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	01/12/2024

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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50026 Based on clinical record review and staff interviews, the facility failed to ensure discharge/transfer paperwork was completed for one resident (#423). The deficient practice could result in resident not receiving a safe and effective transition of care. Findings include: Resident # 423 was admitted to the facility on [DATE], with diagnoses of aftercare following joint replacement surgery, unilateral primary osteoarthritis left hip, chronic kidney disease, and acute post hemorrhagic anemia. A social service note dated December 29, 2023 included resident was able to understand and be understood and had a BIMS (brief interview of mental status) score of 15 indicating intact cognition. Per the documentation, the resident planned to discharge back home. A nursing note dated December 31, 2023 included the resident remained on antibiotic therapy for 38 days for left hip infection. The Minimum Data Set (MDS) assessment on January 3, 2024, revealed a BIMS score of 15 indicating that the resident had intact cognition. A review of progress notes revealed that on January 9, 2024, revealed that the resident had a change of condition. Per the documentation, the resident called for help, had a fixed look, and reported that she was unable to move. The note included that the doctor was notified of the condition; an order was given to send the resident to the ER for evaluation and treatment; and, the DON and family were informed of the change of condition. Further, the documentation revealed 911 was called; the resident's medication sheets and record of health history were given; and, the resident was transported to the hospital. Further review of clinical records revealed no evidence of a physician order for transfer/discharge; and, there was no documentation of any discharge/transfer information was completed for resident #423. (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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with a licensed practical nurse (LPN/staff #16) conducted on January 12, 2024 at 9:45 a.m., the LPN stated that when a resident is transferred/discharged , she puts in a discharge order in the electronic record and this order will show up in the treatment orders. Regarding resident #423, the LPN stated that she was unable to locate a physician order for transfer for the resident. An interview with the Director of Nursing (DON) on January 12, 2024, at 10:32 a.m. Regarding resident #423, the DON stated that the staff mentioned receiving the order in the progress note; however, there was no transfer order found in the clinical record for resident #423. The DON stated that it could be in the mix of it all and she did not put it in electronically.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50026 Based on clinical record review and staff interviews, the facility failed to ensure a written notice of the bed-hold policy and the implications of returning to the facility was provided to one resident (#423). The deficient practice may result in resident and resident representatives not being aware of the bed hold policy and their right to return to the facility immediately to the first available bed. Findings include: Resident # 423 was admitted to the facility on [DATE], with diagnoses of aftercare following joint replacement surgery, unilateral primary osteoarthritis left hip, chronic kidney disease, and acute post hemorrhagic anemia. A social service note dated December 29, 2023 included resident was able to understand and be understood and had a BIMS (brief interview of mental status) score of 15 indicating intact cognition. Per the documentation, the resident planned to discharge back home. The Minimum Data Set (MDS) assessment on January 3, 2024, revealed a BIMS score of 15 indicating that the resident had intact cognition. Review of the clinical record revealed no evidence that the resident #423 was provided with a written notice related to facility's bed-hold policy upon or on resident's admission. A review of progress notes revealed that on January 9, 2024, revealed that the resident had a change of condition, an order was received to send the resident to the ER for evaluation and treatment; and, the DON and family were informed of the change of condition. Per the documentation, the resident's medication sheets and record of health history were given; and, the resident was transported to the hospital. however, the clinical record revealed no evidence that at the time or within 24 hours of transfer on January 9, 2024, resident #423 and/or resident representative were provided with a notice regarding bed-hold policy that includes information explaining the duration of bed-hold. In an interview with a licensed practical nurse (LPN/staff #16) conducted on January 12, 2024 at 9:45 a.m., the LPN stated that when a resident is transferred/discharged , she puts in a discharge order in the electronic record and this order will show up in the treatment orders. In an interview with the social services director (SSD/staff #19) conducted on January 12, 2024 at 10:00 a.m. , she stated that the registered nurse was responsible for obtaining consent for bed-hold. In a later interview with the SSD conducted on January 12, 2024 at 10:40 a.m., the SSD stated that the facility does not have a bed-hold policy.