STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035231	A. Building B. Wing	06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sierra Winds	17300 North 88th Ave Peoria, AZ 85382

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** 42998 Based on observations, clinical record review, staff interviews and policies and procedures, the facility failed to ensure fall safety measures were in place to prevent a fall with major injury for one resident (#19). The deficient practice could contribute to residents being injured during a fall. Findings include: Resident #19 was admitted on [DATE] with diagnoses of metabolic encephalopathy, unspecified dementia severe, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. The MDS (minimum data set) assessment dated [DATE] revealed that the resident was assessed to be a two +person physical assist for bed mobility, transfer and locomotion on the unit. The assessment included a BIMS (brief interview for mental status) score of 10 indicating the resident had moderate cognitive impairment. A Hospice note dated February 3, 2024 revealed the resident was disoriented, legally blind and incontinent; and that, all pathways in the resident's area were to be cleared and the clutter removed. The physician progress note date February 4, 2024 revealed that the resident had underlying advanced dementia, was alert and oriented x 1(alert to person only) and was under hospice care. Further, the note included that the resident had a poor overall prognosis and will continue supportive measures. The clinical record revealed no documentation that the resident was assessed for risk for fall until February 5, 2024; and, there was no evidence of any fall safety measures that were implemented or in place for resident #19. The fall risk assessment dated [DATE] revealed a fall risk score of 13 indicating the resident was at risk for fall. Per the assessment, the resident was disoriented x 3 at all times, was incontinent, ambulatory and required the use of an assistive device. The care plan dated February 8, 2024 revealed that the resident was at risk for falls related to dementia/ non -compliance to safety rules. It also included that the resident had the following fall incidents: (continued on next page)

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

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-September 21 and October 5, 2023 - fall with no injury; -October 14, 2023 - fall with eye laceration; -October 30, 2023 - fall with no injury; -November 8, 2023 - fall from the wheelchair with no injury; -November 22, 2023 - was found on the floor in the bedroom with no injury; and, -February 5, 2024 -fall with injury Interventions included to cue, reorient and supervise as needed; frequently monitor resident's position as she is impulsive and may get up quickly; keep bed in lowest position; keep the surroundings free of obstructions; and, remind the resident of safety measures, supervise ambulation. Further review of the care plan revealed the resident position should be monitored frequently as the resident is impulsive and gets up quickly; bed should be in the lowest position and the surroundings should be kept free from obstructions; the resident was to be reminded of safety measures and ambulation should be supervised to prevent falls; and, the resident was on medications that may cause unsteady gait, frequent falls, balance problems and dizziness/vertigo. The clinical record revealed no documentation of any fall care plan prior to February 2024. The alert note dated February 9, 2024 included that the resident was s/p (status post) fall with rib fractures. The restorative nursing screening note dated April 3,2024 included the resident does not walk and walking was not clinically indicated. An interview was conducted with registered nurse (RN/staff #1) at 3:00 pm on June 21, 2024. She stated that if a resident has frequent falls, interventions were put in place; however, it was difficult with residents that were confused. The RN said that these residents should be checked often and moved to the nurses' station or day room to keep them in the sightline of staff. She also said that fall mats and low beds are often used as interventions for fall; and that, the family may be asked to visit more often to assist with monitoring as well. An interview with certified nursing assistant (CNA/staff #4) was conducted June 21, 2024 at 3:10 p.m. She stated that the bed should be kept in the lowest position and fall mats should be used. She further stated that the staff should check the resident frequently and/or moved to the day room especially when staff were busy so everyone can assist in keeping an eye on the resident during busy times. The CNA stated that staff were made aware that a resident was a fall risk during daily report. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the director of nursing (DON/staff #4) at 3:40 p.m. on June 21, 2024. The DON stated that residents who were deemed as a fall risk were kept at the nurses' station during periods of high anxiety. Regarding resident #19, the DON stated that the resident used her wheelchair to propel herself and then used furniture to support herself to walk and had a family visit almost every day. She also said that the resident confused but had lucid moments; was incontinent and would get urinary tract infections which would add to her confusion. The DON stated that her expectation was that the staff were aware of the fall precautions needed and would be charting on the interventions and frequent checks to ensure the safety of the resident. During the interview, a review of the clinical record was conducted with the DON who stated that interventions and frequent checks completed by staff were not found; and that, there were no documentation of orders regarding fall precautions or interventions found. The DON stated that without documentation there was no way to show that interventions were in place and were being followed. Per the DON (director of nursing) previous care plan records could not be provided as they were in the previous electronic health record system and she no longer had access to them. The electronic health record system was change earlier in 2024. Review of facility policy titled Fall Risk Assessment (revised 3/2018) revealed that assessment data will be used to identify underlying medical conditions that may increase the risk of injuries from falls. The policy also revealed the attending physician will collaborate and address modifiable fall risk factors and interventions to try to minimize the consequences of risks that are not modifiable. Review of the policy Managing Falls and Fall Risk (revised 3/2018) revealed that staff will implement a resident centered fall prevention plan to reduce specific risk factors of falls for each resident at risk for falls. If several possible interventions are identified, the staff may prioritize interventions. If underlying causes cannot be identified, staff will try various interventions based on resident assessment. The staff will monitor and document the resident's response to interventions intended to reduce falling. If falls continue, staff will reevaluate the situation and along with the attending physician shall reconsider possible causes. The policy further states that staff will document the basis for conclusions regarding irreversible risk factors that continue to present a risk for falls.