quarterly MDS was coded correctly for Insulin for R16, the DON said, no, the resident is not on insulin. Review of a facility policy titled Comprehensive Assessments reviewed/updated 05/24 revealed that the comprehensive MDS assessments are conducted to assist in developing person-centered care plans. The facility conducts comprehensive, accurate, standardized, reproducible assessments of each resident's functional capacity using the Resident Assessment Instrument specified by CMS. Comprehensive assessments are conducted and coordinated by a registered nurse with appropriate participation of other health professionals on the interdisciplinary team.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035216	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caring House	510 South Ocotillo Road Sacaton, AZ 85147

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40844 Based on interview, and record review the facility failed to ensure staff provided adequate supervision for two residents out of five facility reported events reviewed. Staff left Resident (R) 63 in the shower unsupervised and R63 fell and sustained a minor injury. Staff failed to effectively supervise R42 during a community outing which resulted in R42 becoming agitated and his hand hit R193 on the leg while attempting to transfer. Findings include: Review of facility reported incident AZ00216917, revealed that during a community outing with the Activities Department an incident occurred where one resident (R42) hit another resident (R193). Review of the witness statements revealed the Activities Department took 7 residents to a ball game on 09/29/24, and while trying to get everyone situated in the suite, described as small and crammed, R42 hit R193 on the left knee. Review of the Admission Record revealed the facility admitted R42 on 12/24/20. The document listed the primary diagnosis as unspecified dementia, unspecified severity, with other behavioral disturbance, onset date 12/05/2023. Other diagnoses listed included other specified disorders of brain, personal history of traumatic brain injury, other amnesia, and adjustment disorder with depressed mood. A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the facility assessed R42 to be cognitively intact scoring 15 out of 15 on a Brief Interview for Mental Status. The Functional Abilities Section GG revealed the facility asses R42 has impairment in the lower extremities, used a wheelchair, and required assistance for transfers. The quarterly Social Services assessment dated [DATE] revealed under GOALS, Progress: Care plans include . support for agitation and aggressive behaviors. It indicated that R42 was doing well in this area as R42 had not had recent occurrences of agitation or aggression. On 11/06/24 at 03:47 PM the Activities Director (AD) described that the residents chose the community outings as a group, and the facility provided a one staff to one resident ratio during the outing. In planning, they had to consider accommodation for specific residents going on the outing, such as ensuring the space was accessible, and activities were appropriate to the residents' needs. The facility could typically accommodate up to eight residents on a group outing. When asked about resident incident where R42 hit R193 on 09/29/24, AD confirmed awareness and described when the R42 got upset during the seating at the ball game and hit R193 on the leg. AD was not there, and did not know exactly what happened, however she stated her staff separated R42 from the other residents. AD described that R42 did not have a history of aggression in groups. AD confirmed during the ball game on 09/29/24, they provide one staff for every resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035216	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caring House	510 South Ocotillo Road Sacaton, AZ 85147

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R42's care plan revealed six focus areas related to behaviors in effect at the time of the ball game outing. The foci included R42 becomes upset with staff when he doesn't 'get his way' . becomes agitated toward staff by striking out during cares . [and] Address the behavioral and safety needs of the resident in accordance with a behavior and safety contract signed by the resident on 4/29/24. The contract included, I prefer not to be told what to do. Please speak to me in a mild manner, I get upset when somebody uses a commanding tone on me. Allow space between us when I am upset . Goals included, Positive behaviors and safety will be maintained while resident is supported through promoting adherence to a behavioral and safety contract. Date Initiated: 09/19/2024; Ensure safety and give [R42] space if he is striking out . will not threaten, physically strike out at staff during cares .; [and] will demonstrate effective coping skills . Interventions planned to help R42 achieve the goals included, Staff will promote understanding of the expectations outlined in the behavioral / safety contract and will provide support .; Avoid power struggles with resident; Maintain a calm and accommodating environment; anticipate resident's needs . When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress .; Assess and address for contributing sensory deficits . provide physical and verbal cues to alleviate anxiety. During a phone interview on 11/07/24 at 05:06 PM, Activities Aide (AA) 5 confirmed they attended the outing on 09/29/24 and witnessed when R42's hand hit R193. AA5 described they were standing in front of R42 trying to assist as the residents were being seated. She described R193 was seated next to R42 and while attempting assist R42 he made a quick strike which hit R193's leg. When asked AA5 if they were familiar with R42's care plan, AA5 indicated they were only aware at the time that R42 was from the A unit (the locked dementia care unit). During an interview on 11/08/24 at 11:46 AM the Director of Nursing (DON) confirmed she completed the facility investigation into the incident during the ball game outing. She described the facility has assessed the box suite for accessibility prior the outing and had had some modifications made to the space, and residents who could transfer would use the stadium seating. The event happened in the beginning, during the time everyone was being seated. The space was small, and it was probably noisy. [R42] has a dementia diagnosis, and he may have been overstimulated . He tried to stand himself up and his arm hit [R193's] leg. He was trying to stand when he just stuck down with his arm . she was speaking loud and he was getting agitated, and he tried to stand. A concurrent review of the statement provided by RN5, the nurse who attended the outing, revealed that R42 usually transferred with the aid of a slide board which they did not bring, and staff were attempting to assist a transfer without it. RN5 asked R42 if he was able to stand and he shouted at me 'That is what I am trying to do! Stop yelling at me'. It was loud in the stadium, and I had to talk loud for him to hear me. I asked the CNA [certified nursing assistant 52] how [R42] transfers at the facility because I have not worked with him before and stated he uses a slide board. RN5 directed staff to have R42 stay in the wheelchair. The DON stated staff notified her immediately and they separated R42 from the other residents and assessed R193 to have no injury; and further described appropriate interventions implemented following the event such as one to one monitoring whenever R42 was off the unit, and activity aides are dedicated to the A unit. She confirmed her expectation was the multiple care plans for behavioral issues should be evaluated during care planning and condensed to a comprehensive care plan. 42306 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035216	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caring House	510 South Ocotillo Road Sacaton, AZ 85147

