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	08/01/2025

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

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, and the facility policy and procedures, the facility failed to ensure two (#21 and #104) of 61 sampled residents' privacy was respected.Findings included: Resident #21 was admitted to the facility on [DATE] with diagnoses that included aftercare following joint replacement surgery, urinary tract infection, and unspecified dementia. The Minimum Data Set, dated [DATE] included a brief interview for mental status score of 4 indicating the resident severe cognitive impairment. The care plan dated July 17, 2025 revealed that resident #21 has impaired cognitive function/dementia or impaired thought processes related to dementia. Interventions included to ask yes/no questions in order to determine the resident's needs and present just one thought, idea, question or command at a time. -Resident #104 was admitted to the facility on [DATE] and re-admitted [DATE] with diagnoses that included acute kidney failure, chronic kidney disease, and sepsis due to escherichia. The MDS dated [DATE] included a brief interview for mental status score of 15 indicating the resident was cognitively intact. During the initial interview process, a certified nursing assistant (CNA/staff #12) entered the room without knocking or asking the resident if it was okay to enter, walked past the surveyor, and told the resident that she was getting her water. The interview process stopped while the staff emptied the resident's gray plastic cup of water in the sink and left the room. Then staff #12 returned and entered the room a second time without knocking or asking the resident if she could enter the room. The staff placed the resident's cup on her tray and left. Then CNA #12 was observed saying hi to a resident (#104) in the room across the hall as she walked into the room without asking the resident if it was okay to enter or waiting to be asked to enter. An interview was conducted on July 31, 2025 at 12:52 p.m. with (CNA/staff #12), who stated that she had received training on resident's rights, which included the resident's right to refuse treatment, the right to do what he or she wants, to be treated with dignity and respect, and the right to privacy. She stated that residents have the right to meet with family and guests in private/alone. She stated that she was trained to knock on the resident's door before entering, even if the door is open, to signal to the resident that she is there, and does it most of the time. She stated that most of the time, the resident will say, come in. The CNA stated that sometimes she peeks in and if the resident is busy, she will come back later. The CNA further stated that the reason for knocking and waiting for the resident to respond is to allow the resident privacy and it also shows respect for the resident's privacy. She stated that residents have the right to say that she cannot come into the room. The CNA stated that she remembered entering the resident's room when the surveyor was in the room, and thought the resident was being interviewed, but wasn't aware that the interviews were private and it was possible that she could overhear something confidential. She stated that usually when she does ice water, she has a habit of walking in, so needs to be more aware. The CNA acknowledged that she also walked into the room across the hall without knocking, explaining why she was there, or waiting for the resident to say it was all right to come in. An interview was conducted on July 31, 2025 at 1:46 p.m. with the Director of Nursing (DON/staff #1), who stated that residents have the right to be treated with dignity, respect, and the right to privacy. The DON stated that staff are trained to knock on the door and wait for a response before entering, and if appropriate, staff may need to announce themselves because the patient may not be able to respond. The Resident Handbook, revised 2024, revealed that the resident has the right to privacy and confidentiality: personal privacy includes accommodations, personal care visits, and meetings of family and resident groups. A policy titled, Resident Rights, reviewed/revised April 2024, revealed that the facility will ensure that all direct care and indirect care staff members, including contractors and volunteers, are educated on residents' rights and the facility's responsibility to properly care for them. The policy included that all residents will be treated equally regardless of age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, or gender identity or expression.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records review, resident and staff interviews, and policy review, the facility failed to ensure that medications were not left at the resident's bedside for 2 of 61 sampled residents (#36, #39). The deficient practice could result in the overmedication or undermedication of residents.-Regarding Resident #36Resident #36 was admitted to the facility on [DATE] with diagnoses that included fracture of the right femur, unspecified fall, acute post hemorrhagic anemia, and hypotension.An admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 15, which indicating intact cognition.During an initial observation of Resident #36's room on July 29, 2025 at 1:40 p.m., a container of Refresh lubricant eye drops 0.5 fl oz (fluid ounce) medication was observed lying on the resident's bedside table.Review of provider orders, revealed no evidence of orders for the Refresh lubricant eye drops. An interview was conducted on July 29, 2025, at 1:40 p.m. with Resident #36, who stated that she brought the eye drops with her and uses them twice a day, both morning and night.A follow-up interview was conducted with a Registered Nurse (RN/staff #46) on July 29, 2025 at 3:17 p.m. as she was entering the resident's room to perform vitals. The RN stated that she observed Refresh tears lubricant eye drops medication on the resident's bedside table, and that she was not aware whether the resident had been assessed for self-administration of medications. The RN then reviewed the resident's clinical record and stated that there was no evidence of a a provider order for the Refresh eye drops.Further review of the clinical record revealed a new physician's order dated July 30, 2025, for the Systane Pro PF Ophthalmic Solution 0.6%, 1 drop in both eyes four times a day for dry eyes for 1 day may have at bedside and self-administration.A progress note dated July 31, 2025, at 5:43 p.m., revealed that the resident had an eye appointment on July 30, 2025, and the physician recommended artificial tears 1 gtt (drop) QID (four times a day) OU (both eyes) as needed for dryness or irritation, may leave at bedside and self-administer eye drops. An interview was conducted on August 1, 2025 at 9:43 a.m. with the Director of Nursing (DON/Staff# 108), who stated that if a resident preferred to self-administration medications, the IDT (interdisciplinary team) would assess the resident and get a physician order for medication self-administration. The DON then stated that Resident #36 had not been assessed for the self-administration of medication because Resident #36 did not ask to self-administer the medication. The DON further stated that the Refresh eye drops found at the resident's bedside was absolutely concerning, and she will educate the staff.-Regarding Resident #39Resident #39 was admitted to the facility on [DATE] with diagnoses that included unspecified dementia, muscle weakness, injury of the head, and low back pain.A Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview of Mental Status (BIMS) score of 13, which indicated intact cognition.During an initial observation of Resident #39's room on July 29, 2025 at 2:54 p.m., the following medications were observed lying on the resident's bedside table: -Refresh Lubricant Eye Drops 0.33 fl oz (fluid ounce) -Systane Lubricant Eye DropsThere was no evidence of a provider order in Resident #39's clinical record regarding eye drops.An interview was conducted on July 29, 2025, at 2:54 p.m. with Resident #39 who stated that her mother bought the eye drops in about a month ago, but she had not yet used them. Review of the clinical record revealed no evidence that a Medication Self-Administration Assessment had been performed. Further review of Resident #39's clinical records revealed no evidence in the progress notes of an Interdisciplinary Team (IDT) meeting related to medication self-administration.An interview was conducted on July 29, 2025 at 3 p.m., with a Licensed Practical Nurse (LPN, Staff #182) regarding Resident #39, who stated that she observed the eye drop medications on the resident's bedside table. The LPN then stated that Resident #39 was incapable to self-administer medication due to her limited mobility and range of motion. The LPN further stated that, as per facility policy, residents should not have any kind of medication on the bed side table. The LPN also stated that when medications are observed at a resident's bedside, staff educate the resident. The LPN then reviewed the resident's clinical record and stated that she did not see a physician's order for the eye drops.An interview was conducted on August 1, 2025 at 9:43 a.m. with the Director of Nursing (DON/Staff# 108), who stated that Resident #39 had not been assessed for the self-administration of medication because the resident did not ask for it. The DON further stated that the medication found on the resident's bedside table was absolutely concerning, and she did not know how long eye drop medications had been there, but she will investigate and educate the staff.Review of the facility's policy titled, Medication Administration, revised in April, 2024, revealed that medications should be

