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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035225 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/22/2024 |
| NAME OF PROVIDER OR SUPPLIER Sun City Post Acute | | STREET ADDRESS, CITY, STATE, ZIP CODE 9940 West Union Hills Drive Sun City, AZ 85373 | |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | |
| <p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47910</p> <p>Based on observations, clinical record review and staff interviews, the facility failed to ensure that medications were not left at bedside and was not readily available for use for one resident (#282). This deficient practice could result in residents not receiving medications as ordered by the physician and in increased risk of side effects.</p> <p>Findings include.</p> <p>Resident #282 admitted on [DATE] with diagnoses of chronic respiratory failure, unspecified whether with hypoxia or hypercapnia, chronic obstructive pulmonary disease, and other nonspecific abnormal finding of lung field.</p> <p>The clinical record revealed a physician order for amoxicillin-pot clavulanate (antibiotic) 875-125 mg (milligram) give 1 tablet by mouth every 12 hours for bacterial infection pneumonia for 10 days.</p> <p>During an observation conducted on March 19, 2024 at 10:03 a.m., resident #282 stated that he forgot to take his pill. The resident then got out of his bed, went to his bedside table, and took a white oval-shaped tablet off the top of the table. The tablet was clearly marked with AMC on one side and 875/125) on the other. The resident stated that the nurse gave him this pill earlier that morning and he had told the nurse he would take it after breakfast because he did not want to take it on an empty stomach. A request was made to show the nurse the pill, prior to ingesting. The resident became upset and said that he had to take the tablet since it was already too late. The resident (#282) placed the tablet in his mouth, but pulled it out immediately after and said that the tablet was too hard to swallow. licensed practical nurse (LPN/staff #123) who assigned to the resident stated that the tablet that resident #282 took was amoxicillin-pot clavulanate 875-125 mg that was prescribed to the resident.</p> <p>An interview with director of nursing (DON/staff #105) and the LPN (staff #123) was conducted on March 19, 2024 at 10:06 a.m. The LPN stated she administered the medication to resident #282 at 7:15 a.m. and had watched the resident take his medication. The LPN said that, the antibiotic amoxicillin was scheduled for 8:00 a.m., and was allowed to administer the medication one hour before and one hour after the scheduled time. The LPN (staff #123) stated the risks of taking the antibiotic at a later time would cause the resident to not get the required dose and would be too close together before the next scheduled dose; or, the resident could also miss a dose. Further, the LPN said that there were no risks associated with taking the prescribed antibiotic outside of the scheduled parameters.</p> <p>(continued on next page)</p> | | |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
| FORM CMS-2567 (02/99) Previous Versions Obsolete | Event ID: | Facility ID: 035225 |
| | | If continuation sheet Page 1 of 5 |

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| <p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview conducted with Director of Nursing (DON/staff #107) on March 20, 2024 at 3:15 p.m., the DON stated when administering medications, the nurse would hand the medication to the resident, stand and watch the resident take the medication as ordered by the physician. The DON said that if the resident should refuse their medications they would let the provider know and document the refusal. The DON further stated it was her expectations that a nurse would not leave medications with a resident to be taken at a later time and that they are to destroy the medication and let the provider know and at no time leave medications at a resident's bedside.</p> | | |

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| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47910</p> <p>Based on clinical record review, resident and staff interviews and review of facility policy, the facility failed to ensure reasonable care was exercised for the protection of one resident's (#64) personal property from loss or theft. The deficient practice could result in residents' personal property not being kept from loss or theft.</p> <p>Findings include:</p> <p>Resident #64 was admitted on [DATE] with diagnoses of peripheral vascular disease, major depressive disorder, unspecified dementia, psychotic disturbance, mood disturbance, anxiety and acquired absence of right leg below knee.</p> <p>Review of the admission note dated October 6, 2021 revealed the resident was admitted from the hospital with no clothing. Per the documentation, there was a wallet with social security card, two keys, credit card and a sealed envelope.</p> <p>Further review of the clinical record revealed there were no personal inventory list for resident #64.</p> <p>The annual Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 9 indicating the resident had moderate cognitive impairment.</p> <p>During an interview with resident #64 conducted on March 19, 2024 at 10:53 a.m., the resident was partially undressed while he was laying on his bed. Resident #64 had a shirt and an incontinence brief on. The resident stated he had been waiting for some shorts or pants from the certified nurse assistant (CNA) so he could get out of bed. The resident also stated that he was missing five pair of pants; and that, he had spoken to laundry and nursing staff about this but the issue had not been resolved. An observation of the resident's personal closet was conducted during the interview and revealed there were a couple of soiled shirts on the bottom of the resident's closet, but there were no pants or shorts found.</p> <p>Another observation was conducted on March 19, 2024 at 11:58 a.m. Resident #64 continued to be on his bed with no pants or shorts on. The resident stated that he was still waiting on some pants to put on.</p> <p>(continued on next page)</p> | | |