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50026 Based on clinical record review, staff interviews, and the facility's policies, the facility failed to meet professional standards of quality by failing to ensure that the physician was notified of low blood pressure readings for one resident (#423). The deficient practice could result in accepted standards of quality service or care not provided to the residents. Findings include: Resident #423 was admitted on [DATE], with a diagnoses of chronic kidney disease, hypertensive heart disease with heart failure, and acute post hemorrhagic anemia. The clinical summary for admitted [DATE] included diagnoses of heart failure, hypertensive heart disease with heart failure and atherosclerotic heart disease of native coronary artery without angina pectoris. Medications included metoprolol (antihypertensive) and losartan (antihypertensive) with orders to hold these medications for systolic blood pressure of <110. Care plan interventions included to medicate resident per physician order, to monitor vital signs as ordered and to notify physician of significant abnormal findings. Goals included that resident will remain free of complications related to hypertension and will maintain BP (blood pressure) within acceptable limits per physician orders. The physician orders dated December 31, 2023 included for the following: -Metoprolol tartrate 50 mg (milligrams) daily and to hold for systolic BP of less than 110; and, -Losartan 25 mg every day and to hold for systolic BP of less than 110. The undated active care plan included that the resident had hypertension. Goal was that the resident will maintain BP within acceptable limits per physician orders. Interventions included to monitor vital signs as ordered and to notify physician of significant abnormal findings. The Minimum Data Set (MDS) assessment on January 3, 2024, revealed a BIMS (brief interview of mental status) score of 15 indicating the resident had intact cognition. The physician admission note dated December 29, 2023 included that the resident was alert and oriented x 3. Assessment included Hypertension. Per the documentation, blood pressure was under control on losartan (antihypertensive). Plan included was to closely monitor blood pressure and if blood pressure starts rising again, another medication will be started and to hold the losartan because of acute kidney injury. The resident vital sign report revealed that on January 7, 2024, the resident had the following BP readings: -at 9:48 a.m., BP of 88/47; -at 4:45 p.m., BP of 89/57; and, (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-at 5:18 p.m., BP of 89/57. There was no evidence found in the clinical record that the physician was notified of the resident's BP reading at 9:48 a.m. until 1:45 p.m. (approximately 4 hours after) on January 7, 2024. A nursing note dated January 7, 2024 at 1:45 p.m. revealed that the provider was notified of the resident's recent blood pressure reading as well as vital signs. The documentation included instructions to encourage the resident to drink more fluids; and, the resident was educated on dehydration and the need to increase oral intake. Further review of the clinical record revealed no evidence that the provider was notified of the resident's blood pressure reading at 4:45 p.m. and 5:18 p.m. on January 7, 2024. Review of MAR for January 2024 revealed that on January 7, 2024, BP reading were documented as 88/47 and 89/57. Further review of the MAR revealed that and losartan and metoprolol were marked as administered on January 7, 2024. There was no evidence found in the clinical record that losartan and metoprolol were put on hold on January 7, 2024. The clinical record revealed no documentation of reason why losartan and metoprolol were administered despite the low BP readings. In an interview with a certified nursing assistant (CNA/staff #73) on January 11, 2024 at 1:15 p.m., the CNA stated that vital signs are taken in the morning, once a shift, or as needed depending on resident's change of condition. The CNA also said that a change of condition would include the resident not exhibiting normal behavior or if the resident's temperature was too high. The CNA said that the normal value for BP would be around 120/70 and vitals higher than that would be too high; and, a systolic blood pressure below 110 would be too low. In an interview with a licensed