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, resident and staff interviews, and review of facility policy, the facility failed to ensure proper infection control was followed and maintained regarding placement of the catheter bag for one of 1 sampled residents (#23). The deficient practice could result in development and transmission of infections.Findings include:Resident #23 was admitted to the facility on [DATE], with diagnoses that included acute kidney failure, retention of urine, type 2 diabetes mellitus with a foot ulcer, and depression.The admission minimum data set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident had intact cognition. The assessment also included that the resident had an indwelling catheter.The foley catheter care plan initiated on July 6, 2025, included interventions to maintain a closed drainage system with the drainage bag lower than the bladder at all times and on a privacy bag.During an interview with Resident #23 conducted on July 23, 2025, at 2:10 p.m., the resident stated that CNA's (certified nursing assistant) generally do all sanitary things, wear personal protective equipment, and empty the catheter bag. An observation was conducted on July 29, 2025, at 2:10 p.m., Resident #23 was sitting in a wheelchair in his room, with his indwelling catheter bag placed under the wheelchair and the bag was touching the floor.During a second observation conducted on July 31, 2025, at 12:17 p.m., Resident #23 was in his room sitting in a wheelchair with the indwelling catheter bag under the wheelchair, touching the floor.During another observation conducted with a CAN (staff #109) on July 17, 2025, at 12:24 p.m., Resident #23 was sitting in a wheelchair eating his lunch and his catheter bag was touching the floor. The CNA stated that the resident's catheter bag was touching the floor, and it shouldn't be. The CNA then hung the catheter bag to the resident's wheelchair and stated that the facility had temporary staff and they generally did not hang the catheter bag. She further stated that risk could result in the resident developing a urine infection because the facility floors may not be clean or disinfected.An interview was conducted with a Registered Nurse (RN/staff #213) on July 17, 2025, at 12:47 p.m., who stated that catheter bags should be below the bladder and placed on side of the bed to prevent falls, of under the wheelchair so that the catheter bag is below the bladder and not touching the floor. The RN further stated that the risks due to a catheter bag touching the floor could result in the resident running over the tubing/bag, and could cause trauma (bleeding, pain) to the resident. The RN further stated that if a catheter bag touches the floor there is an infection issue because the floor may not be disinfected.In an interview conducted with the Director of Nursing (DON/staff #108) on August 1, 2025, at 9:55 a.m., who stated that catheter bags should be placed in a covered bag and secured to the side of the bed or under the wheelchair. The DON further stated that the indwelling catheter bag should not be resting on the floor, and should be elevated at least a centimeter above the floor to prevent the risk of infection.A facility policy titled, Catheter Care, revised on April 4, 2024, revealed that if a foley catheter drainage bag or tubing touches the floor, it is considered contaminated and should be replaced as soon as possible. If immediate replacement is not feasible, the contaminated external surfaces should be disinfected with a facility- approved disinfectant wipe and allowed to air dry. The bag should be securely elevated off the floor to prevent further contamination. Staff must change the system as soon as possible.