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Admission Record located under the Profile tab in the Electronic Medical Record (EMR) revealed that Resident 63 (R) was admitted on [DATE] with diagnoses that included other sequelae of cerebral infarction, memory deficit following cerebral infarction, neuromuscular dysfunction of bladder, unspecified dementia, degenerative disease of nervous system, and bunion of unspecified foot. Review of a Care Plan initiated on 03/30/23 for Activities of Daily Living (ADLs) for self-care deficit included a goal that demonstrate improved ADL performance as evidenced needing limited assist) with all ADLs. An intervention for this goal included that a minimum of one staff to remain with resident while resident is showering Review of a facility investigation dated 07/10/24 revealed that Certified Nursing Assistant 71 (CNA) had left Resident 63 alone, unsupervised, in the shower on 07/01/24. The investigation included that another CNA (45) noticed 10-15 minutes after CNA71 left R63 alone, the call light was on in the resident's room. When CNA 45 entered the room with CNA 71 they found R63 on the floor of the bathroom. The investigation included that R63 was administered acetaminophen after the fall for headache pain. The investigation included that R63 usually requires substantial/maximum assistance of one to two as indicated for the ability to bathe self including washing, rinsing, and drying self. The investigation also included that CNA 71 received disciplinary action for poor judgement in leaving the resident unattended in the shower. Review of a Health Status Note dated 07/01/2024 entered at 10:06 PM by a Licensed Practical Nurse (LPN) in the Progress Notes under the Progress Notes tab revealed R63 was found lying on the shower floor on his (L) side, shower chair was also lying on its side. Resident denies hitting head on the floor. Skin assessment completed with no apparent injuries noted. The resident's range of motion was within normal limits to all extremities. The note included that the resident denied any pain. Review of another Health Status Note dated 07/01/2024 entered at 10:30 PM included that the resident was found lying on the floor. The note included that the resident stated they were seated in the shower chair and tried to reach for a wash cloth that had fell on the floor causing the resident to slip. Review of Orders written by the provider under the Orders tab in the EMR revealed the following: -STAT CT of the head with neuro consult. New contusion areas to forehead and Left eye orbit area. (ordered 07/02/2024) Review of a Care Plan initiated on 07/09/2024 for Showering included an intervention that Nursing staff will check the water before [NAME] sit for 10 min on the shower chair with just the water running on him per his preference after the shower tasks are complete and supervise him. During an interview on 11/05/24 at 10:08 AM, Resident 63 (R) stated they were in a shower chair when staff left him alone on 7/1/24. He reached for a wash cloth and the body went one way and the wheelchair went the other way. Resident 63 stated he did not get hurt. A call was placed to CNA 71 and a message was left. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035216	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caring House	510 South Ocotillo Road Sacaton, AZ 85147

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/07/24 at 01:19 PM with the Director of Nursing (DON) and Administrator, the DON stated they were notified the morning of 07/02/24 that R63 had been found lying in the shower by staff and at that time they initiated an investigation into an allegation of Neglect based on the information they were provided. The Administrator stated that they took disciplinary action because CNA 71 left R63 alone in the shower. On 11/07/24 at 02:02 PM an interview was conducted via phone with CNA 45. CNA 45 stated that they had left the resident with CNA71 and that at some point CNA71 must have left the room. CNA45 stated that when they were answering the call light for R63, CNA71 was not in the room. CNA45 stated that when they entered the bathroom the resident was found lying on the bathroom floor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035216	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caring House	510 South Ocotillo Road Sacaton, AZ 85147