practical nurse (LPN/staff #303) conducted on January 11, 2024, at 1:37 p.m., the LPN stated that she administers medications, oversees CNAs, keeps residents stable, and communicates with doctors and bosses. The LPN said that the CNAs get the vitals, and she will recheck if needed and/or if the resident has hypertension, low O2 sat (oxygen saturation), or abnormal vitals. The LPN stated blood pressure varies per resident depending on their baseline; and, the doctor determines the baseline. The LPN also said that hypotension was in a range below 100 systolic and below 60 diastolic; and, if the doctor says it was okay, then normal vital signs times are completed. The LPN stated that there are no changes in the frequency of when vitals are taken unless the doctor specifies it. The LPN also stated that normal vital signs are taken once a shift; and, blood pressures are always checked before giving blood pressure meds. The LPN stated if the resident is not at baseline but the provider says to continue to monitor, she would send the resident out to the hospital and notify the provider later; unless the doctor specified not to send the resident out to the hospital. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Director of Nursing (DON/staff #90) conducted on January 12, 2024, at 8:14 a.m., the DON stated that the doctor usually requests monthly vitals for skilled residents and every shift, and a set of vitals would be taken with changes. The DON said that a change of condition is when a resident is not acting right and/or exhibiting new abnormal vitals. The DON stated that in the event of a change of condition, vitals are taken and it is expected for staff to notify the provider or hold medications due to nursing judgment. Further, the DON said that when there is a change in condition, vitals are expected to be taken every 2 hours. A review of the blood pressure policy revealed that hypotension is defined as blood pressure less than 100/60, and hypotension should be reported to the physician. Staff should record several readings throughout the day, including before and after meals. The facility policy on Resident Examination and Assessment included a purpose to examine and assess the resident for any abnormalities in health status, which provides a basis for the care plan. It also included to notify the physician of any abnormalities such as, but not limited to abnormal vital signs. The facility policy on Standards of Care revealed that each resident shall receive medical and nursing care which fosters the rehabilitation of the resident to their maximum capacity. Review of the facility's policy on Administering Medications included that medications are administered in a safe and timely manner, and as prescribed; and, medications are administered in accordance with prescriber orders, including any required time frame.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 49744 Based on observations, clinical record reviews, resident and staff interviews, facility documentation, policy, and procedures, the facility failed to ensure safety measures were in place to prevent a fall that resulted in a fracture for one resident (#73); and, the facility failed to ensure water temperatures were within the safe water temperature range for resident use. The deficient practices resulted in a fracture for resident #73; and, placed the residents at increased risk for serious injury and harm, such as burns and scalding. As a result, the Condition of Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) were identified. Findings Include: On January 9, 2024, at 2:30 p.m., the Condition of IJ was identified. The Administrator (staff #271) and the Director of Nursing (DON/staff #62) were informed of the facility's failure to ensure water temperatures were within the safe water temperature range. During the initial screening there were multiple resident rooms in different hallways had hot-water sinks/faucets temperatures exceeding 120 degrees Fahrenheit (F). Water temperature readings were conducted with the Maintenance Director (staff #56) who tested the water temperatures in 17 resident rooms using facility thermometer and stated that the water temperature readings exceeded 120 degrees Fahrenheit. The Administrator (staff #271) presented a Plan of Correction (POC) on January 9, 2024 at 4:25 p.m. The administrator was informed that the POC was not acceptable and failed to include the following: in-service regarding high water temperature for which staff will be in-serviced, projected completion date for the in-service, define all staff, and provide a plan for how the facility will train staff who were not on shift or who are on leave. A revised POC was received on January 9, 2024, at 5:32 p.m. The Administrator (staff #143) was informed that the POC failed to include Contractors as a part of the staff that would be educated. At 5:53 p.m., another POC was received and was accepted at 6:30 