STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035265	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sun Health Grandview Care Center	14505 West Granite Valley Drive Sun City West, AZ 85375

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49325 Based on clinical record reviews, staff interviews, the Resident Assessment Instrument (RAI) manual, and facility policies, the facility failed to develop and complete a Discharge Minimum Data Set (MDS) assessment within the required timeframe for Resident # 11. The deficient practice could result in delayed identification of potential risks and care needs of the residents. Findings include: Resident # 11 was admitted into the facility on [DATE] at 09:05 PM with diagnoses that included atherosclerotic heart disease of native coronary artery with unspecified angina pectoris, acute respiratory failure with hypoxia, and unspecified chronic kidney disease. Review of the MDS assessment history, revealed an Admissions MDS Assessment was completed and accepted March 01, 2024. Resident # 11 was discharged on [DATE] at 11:00 AM; however, medical records revealed no discharge MDS was completed at this time. An interview was conducted on July 30, 2024 at 08:55 AM with MDS Coordinator (Staff #970) who stated the MDS Coordinator role was to complete admission entry records including long-term care admission, quarterly, annual, and discharge assessments. Staff #970 (MDS Coordinator) stated admission and discharge MDS assessments are due on the 14th day from day of event. Staff #970 (MDS Coordinator) confirmed through electronic medical review that discharge MDS assessment was not created nor completed for Resident # 11. Staff #970 (MDS Coordinator) stated she was confused that no discharge MDS assessment was completed because MDS Coordinators receive reports of all discharges. Staff #970 (MDS Coordinator) stated the discharge MDS assessment for Resident # 11 would be completed, however would be considered late. Staff #970 (MDS Coordinator) stated the risks were that section GG 'functional abilities and goals', would be unavailable for review, there would be no quality measures in place, and that, it's like the discharge never happened. An interview was conducted on July 30, 2024 at 12:31 PM with Director of Nursing (Staff #385/DON) who stated that after learning about Resident # 11 not having a discharge MDS assessment completed -- initiated an audit. Staff #385 (DON) stated risks were that whenever MDS assessment are incomplete, federal and state government would not be updated of quality measures. Staff #385 (DON) stated not having completed an discharge MDS assessment did not meet facility's expectations. (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Policy titled, Resident Assessment - Resident Assessment Instrument, (revised July 2024) revealed, facility makes a comprehensive assessment of each resident's needs, strengths, goals, life history and preferences using the resident assessment instrument (RAI) specified by Centers for Medicare & Medicaid Services (CMS). The current version of the RAI (MDS 3.0) will be utilized when conducting a comprehensive assessment of each resident in accordance with the instruction found in the RAI Manual. The assessment will include at least the following: identification and demographic information; customary routine; cognitive patterns; communication; vision; mood and behavior patterns; psychological well-being; physical functioning and structural problems; continence; disease diagnosis and health conditions; dental and nutritional status; skin conditions; activity pursuit; medications; special treatments and procedures; discharge planning. Facility will maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessment to develop, review and revise the resident's comprehensive care plan.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47911 Based on clinical record review, staff interviews and facility policy review, the facility failed to ensure that a physician order for the use of a foley catheter was in place for one resident (#20). The sample size was 15. The deficient practice could result in inappropriate use of a catheter. Findings include: Resident #20 was admitted on [DATE] with diagnosis including sepsis, UTI (urinary tract infection), klebsiella pneumoniae, hypertension and hypothyroidism. A review of the admission MDS (minimum data set) dated July 24, 2024 revelaed that resident #20 had a BIMS (brief interview of mental score) of 14, suggesting that the resident was cognitively intact. A review of the physician orders in the electronic health records revealed no evidence of a physician order for a catheter or catheter care. A review of the TAR (treatment administration record) since admission of the resident, revealed no evidence of an order for catheter care or that catheter care was being tracked or that input or output were being tracked