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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42306 Based on observations, interviews, review of the [NAME] Drug Guide, and review of records and policies and procedures, the facility failed to provide services to manage the pain for one of two residents sampled for pain (Resident [R]46) consistent with professional standards, the comprehensive person-centered care plan, and the residents' goals and preferences. Specifically: 1) Staff did not follow facility policy and procedures for assessment and recognition of R46's pain failing to identify location, intensity, frequency, pattern, and severity for each reported pain occurrence. 2) The facility's failure to provide pain management resulted in harm when R46's pain reached a level, exhibited by crying and being tearful, for a documented two hours and twenty minutes before transferring to a hospital for severe back pain. 3) Staff did not reassess type, location and intensity of pain R46 within 1 hour (HR) of administration of an As Needed (PRN) opioid (narcotic pain medication, oxycodone) in accordance with professional standards. Findings include: Review of the Admission Record located under the Profile tab in the Electronic Medical Record (EMR) revealed that Resident 46 (R) was admitted on [DATE] and readmitted on [DATE] with diagnoses that included pain in thoracic spine, systemic lupus erythematosus (a chronic autoimmune disease that occurs when the body's immune system attacks its own healthy tissues and organs), Sjogren syndrome (a chronic autoimmune disease that occurs when the body's immune system attacks the glands that produce tears and saliva), Ankylosing Spondylitis (a chronic inflammatory disease that causes inflammation in the spine and other joints) of unspecified sites in spine, chronic pain syndrome, age-related osteoporosis (a medical condition characterized by a significant decrease in bone mass and density, resulting in weakened bones that are more susceptible to fractures) without current pathological fracture, fusion of spine, cervicalgia (neck pain), fracture of neck, and limitation of activities due to disability. Review of physician orders found in R46's EMR under the orders tab revealed the following: -Monitor and Record Pain Assessments Q (every) Shift, using 0-10 scale. 0= no pain,1-3 Mild Pain,4-5 Moderate Pain,6-10 Severe Pain. If [the resident is] Unable To Verbalize, Use Wong-Baker's Corresponding Facial Expression. Documentation to Include- Location of Pain, Non-Medication Interventions offered, received PRN medication or med was offered and declined. Non-Medication Interventions, 1. Back Rub 2. Reposition 3. Diversional Activity 4. Received Scheduled Pain Meds. every shift (ordered 09/16/24, discontinued 10/16/24, and reordered 10/16/24). -oxyCODONE HCl ER Oral Tablet ER 12 Hour Abuse Deterrent 10 MG (Oxycodone HCl) Give 1 tablet by mouth one time only for Chronic pain for 1 Day (ordered 09/16/26, ended 09/17/24). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035216	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caring House	510 South Ocotillo Road Sacaton, AZ 85147

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 0697 Level of Harm - Actual harm Residents Affected - Few	-oxyCODONE HCl ER Oral Tablet ER 12 Hour AbuseDeterrent 10 MG (Oxycodone HCl) Give 1 tablet by mouth two times a day for Pain for 3 Days (ordered 09/16/24, end date 09/19/24). -oxyCODONE HCl Oral Tablet 10 MG (Oxycodone HCl) Give 1 tablet by mouth every 6 hours as needed for Pain 6-10 for 3 Days (ordered 09/16/24, end date 09/19/24). -Lyrica Oral Capsule 100 MG (Pregabalin) Give 100 mg by mouth three times a day related to CHRONIC PAIN SYNDROME (G89.4) (ordered 09/18/24, reordered 10/16/24). -oxyCODONE HCl Oral Tablet 10 MG (Oxycodone HCl) Give 1 tablet by mouth every 6 hours as needed for Pain 6-10 until 10/04/2024 23:59 (ordered 09/17/24, end date 10/04/24). -oxyCODONE HCl Oral Tablet 10 MG (Oxycodone HCl) Give 1 tablet by mouth every 6 hours as needed for Pain 6-10 until 10/24/2024 23:59 (ordered 10/04/24, end date 10/24/24). -oxyCODONE HCl Oral Tablet 10 MG (Oxycodone HCl) Give 1 tablet by mouth every 6 hours as needed for Pain 6-10 (ordered 10/16/24). -Send to ED for evaluation and treatment one time only for resident request for back pain for 1 Day (ordered 10/10/24). Review of a Care Plan initiated 09/19/24 for chronic pain/discomfort related to Rheumatoid arthritis flare, Lupus Erythematosus, Rheumatoid arthritis and osteoarthritis of multiple sites, and carpal tunnel syndrome included a goal that R46 would state/demonstrate relief or reduction in pain intensity within one hour after receiving interventions. The interventions for this goal included to Administer medications as ordered, for staff to evaluate/record/report effectiveness, and to monitor and record any complaints of pain including the location, frequency, effect on function, intensity, alleviating factors, and aggravating factors. Review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/23/24, indicated R46 had no cognitive deficits with a Brief Interview for Mental Status (BIMS) score of 15. The assessment included that R46 had upper and lower extremity impairment on both sides and needed partial/moderate assistance with rolling left to right, going from a sitting to lying position, and from a lying to sitting position. The assessment included that R46 had medical conditions that included arthritis and osteoporosis and that R46 was receiving scheduled and as needed pain medication for pain management. The Pain assessment included that the resident had frequent pain that did not affect sleeping but would occasionally interfere with therapy activities. Review of a Provider Progress Note dated 09/23/24 entered at 01:42 PM located in the Progress Notes under the Progress Notes tab revealed R46 was not satisfied with her current pain management and would like a new referral to see a different pain management clinic. Review of the Medication Administration Record (MAR) for September 2024 located in the Reports of the EMR and review of pain reassessments located in Progress Notes located under the progress notes tab in the EMR revealed R46 had received oxycodone hcl oral 10 milligram tablet by mouth for pain on the following days that was documented as ineffective or unknown effectiveness with reassessments over one hour later: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035216	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caring House	510 South Ocotillo Road Sacaton, AZ 85147