p.m. The accepted POC included the following: the mixing valves were adjusted, all water temperatures were retested , water temperature check in all residents' rooms every 4 hours for the next 14 days and then three times per day, water temperature checks once per shift for at least 90 days then daily after that, all employees will be in serviced on reporting abnormal water temperature, employees that were on vacation will be in-serviced on abnormal water temperature upon their return and calling service company to assess water temperature. Multiple observations were conducted of the facility implementing its POC, which included in-service training, contractors and plumbers present in the facility, and staff measuring water temperatures in rooms. On January 10, 2024, at 4:10 p.m., the Condition of IJ was abated after the following: the facility provided documentation that more than 50% of their staff were in-serviced, daily water temperatures records revealed water temperature below 120 degrees F. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the water temperature log revealed that water temperatures were checked on January 5, 2024 and the readings ranged from 100 degrees to 101 degrees Fahrenheit. Continued review of the log revealed that there were water temperature checks conducted from January 6 through 8, 2024. The facility's water temperature log for multiple resident rooms dated January 9, 2024 included water temperature readings ranges from 108.7 degrees to 112.9 degrees Fahrenheit. Review of the adjustment to boiler temperature log included that boilers #1, #2 and #3 were adjusted from 125 degrees Fahrenheit to 120 degrees Fahrenheit on January 10, 2024 at 10:15 a.m. Further review of the log revealed that on January 10, 2024 at 2:10 p.m., boiler #3 was adjusted from 120 degrees to 100 degrees Fahrenheit. In an interview with a licensed practical nurse (LPN/staff #58) conducted on January 9, 2024 at 11:26 a.m., the LPM stated that she had been at the facility for 5 years; and that, she thought that safe water temperature is over 120 degrees Fahrenheit. She stated that she just found out that safe water temperature was 100 degrees Fahrenheit. She further stated that residents complained that the water was too cold but did not complain that the water was too hot. In an interview conducted with the maintenance director (staff #56) on January 09, 2024, at 11:50 a.m., staff #56 stated that the facility has two boilers for each unit, East and West; and that, the facility had increased the internal temperature of the water in the boiler due to cold weather. Staff #56 further stated that the temperatures were high due to this change; and that, they had not had time to level out and find its Sweet Spot. He further stated that the last time the water temperatures had been checked was on January 5, 2024. During the interview, water temperature readings were conducted with the Maintenance Director (staff #56) who tested the water temperatures in 17 resident rooms using facility thermometer. The maintenance director stated that the water temperature readings exceeded 120 degrees Fahrenheit for these 17 resident rooms; and, the readings were as follows: -131.2 degrees Fahrenheit; -130.2 degrees Fahrenheit; -130.2 degrees Fahrenheit; -130.5 degrees Fahrenheit; -126.5 degrees Fahrenheit; -126.3 degrees Fahrenheit; -126.6 degrees Fahrenheit; -125.7 degrees Fahrenheit; -125.5 degrees Fahrenheit. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-125.9 degrees Fahrenheit; -126.5 degrees Fahrenheit; -127.6 degrees Fahrenheit; -126.5 degrees Fahrenheit; -127.4 degrees Fahrenheit; -126.5 degrees Fahrenheit; -129.2 degrees Fahrenheit; -128.5 degrees Fahrenheit. An interview was conducted on January 9, 2024 at 3:06 p.m. with another LPN (staff #23) who stated that safe water temperature was at 121 degrees Fahrenheit. During an interview with a registered nurse (RN/staff #259) conducted on January 9, 2024 at 3:14 p.m., she stated that safe water temperature was at 100 degrees Fahrenheit. An interview with a restorative nursing assistant (RNA/staff #264) was conducted on January 10, 2024 at 8:53 a.m. The RNA stated that maintenance staff check the water temperatures at the facility. He said that before providing showers/baths to a resident, he checks the water by feeling the water with his hands first. He said that if the water is too hot for him them he adjusts the water temperature to make it comfortable for the residents. The RNA further stated that 100 degrees Fahrenheit was safe water temperature. An interview with a certified nursing assistant (CNA/staff #204) was conducted on January 10, 2024 at 8:40 a.m. The CNA stated that if the water was too hot she would tell the maintenance staff right away and put it in the work book. An interview was conducted on January 10, 2024 at 8:53 a.m. with another CNA (staff #284) who said that water temperatures were supposed to be 115 