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| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>An interview was conducted with a CNA (staff #132) on March 21, 2024 at 12:42 p.m. The CNA stated the process for a new admissions personal property was to list and mark all resident belongings on a personal inventory list. She stated the completed personal inventory list was then given to the nurse who gives it to the social services department. The CNA stated that when a family or the resident brings in new items at the facility, a new personal inventory sheet was completed by the CNA; and that, any personal clothing will have their name labeled on them. The CNA further stated that due to missing clothing issue, the facility had a new system in place. The CNA said that each resident was provided with a laundry bag with their name on it; and, all soiled personal clothing goes in the bag and taken to laundry to be laundered. She said that the cleaned laundered clothes will be placed in the same bag and returned to the resident. Further, the CNA stated that if a resident was missing personal laundry they communicate this to laundry who will try to locate the missing items and a grievance form was also sent to the laundry.</p> <p>An interview was conducted on March 21, 2024 at 12:53 p.m. with a licensed practical nurse (LPN/staff #156) who stated that the facility has a checklist which was completed by the CNA for newly admitted residents; and that, anything of value will go to social services. The LPN said the document was uploaded by medical records and updated in the resident's files. She stated residents clothing was identified by their room number or by their name and the residents have their own personal closet in their rooms. The LPN further stated that if a resident was missing personal clothing the facility process was that staff will check with laundry for the missing clothing then go to social services.</p> <p>In an interview with the Director of Social Services (SSD/staff #87) conducted on March 21, 2024 at 12:58 p.m., the SSD stated an inventory list was completed upon resident admission; and, the following day the social services department will make sure that the form was completed and scanned by medical records. He stated the personal inventory list was uploaded into the resident's miscellaneous records; and that, the resident's inventory list was updated with new items or any new items brought in for the resident. The SSD said that if a resident was missing any personal items there will be a grievance form that is submitted to social services. However, the SSD said that the grievance can be submitted to the social services office verbally or by completing the form; and, he will bring the grievance to the morning meeting. The SSD said that staff will give the grievance on missing personal items including clothes to the appropriate department head who will then need to resolve the issue. The SSD said that the department head notifies social services if the items have been located or not; and that, if the items were not located the resident was reimbursed financially or clothes from the donation closet will be given to the resident. He said the resident had the choice on which resolution they want. Regarding resident #64, a review of the clinical record was conducted with the SSD who stated that there was no admission or updated personal inventory sheet completed found for resident #64 since the resident's admission.</p> <p>On 03/21/24 at approximately 2:30 p.m., an observation of the resident's (#64) closet was conducted with the SSD (staff #87). There were clean clothes with the resident's name hanging in the closet. Resident #64 stated that he was pleased to have his clothes returned. A review of the clinical record was conducted with the SSD immediately following the observation. The SSD stated that a personal inventory list had not been created to reflect the clothing items in the resident's closet.</p> <p>Review of the facility policy on Personal Property revealed that residents are permitted to retain and use personal possessions and appropriate clothing, as space permits. The resident's personal belongings and clothing shall be inventoried and documented upon admission and as such items are replenished.</p> | | |

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| <p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>50116</p> <p>Based on observations and staff interviews, the facility failed to ensure there were no expired medications readily available for resident use; and, failed to ensure that medications were not left unattended. The deficient practice could result in increase risk for side effects and resident having access to unnecessary medications.</p> <p>Findings include:</p> <p>A medication cart observation in the A-hall was conducted with a licensed practical nurse (LPN (staff #191) on March 21, 2024 at 9:59 a.m. There was an expired enteric coated aspirin was found in the top drawer of the medication cart. The LPN removed the bottle from the medication cart; and, the LPN stated that she had been through that cart multiple times looking for outdated medications.</p> <p>In an interview with another LPN (staff #198) conducted on March 21, 2024, the LPN stated that if an expired medication was given to the resident, she would notify the unit manager and the doctor, make a notation in the resident's clinical record.</p> <p>During the medication pass observation conducted with another LPN (staff #92) on March 22, 2024 at 8:26 a. m., the LPN was preparing the medications for administration. The LPN pressed the Bumetanide 1 mg (milligram) out of the blister package and into the medication cup. The blister package had an expiration date of January 30, 2024. The LPN then started to prepare another medication and placed it on the same medication cup. The LPN started to walk away from the cart with the medication cup. An interview was conducted with the LPN immediately following the observation and the LPN read the date on the blister pack out loud and then pulled a different blister package for Bumetanide with an expiration date of April 30, 2024. The LPN could not explain why the Bumetanide blister pack with expiration date of January 30, 2024 was still in the medication cart and is readily available for resident use. The LPN left the blister pack with the expired Bumetanide on top of the medication cart and proceeded to give the unexpired medication to the resident in the room. A review of the Bumetanide blister pack with expiration date of January 30, 2024 revealed that pill numbers of 1 through 14 and 22 through 30 were punched out.</p> <p>An interview with the director of nursing (DON/staff #107) conducted on March 22, 2024. The DON stated that the LPN (staff #92) had informed her of the expired medication but did not inform of the expired medications being left on the top of the cart unattended. The DON further stated that there should be no expired medications in the medication carts; and, staff were not to leave medications unattended.</p> | | |