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 0697 Level of Harm - Actual harm Residents Affected - Few	-On 09/24/24 at 01:37 PM staff administered oxycodone for documented pain level of 8/10 with a reassessment of effectiveness of unknown (U) documented 4 hours 54 minutes later, on 09/24/24 at 06:31 PM. Review of an Administration Note dated 09/24/24 entered at 01:37 AM located in the Progress Notes under the Progress Notes tab revealed R46 had 8 out 10 (1 being little or no pain and 10 being the worst pain possible) and that pain was located in the back. Review of another Administration Note dated 09/24/24 entered at 06:31 PM located in the Progress Notes under the Progress Notes tab revealed the PRN [as needed] Administration was: Unknown. Review of a third Administration Note dated 09/24/24 entered at 07:37 PM located in the Progress Notes under the Progress Notes tab revealed R46 had 8 out 10 and that pain was located in the back. -On 09/26/24 at 09:32 AM staff administered oxycodone for documented pain level 9/10 with a reassessment of effectiveness of ineffective (I) documented 3 hours 18 minutes later, on 09/26/24 at 12:54 PM. Review of an Administration Note dated 09/26/24 entered at 12:54 PM located in the Progress Notes under the Progress Notes tab revealed a Registered Nurse (RN) entered the following: PRN Administration was: Ineffective, Resident reports pain is the same but this is her normal pain and medication regime that [they] has been like this for [AGE] years. Follow-up Pain Scale was: 9. -On 09/28/24 at 07:22 PM staff administered oxycodone for documented pain level of 9/10, with a reassessment of effectiveness of ineffective (I) documented 2 hours 34 minutes later, on 09/28/24 at 09:56 PM. Review of an Administration Note dated 09/28/24 entered at 09:56 PM located in the Progress Notes under the Progress Notes tab revealed a Registered Nurse (RN) entered the following: PRN Administration was: Ineffective, Resident reports pain 9/10, states this is her regular, medicated with scheduled med. Follow-up Pain Scale was: 9. -09/28/24 at 11:22 PM staff administered oxycodone for documented pain level pain level of 9/10 with a reassessment of effectiveness of ineffective (I) documented 6 hours 3 minutes later, on 09/29/24 at 05:25 AM. Review of an Administration Note dated 09/29/24 entered at 05:25 AM located in the Progress Notes under the Progress Notes tab revealed a Licensed Practical Nurse (LPN) entered the following: PRN Administration was: Ineffective, Follow-up Pain Scale was: 8. Review of a Administration Note dated 09/29/24 entered at 11:30 AM located in the Progress Notes under the Progress Notes tab revealed R46 had 10 out 10 and that pain was located in the back. -09/29/24 at 11:50 PM staff administered oxycodone for documented pain level of 6/10 with a reassessment of effectives of unknown (U) documented 6 hours 2 minutes later, on 09/30/24 at 05:52 AM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035216	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caring House	510 South Ocotillo Road Sacaton, AZ 85147

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 0697 Level of Harm - Actual harm Residents Affected - Few	Review of an Administration Note dated 09/30/24 entered at 05:52 AM located in the Progress Notes under the Progress Notes tab revealed a Licensed Practical Nurse (LPN) entered the following: PRN Administration was: Unknown, sleeping. Review of another Administration Note dated 09/30/24 entered at 11:49 AM located in the Progress Notes under the Progress Notes tab revealed R46 had 8 out 10 and that pain was located in the back. -09/30/24 at 05:58 PM staff administered oxycodone for documented pain level of 8/10 with a reassessment of effectives of ineffective (I) documented 3 hours 13 minutes later, on 09/30/24 at 09:05 PM. Review of a Administration Note dated 09/30/24 entered at 05:58 PM located in the Progress Notes under the Progress Notes tab revealed R46 had 8 out 10 and that pain was located in the back. Review of an Administration Note dated 09/30/24 entered at 09:05 PM located in the Progress Notes under the Progress Notes tab revealed a Licensed Practical Nurse (LPN) entered the following: PRN Administration was: Ineffective Follow-up Pain Scale was: 8 Review of the EMR revealed no evidence that any assessments were completed within one hour of medication administration or that the provider was notified of the Ineffectiveness of the pain medication. The EMR did not reveal any evidence of any additional interventions offered when pain medication was ineffective or a provider notification for the infectiveness of the opioid pain medication. Review of the Medication Administration Record (MAR) for October 2024 located in the Reports of the EMR and review of pain reassessments located in Progress Notes located under the progress notes tab in the EMR revealed R46 had received oxycodone hcl oral 10 milligram tablet by mouth for pain on the following days that was documented as ineffective or unknown effectiveness: -10/01/24 at 12:02 AM staff administered oxycodone for documented pain level for pain level of 8/10 with a reassessment of effectiveness of ineffective (I) documented 6 hours 4 minutes later, on 10/01/24 at 06:06 AM. Review of an Administration Note dated 10/01/24 entered at 06:06 AM located in the Progress Notes under the Progress Notes tab revealed a Licensed Practical Nurse (LPN) entered the following: PRN Administration was: Ineffective. Follow-up Pain Scale was: 7. -10/02/24 at 08:18 PM staff administered oxycodone for documented pain level for pain level of 8/10 with a reassessment of effectiveness of unknown (U) documented 2 hours 12 minutes later, on 10/02/24 at 10:30 AM. Review of an Administration Note dated 10/02/24 entered at 10:30 PM located in the Progress Notes under the Progress Notes tab revealed a Licensed Practical Nurse (LPN) entered the following: PRN Administration was: Unknown Resident sleeping. Review of an Administration Note dated 10/09/2024 entered at 12:00 AM in the Progress Notes under the Progress Notes tab revealed R46 had complained of neck and knee pain at a level of 6/10. The note included that R46 was administered : oxyCODONE HCl Oral Tablet 10 MG, 1 tablet by mouth. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035216	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caring House	510 South Ocotillo Road Sacaton, AZ 85147