degrees Fahrenheit which is safe the for bathing. In an interview with another RN (staff #86) conducted on January 10, 2024 at 8:55 a.m., the RN stated that she was not sure on what the safe water temperature readings are. She stated that she will contact the maintenance staff if there is a problem with the water temperature. During an interview with another LPN (staff #16) conducted on January 10, 2024 at 9:13 a.m., the LPN stated that safe water temperature was under 120 degrees Fahrenheit. In an interview with the administrator (staff #271) conducted on January 10, 2024 at 11:35 a.m., he stated that the safe water temperature was 100 degrees Fahrenheit. An interview was conducted on January 10, 2024 at 2:37 p.m. with another CNA (staff #267) who stated that the water temperature for bathing and washing hands was 100 degrees Fahrenheit. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview with another CNA (staff #72) conducted on January 10, 2024 at 2:58 p.m., the CNA stated that 100 degrees Fahrenheit water temperatures were safe for resident use. A review of the facility policy titled Water Temperatures, Safety, revised December 2009 revealed that tap water in the facility shall be kept within a temperature range to prevent scalding of residents. It also included that water heaters that service resident rooms, bathrooms, common areas, and tub/shower areas shall be set to temperatures no more than 120 degrees Fahrenheit or 48.89 degrees Celsius or the maximum allowable temperature per state regulation. Maintenance staff is responsible for checking thermostats and temperature controls in the facility and recording these checks in a maintenance log. Maintenance staff shall conduct periodic tap water temperature checks and record the water temperatures in a safety log. If at any time water temperatures feel excessive to the touch (i.e., hot enough to be painful or cause reddening of the skin after removal of the hand from the water), staff will report this finding to the immediate supervisor. Further, the policy included that the length of exposure to warm or hot water, the amount of skin exposed, and the residents current condition affect whether or not exposure to certain temperatures will cause scalding or burns. Therefore, ongoing resident observation and assessment during prolonged exposure to warm or hot water will help to determine the safety of the situation. 47669 Regarding fall with injury for Resident #73 -Resident #73 was admitted to the facility on [DATE] with diagnoses of nontraumatic subcortical intracerebral hemorrhage in hemisphere, unspecified hemiplegia affecting right dominant side, generalized muscle weakness, compression of brain, cerebral edema and pain. The physician admission note dated October 29, 2022 included assessments of nontraumatic basal ganglia bleed with midline shift and seizures. A nurse practitioner (NP) note dated October 30, 2022 revealed the resident was alert and oriented x 1-2, had right facial droop, right tongue deviation and was aphasic. Per the documentation, the resident required supervision with transfers and ambulation, required minimal assistance with toileting and will benefit from continued therapy for strengthening, endurance, functional transfers and progressive ambulation. Problems included non-traumatic basal ganglia bleed with midline shift and seizures. Review of the clinical record revealed the resident was using oxygen, was on heparin (anticoagulant) and was on continuous feeding tube. The undated active care plan included that the resident was a fall risk, had impaired ability to see in adequate light, was occasionally incontinent with bladder, and had self-care deficit on toileting and transfers. Interventions included the following: -Keep area clutter free and well lighted; -Keep call light and most frequently used items in a consistent area within easy reach; -Check and change frequently for safety and toileting needs; (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-Bed in lowest position while in bed for safety; -Fall risk assessment; and, -Frequent monitoring and observation to determine safety and prevent falls. Review of the clinical record revealed the resident had a Brief Interview of Mental Status (BIMS) score of 06 indicating resident had severe cognitive impairment. A social service note dated November 4, 2022 included that the according to the resident's family, impulsiveness is the resident's natural behavior even before the stroke. A nursing note dated November 11, 2022 included that at approximately 7:30 p.m., the resident had fallen while ambulating by herself to the bathroom. Per the documentation, the resident forgot she was hooked up to the tube feed line and oxygen which got pulled while she was moving forward and she fell . It also included that the resident suffered a 3 mm (millimeter) laceration to the right eyebrow and had a right hip pain. The documentation included that