for the resident. A review of the care plan revealed of focus are of urinary track infections and sepsis that were being tracked and noted interventions included encouraging fluid intake, providing antibiotic therapy as ordered as well as antipyretics, analgesics and antispasmodics as ordered. The interventions further noted to track for signs and symptoms of worsening sespis and UTI, lab work as ordered, reporting of results to the physician as well as teaching of good hygiene practices; however the care plan made no mention that the resident had a catheter in place or was receiving catheter care. A review of the clinical admission progress notes dated July 18, 2024 revealed, under the genitourinary subsection, a notation that a catheter was in place due to urinary retention, size 18 french. A further progress note notation dated July 19, 2024 also documented that the resident had an indwelling catheter. A progress note entry on July 20, 2024 revealed that the resident had a catheter in place; however, on this entry the catheter size is noted as 16 french. An interview was conducted on July 31, 2024 at 9:41 A.M. with staff #620 (LPN-licensed practical nurse). Staff #620 stated that daily Foley catheter care involves washing and cleaning the peri area and checking to make sure that the catheter is draining and reinserting as required. Staff #620 stated that catheter care always includes measuring the resident's fluid intake and output. Staff #620 stated that orders would be needed for catheter care. Staff #620 reviewed the resident record and stated that there was no evidence of an order for catheter care. Staff #620 stated that the expectation is for the orders to be in place and that the risk could include infection as no direction is given to staff regarding the catheter care. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on July31, 2024 at 9:58 A.M. with staff #385 (DON-director of nursing). Staff #385 stated that her expectation is that catheter care should be done every week. Staff #385 stated that for catheter care there should be a standard order in place or it should be on the cardex. Staff #385 reviewed the residents' record and stated that she did not see an order in place for the catheter and associated care. She stated that she would be contacting the physician to ensure the procedural orders are in place. Staff #85 stated that risk could include infection and lack of communication with staff. A review of the facility policy entitled catheter care revised March, 2024 revealed that residents with indwelling catgheters are to receive appropriate catheter care when indwelling catheters are in place.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47911 Based on observation, staff interviews, and policy review, the facility failed to ensure food was stored in accordance with appropriate temperature guidelines for facility refrigerators and the kitchen freezer. The universe was 57. The deficient practice could increase the risk for foodborne illness. Findings include: An observation was conducted on July 29, 2024 at approximately 7:40 A.M on the third floor of the facility. The refrigerator temperature log identified with the location of Canyon revealed that on July 22, 2024, the refrigerator had a temperature of 44 degrees Fahrenheit at 8:00 A.M. Per the temperature log, there was not documented evidence that any corrective action had taken place or that the manager had reviewed the temperature log for that day. A further review of refrigerator temperature logs, revealed that for the Red Rock location on July 7, 2024 and July 20, 2024 the refrigerator was outside of designated parameters. The temperature noted for July 7, 2024 at 4:28 P.M. was noted to be 45 degrees Fahrenheit and the temperature noted on July 20, 2024 at 4:31 was noted to be 50 degrees Fahrenheit. Both instances documented that the door was open; however, there was no evidence that the temperature had been rechecked or that any corrective action had taken place. It was noted that both instances were reviewed by the manager. A review of the temperature log for the Kitchen location for July 24, 2024 at 6:00 A.M. revealed a temperature of 42 degrees Fahrenheit. The log further revealed no evidence of corrective action or that the manager had reviewed the log. A review of the freezer temperature logs for July, 2024 revealed that on July 13, 2024, July 23, 2024 and July 26, 2024 at 6:00 P.M. the temperature was noted to be 2 degrees Fahrenheit. The log showed no evidence of corrective action or that it was reviewed. An interview was conducted with staff #201 (Nutrition Mgr) on July 29, 2024 at approximately 7:40 A.M. Staff #201 stated that she did recall the occurrance on July 22, 2024 of 44 degrees Fahrenheit on the Canyon location refrigerator. She stated that maintenance had looked at the refrigerator and repaired it. She stated that she thought the food items, in the refrigerator at the time, were temperature checked, but that the facility did not maintain a log of food temperature checks if a refrigerator or freezer are outside of temperature zones for food safety guidelines. She stated that her expectation is that all temperature are re-checked and documented and that food temperatures are taken. She stated that if the food is outside of the safety zone, over 41 degrees for the refrigerator and over 0 degrees for the freezer, that it should be discarded. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on July 31, 2024 at 1:49 P.M. with staff #205 (Maintenance Technician). Staff #205 stated that he could not find any July 2024 work orders for the refrigerators or freezer prior to July 29, 2024. He stated that the first time he had heard of a concern regarding the refrigerator temperatures was on July 29, 2024. Staff #205 stated that he tries to ensure that the refrigerators are kept below 38 degrees Fahrenheit. He stated that he was not aware what happened to the food items in the refrigerators or freezer when they were outside of the safety zone, since he was only notified of the issue on Monday, July 29, 2024. An interview was conducted on July 31, 2024 at 8:37 A.M with staff #208 (Facilities Director). Staff #208 stated that they try to keep the refrigerators set to 38 degrees Fahrenheit. He stated tha he was aware of a refrigerator that outside of food safety parameters. He stated that they cleaned the condensor and that the fan was running without issue. He stated that he was not aware if temperatures were initially re-checked or what had happened to the food in the unit. Staff #208 stated he was not made aware of any issues until Monday, July, 29, 2024. An interview was conducted on July 31, 2024 at approximately 8:45 A.M. with staff #201(Nutrition/kitchen Mgr). Staff #201 stated that maintenance had been notified but sometimes she or staff would just verbally alert maintenance when they are in the area and not always put in a formal work order. She stated that on Monday, July 29, 2024 maintenance had conducted a deep clean of the vent area and vacuumed out the coils, but stated that she had no evidence of prior documentation addressing the refrigerator and freezer temperature concerns. She stated that refrigerators outside of the kitchen are temperature checked by the dining room staff, who should put in a work order, document the action they took on the log and notify her, but stated that this had not occured for the dates in question. She stated that her expectation is that refrigerator temperatures are maintained under 41 degrees and freezer temperatures are maintained at 0 degrees Fahrenheit or below. Upon review of the logs, she stated that there was no evidence that the temperatures had been rechecked when temperatures were outside of parameters, nor was there evidence of the action that staff took regarding the food items in the refrigerators or freezer, or that any notifications had taken place. Staff #201 stated that if any food items tested within a refrigerator or freezer were outside of the safety zone and potentially served to residents, the process would be that the administrator and director of nursing would be notified. She stated she was uncertain what food items may have been outside of safety guidelines, or whether they were served to residents. She stated that post observation on the 3rd floor on July 29, 2024 at 7:40 A.M., she did notify the administrator and DON. She stated that no adverse outcomes had been reported for the dates in question. Staff #201 stated that the risk is when temperatures are taken and are outside of parameters, it needs to be documented what transpired, otherwise no one knows what follow-up actually happened. She stated that going forward everything will be documented to ensure proper communication. An interview was conducted on July 31, 2024 at 2:13 P.M. with staff #935 (administrator). Staff #935 stated that the expectation is that refrigerators and freezers are at the correct temperatures at all times. Furthermore, that staff notify their supervisor when temperatures are out of range, which she stated did not happen. Staff #935 stated that food needs to be re-checked when the refrigerator or freezers are out of range. She stated that the risk could include formation of bacteria on the food. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the cold temperature storage policy revised January, 2024 revealed that frozen storage temperatures are to be maintained at 0 degrees Fahrenheit or below and refrigerated storage is to be maintained at 41 degrees of below. The policy further notes that prompt corrective actions are to be taken to preserve the wholesomeness and quality of foods exposed to improper storage temperatures and that any deviant readings on the log are to be circled and temperatures should be rechecked in an hour and documented.