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 0697 Level of Harm - Actual harm Residents Affected - Few	Review of another Administration Note date 10/09/24 entered at 01:11 AM revealed the oxycodone administered at 12:00 AM was effective and the current pain level for R46 was a 3/10. Review of an Administration Note dated 10/09/2024 entered at 06;00 AM in the Progress Notes under the Progress Notes tab revealed R46 had complained of neck and knee pain at a level of 7/10. The note included that R46 was administered : oxyCODONE HCl Oral Tablet 10 MG, 1 tablet by mouth. Review of another Administration Note date 10/09/24 entered at 07:00 AM revealed the oxycodone administered at 06:00 AM was effective and the current pain level for R46 was a 0/10. Review of a Health Status Note dated 10/09/2024 entered at 07:55 AM by Licensed Practical Nurse (LPN) in the Progress Notes under the Progress Notes tab revealed R46 stated she was having chest pain that started around 04:00 AM. Resident states she considered notifying night shift staff but decided not to, encouraged resident to immediately notify staff of all medical changes/concerns to reduce risks of poor outcomes. Resident states her understanding. Resident denies shortness of breath, confirms feeling pressure to chest and having new onset of upper back pain. Heart rate 92/pulse bounding, other vitals stable. Resp even and unlabored, alert and orientated times 4, and able to make needs known. 911 called and EMS [Emergency Medical Services] evaluation/transport dispatched. Provider made aware. Review of another Health Status Note dated 10/09/2024 entered at 02:00 PM by a Licensed Practical Nurse (LPN) in the Progress Notes under the Progress Notes tab revealed R46 returned from HHK ED via EMS. No new cardiac findings reported. HHK ED provider note states CT scan of chest shows age-indeterminate minimal superior endplate deformity of the T4 for vertebral body. Resident states pain medication was received at ED and is being well managed. She [the resident] denies pain or discomfort to chest, shortness of breath or pain outside of her normal tolerated range. Review of a Health Status Note dated 10/09/2024 entered at 03:56 PM by a Registered Nurse (RN) in the Progress Notes under the Progress Notes tab revealed R46 was medicated for general pain after returning from emergency room with prn Oxycodone 10 mg, 02:00 PM Lyrica and baclofen. The note included that the nurse was unable to sign out 02:00 PM medication on mar because medication resumed after 02:00 PM. Then the note said the resident was given scheduled 02:00 PM medication as ordered. Hob (head of bed) elevated call light in reach. Review of a Health Status Note dated 10/10/2024 entered at 05:35 AM by Licensed Practical Nurse (LPN) in the Progress Notes under the Progress Notes tab revealed R46 was medicated with Oxycodone PRN x 2 r/t increased back pain and arms pain. Resident rated her pain 9 out 10. Resident is tachycardia thru out the night. HR fluctuated between 103-108 bpm. Resident voiced her concerns regarding the x-ray result. Resident had crying episodes r/t increased back pain. Resident was concerned regarding her fracture T3-T4. Resident was restless thru out the night. Resident was crying after she had her brief changed. Writer asked why she was tearful [and] states, I'm in a lot of pain when I was changed. Informed resident that provider will be informed of her recent increased pain. Endorse to oncoming nurse. Review of the EMR revealed no evidence a provider was notified of R46 crying in pain on 10/10/24 from 05:35 AM to 07:55 AM, a total of two hours and twenty minutes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035216	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caring House	510 South Ocotillo Road Sacaton, AZ 85147