the resident had full ROM (range of motion) with the presence of pain to the right hip; had no deformities, abrasions or bruising of the right hip; and that, the resident was assisted back to bed and the physician was notified. The documentation did not include intervention to address the resident's complaint of right hip pain. A nursing note dated November 12, 2022 at 10:23 a.m. revealed the resident's POA (power of attorney) reported that the resident was unable to stand and walk as she could on Friday; and, had reported pain her hip and wrist. The documentation also included that the resident had bruising to the right eye where the laceration was present; and that, the provider was notified and agreed to send the resident to the ER (emergency room) for evaluation and treatment of hip pain. The note also included that the provider agreed to a head CT scan due to resident's recent stroke, heparin use and laceration to the right eyebrow. Per the documentation, the nurse called the county ambulance for transfer of resident to the hospital. However, the clinical record revealed no evidence that the resident was seen or was transferred to the hospital/ER on November 11, 2022. There was also no documentation found in the clinical record of why the resident was not sent to the hospital/ER. The fall care plan was revised on November 11, 2022 to include that the resident had a fall with injury on November 11, 2022. The nursing note dated November 12, 2022 at 5:53 p.m., revealed that at approximately 2:13 p.m., the RN (registered nurse) went into the resident's room after an RT (respiratory therapist) suggested that an X-ray of the right hip and right wrist should be taken s/p (status post) fall. The note included that the PT (physical therapist) stated that the resident was still having trouble standing and walking compared to Friday morning of November 11, 2022. Per the documentation, the DON (director of nursing) told the RN that the DON was not aware of the fall that took place on November 11, 2022 at approximately 7:00 p.m. It also included that the resident's emergency contact like for the resident to go to the ER to have a head CT scan due to a change in condition. Further, the documentation included that X-ray orders of the right wrist and right hip were also ordered. (continued on next page)

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	01/12/2024

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 - Immediate jeopardy to resident health or safety Residents Affected - Some	Another nursing note dated November 12, 2022 at 8:58 p.m. revealed that transportation arrived at approximately 7:15 p.m. to transport resident #73 to the hospital for CT scan of the head and X-rays of the right wrist and right hip. The nursing note dated November 13, 2022 at 12:15 a.m. included that staff received a report from hospital provider that resident #73 had a right hip fracture. In an interview with a certified nurse assistant (CNA/staff #205) conducted on January 11, 2024 at 10:30 a.m. , the CNA stated that when she sees a resident fall or when a resident is found on the floor, she will pull the call light, get the nurse and check the resident's vital signs. The CNA said that the nurse would take over and the resident is treated immediately. An interview with a licensed practical nurse (LPN/staff #16) was conducted on January 11, 2024 at 11:30 a. m. The LPN stated that when a resident had a fall, she will conduct head to toe assessment, notify the DON, provider and the resident's medical POA. The LPN stated that if the resident had an injury such as skin tear, laceration or abrasion, it will be treated immediately. The LPN also said that if the resident complained of severe pain or has deformity, the LPN will call 911, send the resident out to the ER; and, she will not wait to hear back from the provider as it could be up to an hour or more. During an interview with the Director of Nursing (DON/staff #62) conducted on January 11, 2024 at 11:45 a. m., the DON stated that she expected that when a resident fall, staff will take the resident's vital signs, assess the resident and notify the resident's POA, provider and DON. Further the DON stated that care for any injury sustained by the resident will be provided. Review of the facility policy on Managing Fall and Fall Risk revealed that based on previous evaluation and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The policy also included that the staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of fall for each resident at risk or with history of falls. The facility's policy on Standards of Care included each resident is free from evident environment hazards, e. g., absence of hazardous equipment, floor surfaces, furniture, etc. The policy also included that whenever possible residents are assisted in or out of bed to enable as much mobility and stimulation as possible, in full accordance with physician's orders.