

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  035254	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/30/2024
NAME OF PROVIDER OR SUPPLIER  Winslow Campus of Care		STREET ADDRESS, CITY, STATE, ZIP CODE 826 West Desmond Street Winslow, AZ 86047	

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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48932</p> <p>Based on clinical record review, interviews, and review of facility documentation, the facility failed to ensure the physician was notified of a change in condition for one resident (#1). The deficient practice could result in resident not receiving continuity and coordination of needed care.</p> <p>Findings include:</p> <p>Resident #1 was admitted on [DATE] with diagnoses that included Chronic Kidney Disease, stage 3, chronic pain, and hypertension.</p> <p>The nursing progress note dated May 23, 2024 included that the resident was alert and oriented x3 and was hard of hearing.</p> <p>The baseline care plan dated May 24, 2024 included that the resident required assistance with self-cares related to limited mobility due to aging.</p> <p>A review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Brief Interview for Mental Status (BIMS) score of 13 indicating the resident was cognitively intact.</p> <p>The clinical record revealed a lab result that indicated the last covid-19 test that was administered was on July 11, 2024 and the result was negative.</p> <p>A nursing progress note dated July 12, 2024 included that a message was left to the family that there was COVID-19 in the building.</p> <p>The vitals log revealed that on July 18, 2024, the resident had an oxygen saturation (O2 sat) of 90% and respiration rate was at 19 per minute.</p> <p>The vitals check dated July 19, 2024 included that the O2 sat was at 99% and respiration rate was at 16 per minute.</p> <p>A progress note entry dated July 20, 2024 revealed that the resident's family picked up the resident and informed the licensed practical nurse (LPN/staff #4) that they would be taking the resident to Indian Health Services (IHS). The documentation did not include that the resident's primary care physician or the facility provider was notified that the resident will be taken to a community clinic by the family.</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the clinical record revealed the resident was hospitalized on [DATE].</p> <p>The Hospital History and Physical (H&amp;P) dated July 20, 2024 included that the resident was found to have an acute covid-19 infection with dyspnea and metabolic acidosis; and that, it was unknown how long the resident had COVID.</p> <p>The clinical record revealed that the resident was discharged from the facility on July 22, 2024.</p> <p>A late entry progress note dated July 23, 2024 revealed that on July 18, 2024, the resident reported and complained to her family that she was having chest pains, difficulty breathing and the staff were not assisting her. It also included that the resident reported that she had a hard time sleeping last night because her chest was hurting and it was hard to breathe; and that, during the conversation, the resident was taking deep breaths and appeared to have a little trouble talking. The documentation also included that the resident's family notified the social services who followed up with the resident; and, the nurse checked in with the resident regarding the breathing and oxygen level.</p> <p>There was no evidence found in the clinical record that the physician was notified of the resident's change in condition.</p> <p>A social service progress note dated July 23, 2024 revealed that the resident's family confirmed that the resident was taken and was admitted at the hospital. Per the documentation, resident was not feeling well, was COVID positive and was not doing well.</p> <p>An amended progress note dated on August 1, 2024 included that the on-call physician was not notified as family stated that resident would be going with them on a therapeutic leave.</p> <p>In an interview conducted with the administrator (staff #9) on July 30, 2024 at 2:22 p.m., the administrator stated that the facility did not have documentation to show a provider was notified.</p> <p>An interview was conducted on July 30, 2024 at 2:30 p.m. with an LPN (staff #117) who stated that if family picked up a resident to take to the community clinic, staff would inform the Director of Nursing (DON) and the provider and document on the progress note in the resident's chart.</p> <p>An interview with the Assistant Director of Nursing/Behavioral Unit Manager (ADON/BUM/staff #82) was conducted on July 30, 2024 at 3:37 p.m. The ADON stated that when there was a change in condition in a resident, this should be documented in a progress note and should be communicated to the DON, physician, family member and case manager. Regarding resident #1, the ADON stated that when she reviewed the clinical record for resident #1, the progress notes entries did not indicate that anyone was notified that the resident was picked up by family and taken to the hospital; and that, the documentation should include that the health provider and DON were notified. The ADON stated that the documentation in the clinical record did not meet the facility's standards. Further, the ADON said that if the provider and DON were not notified of the resident leaving the facility to go to the hospital, the receiving provider would not be able to get documents needed and this would compromise the continuity of care.</p> <p>(continued on next page)</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility policy on Change in a Resident's Condition or Status with last revision date of February 2021 revealed that the nurse will notify the resident's attending physician or physician on call when there has been a(an): .need to transfer the resident to a hospital/treatment center.</p> <p>The policy on Charting and Documentation revealed that if there is a change in the resident's condition or an event that occurred with the resident, it is to be documented in the resident's medical record. The policy also included that documentation will also include information regarding notification of family, physician or other staff, if indicated.</p>		