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 0697 Level of Harm - Actual harm Residents Affected - Few	Review of another Health Status Note dated 10/10/2024 entered at 07:55 AM by a Licensed Practical Nurse (LPN) in the Progress Notes under the Progress Notes tab revealed R46 was assessed as a follow up with ED visit yesterday r/t chest and upper back pain, as well as elevated heart rate during this mornings vital assessment. Resident was lying in bed and visibly in pain, crying. She was medicated as ordered prior to assessment. Resident requests to be sent to ER for further evaluation, stating she believes the hospital can manage her pain better during CT scans and xrays ordered by neurosurgeon. Provider made aware. Resident denies shortness of breath or chest pain. Heart rate 117/pulse bounding, other vitals stable. Resp even and unlabored. A&Ox4, able to make needs known. 911 called and EMS dispatched. Provider made aware. Review of a Notice of Resident Transfer or discharge date d 10/10/24 located in the EMR revealed R46 had been transferred to the hospital. The notice included that the transfer is necessary for the resident's welfare and the resident's needs cannot be met by the facility (i.e. urgent medical need). Specifically severe back pain. Review of another Health Status Note dated 10/10/2024 entered at 03:59 PM by Licensed Practical Nurse (LPN) in the Progress Notes under the Progress Notes tab revealed R46 was admitted to the hospital for observation and treatment. Review of a History and Physical from an emergency room visit hospital visit on 10/10/24 located in the MISC tab of the EMR revealed R46 was sent to the hospital for back pain. The History and Physical included that R46 had reported acute worsening pain in back over past few days despite taking home pain meds. Pt reports having fever at home. no chills. denies nausea vomiting. + pain persist. denies joint pain at this time which patient states is usual for acute ra [Rheumatoid arthritis] flare The hospital records included that x-rays were completed without any new fractures. During an interview conducted on 11/05/24 at 01:17 PM, R46 stated they had been removed for the original pain management program which had been working. The resident stated that she was hospitalized in October because the pain went from their back through their chest. R46 stated that now the pain hardly ever gets below a 9/10 because staff do not provide requested pain medications timely. R46 stated when pain meds are NOT given regularly, her pain level is 7/10 and she is not able to perform therapy and ADLs. R46 stated the uncontrolled pain had been going on for weeks. An observation conducted on 11/07/24 at 09:05 AM of medication administration to R46, Registered Nurse 14 (RN) entered the room to provide scheduled morning medications. During the observation, RN14 asked the resident if they were still having pain after giving as needed pain medication earlier that morning. R46 stated the pain was still a 9/10. RN14 was observed continuing with the medication administration but did not ask where the pain was currently located, the intensity, duration, or if it was a different pain than reported in the morning. After the administration, RN14 was asked by the resident to ensure their pain was managed by 10:00 AM to 10:30 AM so that R46 could attend a physical therapy appointment. R14 agreed and left the room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035216	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caring House	510 South Ocotillo Road Sacaton, AZ 85147

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 0697 Level of Harm - Actual harm Residents Affected - Few	On 11/07/24 at 09:10 AM an interview with concurrent record review was conducted with RN14. When asked when R46 had received the as needed pain medication, RN14 stated she had given on oxycodone at 07:30 PM. When asked how long after oral pain medication should a reassessment be performed, RN14 stated, in about a half hour to 40 minutes. When asked if the pain medication is ineffective what is usually done, RN14 stated they would call the medical provider. RN14 stated that R46 always has a pain level of 9/10 and that the pain reassessment was not done until 09:10 AM because she was busy with another resident. When asked what the components of a pain assessment include, RN14 stated she would ask, where the pain is, the intensity of the pain, the duration of the pain, if the pain was different, intermittent versus constant, and if anything made the pain better. When asked why she did not do that when the resident complained of a 9/10 pain, RN14 stated she assumed the pain was in the resident's back because that is where it normally is located. When asked how pain assessments are documented, RN14 stated that it is in the EMR under the MAR or in a Progress Note but they only document if the medication was effective or not and a pain level. RN14 stated the system doesn't require them to do a full pain assessment unless it is an annual or quarterly pain assessment or a new admission. When asked what the potential outcome could be for not completing a pain assessment, RN14 stated that, if the medication is not working it would be important to make sure there are not other things going on causing serious harm, or complications from the medication. Or if the medication is effective they [physician] may want to cut back. Review of a Progress Note Linked note created on 11/7/24 at 05:52 PM by RN14 included documentation that R46's pain level at 08:30 AM was a 0/10. During an interview on 11/08/24 at 09:27 AM with RN14, she stated that, I think I was rushing, she [the resident] still had pain, I don't why put zero, [the pain] wouldn't be a zero. When asked what would be the potential risk of not documenting pain accurately, RN14 stated the doctor could look at that [the zero] and think the medication is working and possible lower the dose. When asked if she had completed a the pain assessment documented at 08:30 AM, RN14 stated, no. I chose that 08:30 AM time because they [the facility] like the times to match, that is the goal. When asked if she was instructed to document something inaccurately at the end of her shift, RN14 said, no, she just did that. It should be documented when it is done. R14 stated she had to give more pain pills between the 09:10 AM and the end of her shift but did not complete a full pain assessment during the shift from 06:00 AM to 06:30 PM on 11/08/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035216	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caring House	510 South Ocotillo Road Sacaton, AZ 85147

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 0697 Level of Harm - Actual harm Residents Affected - Few	On 11/08/24 at 09:44 during an interview with concurrent record review, Registered Nurse 19 (RN) stated that a pain assessment is completed on admission, quarterly, on readmission, and annually with the MDS assessment schedule. RN19 stated that daily pain assessments include the pain level but could not recall if the location is included in the assessment. RN19 stated that providers should be notified if pain medication is not working and PRN pain medications should be assessed for effectiveness within one hour. RN19 stated the expectation is to follow policies, procedures, and professional standards for assessing a resident's pain. RN19 stated that if a nurse cannot document in real time, when they do document it should be truthful to include the assessment, what they gave, when they gave it, and how effective it was. RN19 stated the R46's pain level is normally at a level of 9/10. When asked what the potential danger would be in not accurately assessing or documenting pain for a resident, RN19 said, you wouldn't know if the medication is effective or not. RN19 stated if the provider was to print them [records] off it would potentially affect the care given to the resident. When reviewing the delayed time in completing reassessments of pain after the administration of as needed pain medications, RN19 was asked if the documentation showed professional standards were met. RN19 stated no, and when asked how long after a PRN pain medication is administered should the pain be assessed, RN19 said, one hour. On 11/08/24 at 10:53 AM an interview with concurrent record review was conducted with the Director of Nursing (DON). The DON stated that once a PRN pain medication is given, the evaluation of the effectiveness should be documented between 30 to 60 minutes later. The DON stated that the documentation should be in real time if possible. The DON stated that if a PRN pain medication is ineffective, the expectation is for staff to notify the provider. The DON stated the assessment should get more information like the number (pain level or scale), location, describing what type of pain (throbbing/stabbing/ache), specifically make it [the pain] worse, and is there something to elevate it [the pain]. The DON stated that the complete assessment should be documented in the EMR. When asked what the potential problem would be from not documenting accurate pain levels or completing pain assessments within one hour of administration, the DON stated it would be difficult to know the effectiveness of the medications on the resident's pain. When asked if reassessing PRN pain medication hours after it has been administered followed facility policies and procedures in the treatment of pain, the DON said, no. When asked if documenting inaccurate pain levels is an accepted practice at the facility, the DON said, no. When asked if pain assessments longer than an hour meet professional standards for PRN pain medication administration, the DON said, no. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035216	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caring House	510 South Ocotillo Road Sacaton, AZ 85147

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 0697 Level of Harm - Actual harm Residents Affected - Few	Review of a facility policy titled Pain - CP Assessment and Recognition revised 06/2024 included that the physician and staff will identify individuals who have pain or who are at risk for having pain. This includes reviewing known diagnoses and conditions that commonly cause pain; for example, degenerative joint disease, rheumatoid arthritis, osteoporosis (with or without vertebral compression fractures). diabetic neuropathy, oral or dental pathology, and post-stroke syndromes. It also includes a review for any treatments that the resident currently is receiving for pain, including complementary and non-pharmacologic treatments. The nursing staff will assess each individual for pain upon admission to the facility, at the quarterly review, whenever there is a significant change in condition, and when there is onset of new pain or worsening of existing pain. The staff and physician will identify the characteristics of pain such as location, intensity, frequency, pattern, and severity. Staff will use a consistent approach and a standardized pain assessment instrument appropriate to the resident's cognitive level. The staff will reassess the individual's pain and related consequences at regular intervals, at least each shift for acute pain or significant change in level of chronic pain and at least weekly in stable chronic pain. a. review of pain should include frequency, duration and intensity of pain, ability to perform activities of daily living (ADLs). Jeep pattern, mood, behavior, and participation in activities. Periodically the physician will evaluate and summarize the status of an individual with chronic or fluctuating pain including the status of any active conditions that exacerbate pain, consequences or complications of pain, and effectiveness of current interventions for pain. Review of the [NAME] Drug Guide dated 11/2024 revealed that an assessment for oral oxycodone includes to assess type, location and intesnity of pain prior to and 1 hr (peak) after administration. The guide also included that a repeat dose can be safely administered at the time of the peak if previous dose is ineffective and side effects are minimal. Cross Reference F842

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035216	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caring House	510 South Ocotillo Road Sacaton, AZ 85147

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42306 Based on observations, interviews, and review of records and facility policies and procedures, the facility failed to ensure medical records were accurate for one of one reviewed resident (Resident [R]46) when Registered Nurse (RN)14 entered an inaccurate pain assessment. The deficient practice could result in resident records not reflecting the actual care and services provided to R46. Findings include: Review of the Admission Record located under the Profile tab in the Electronic Medical Record (EMR) revealed that R46 was admitted on [DATE] and readmitted on [DATE] with diagnoses that included pain in thoracic spine, systemic lupus erythematosus (a chronic autoimmune disease that occurs when the body's immune system attacks its own healthy tissues and organs), Sjogren syndrome (a chronic autoimmune disease that occurs when the body's immune system attacks the glands that produce tears and saliva), Ankylosing Spondylitis (a chronic inflammatory disease that causes inflammation in the spine and other joints) of unspecified sites in spine, chronic pain syndrome, age-related osteoporosis (a medical condition characterized by a significant decrease in bone mass and density). Review of physician orders found in R46's EMR under the orders tab revealed the following: Monitor and Record Pain Assessments every Shift, using 0-10 scale. 0= no pain,1-3 Mild Pain,4-5 Moderate Pain,6-10 Severe Pain. Documentation to include- Location of Pain, Non-Medication Interventions offered, received PRN (as needed) medication or med was offered and declined. The pain medication order included, oxyCODONE HCl Oral Tablet 10 mg (milligram) to give 1 tablet orally every 6 hours as needed for pain of 6-10 ordered on 10/16/24. Review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/23/24, indicated R46 had no cognitive deficits. The assessment included that R46 had arthritis and osteoporosis and was receiving scheduled and as needed pain medication for pain management. The pain assessment included that the resident had frequent pain that did not affect sleeping but would occasionally interfere with therapy activities. A medication administration observation conducted on 11/07/24 at 09:05 AM for R46, RN14 entered the room to provide scheduled morning medications. During the observation, RN14 asked the resident if they were still having pain after giving as needed pain medication earlier that morning. R46 stated the pain was still a 9/10. RN14 was observed continuing with the medication administration but did not ask where the pain was currently located, the intensity, duration, or if it was a different pain than reported in the morning. After the administration, RN14 was asked by the resident to ensure their pain was managed by 10:00 AM to 10:30 AM so that R46 could attend a physical therapy appointment. R14 agreed and left the room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035216	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caring House	510 South Ocotillo Road Sacaton, AZ 85147

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 11/07/24, at 09:10 AM, RN14 stated she had given R46 oxycodone at 07:30 AM. RN14 stated, after oral medication administration, reassessment of pain should be performed in about a half hour to 40 minutes. If the pain medication is ineffective, RN14 stated they would call the medical provider. RN14 stated that R46 always has a pain level of 9/10 and that the pain reassessment was not done until 09:10 AM because she was busy with another resident. When asked how pain assessments are documented, RN14 stated that it is in the EMR under the MAR or in a Progress Note but they only document if the medication was effective or not and a pain level. When asked what the potential outcome could be for not completing a pain assessment, RN14 stated that, if the medication is not working it would be important to make sure there are not other things going on causing serious harm, or complications from the medication. Or if the medication is effective they [physician] may want to cut back. Review of a Medication Administration Record (MAR) for November 2024 revealed R46 had received a PRN Oxycodone on 11/07/24 at 07:30 AM for a pain level of 9/10. The MAR did not indicate a reassessment of the pain medication to indicate if it was effective (E), ineffective (I), or unknown (U). This MAR was printed on 11/07/24 at 09:07 AM. On 11/08/24 at 05:00 AM, a second Review of the MAR for November 2024 revealed that R46 was re-evaluated after the PRN pain medication administration on 11/07/24 at 07:30 AM and was documented as an E which means effective. Review of a Progress Note Linked note by RN14 included documentation that R46's pain level on 11/07/24 at 08:30 AM was a 0/10. The progress note was created by RN14 on 11/07/24 at 05:52 PM (10 hrs after administration of pain medication at 07:30 AM). During an interview and review of R46's 10/07/24 pain reassessment, on 11/08/24 at 09:27 AM, RN14 stated, I think I was rushing, she [R46] still had pain, I don't remember why I put zero [pain level] wouldn't be a zero. RN14 confirmed that the oxycodone administered on 11/07/24 at 07:30 was ineffective. RN14 stated, The doctor could look at that [the zero] and think the medication is working and possible lower the dose [of pain medication]. RN14 explained I chose that 08:30 AM time [to document the pain reassessment] because they [the facility] like the times to match, that is the goal. It should be documented when it is done [reassessment]. On 11/08/24 at 10:53 AM an interview with concurrent record review was conducted with the Director of Nursing (DON). The DON stated that once a PRN pain medication is given, the evaluation of the effectiveness should be documented between 30 to 60 minutes later. The DON stated that the documentation should be in real time if possible and the complete assessment should be documented in the EMR. The DON stated it would be difficult to know the effectiveness of the medications on the resident's pain if reassessment was not completed within one hour of medication administration. According to the DON pain reassessments longer than an hour after pain medication administration and inaccurate documentation of pain level is not an acceptable practice in the facility and does not conform with professional standards. Review of a facility policy titled Health Information Management Documentation of Electronic Health Record Notes revised 06/24, revealed electronic medical records may be used in lieu of paper records when approved by the administrator. Electronic records are an acceptable form of medical record management.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035216	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caring House	510 South Ocotillo Road Sacaton, AZ 85147

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 40844 Based on observation, interview, and record review the facility staff, LPN24, failed to implement hand hygiene appropriately for Resident (R) 73 during a medication observation. This practice had the potential to spread infection. Findings: During a medication administration observation on 11/07/24 at 08:44 AM Licensed Nurse LPN24 prepared and administered an intravenous (IV) antibiotic. LPN24 completed a flush of the PICC line (Peripherally inserted central catheter [PICC] line is used to deliver medications and other treatments directly to the large central veins near the heart) prior to the medication administration following aseptic technique. LPN24 then moved the IV pump closer to R29, and the electrical cord fell off the back, disconnecting the pump. LPN24 picked up the cord and reconnected it to the pump stating she would need to change her gloves now. Observed LPN24 doff (remove) gloves, and immediately donned (put on) a new pair of gloves and resumed the IV medication administration. LPN24 did not perform hand hygiene after removing the contaminated gloves. Following the observation LPN24 confirmed she had skipped a step following doffing gloves stating hand hygiene should occur after taking off gloves. During an interview on 11/07/24 at 12:03 PM The facility Infection Preventionist (IP) confirmed their expectation was that hand hygiene occurred between glove changes. Review of policy titled Infection Prevention and Control Program with revision date 06/2024 read under Standard Precautions, Standard precautions represent the infection prevention measure that apply to all resident care, regardless of suspected or confirmed infection status of the resident in any setting where healthcare is being delivered. These evidence-based practices are designed to protect healthcare staff and resident s by preventing the spread of infections among residents and ensure staff do not carry infectious pathogens on their hands or via equipment during resident care . standard precautions include hand hygiene . Staff must perform hand hygiene (even if gloves are used): . performing an aseptic task; . After removing personal protective equipment (e.g., gloves .).