STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035266	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Healthcare of Mesa	5755 East Main Street Mesa, AZ 85205

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** 40581 Based on clinical review, staff interviews and the facility policy and procedures, the facility failed to ensure one resident (#86) was permitted to return to the facility after a hospitalization . Findings include: Resident #86 was admitted to the facility on [DATE] with diagnoses that included periprosthetic fracture around internal prosthetic left knee joint, acute and chronic respiratory failure with hypoxia, and chronic pain syndrome. The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 13 indicating the resident was cognitively intact. Review of a Covid-19 test dated November 14, 2023 revealed a positive result. A progress note dated November 14, 2021 at 4:17 PM revealed that the resident had a rapid Covid test and tested positive earlier today. The resident complained of shortness of breath, with wet cough. The physician was notified and the resident was transferred to the emergency department (ER) via ambulance for further medical management. The family was notified about the hospital transfer and the resident's belongings were sent along with her. A progress note dated November 14, 2021 at 10:08 PM revealed that the resident's daughter called the facility to report on the resident regarding the ER admission and discharge. The daughter was notified about the facility Covid-19 positive patient protocol. Despite being educated, the concerned family member was audibly upset due to the fact the resident cannot be readmitted into this facility with a positive Covid-19 status. Review of the clinical record did not reveal a bed-hold policy signed and dated by the resident or a family member. (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	An interview was conducted on November 8, 2023 at 8:27 AM with the Director of Nursing (DON/staff #81), who stated that the the resident was transferred to the hospital because she tested positive for Covid, was symptomatic, and the physician wanted her transferred to the hospital. She stated that the facility did not keep residents who tested positive for Covid and would transfer them to the hospital or another facility. She stated that if the resident would have passed the quarantine period, she would have been able to come back to the facility. Then she reviewed the progress notes and stated that the daughter was told on November 14, 2021, that the resident could not return to the facility, which is the same day that the resident was transferred to the hospital. She acknowledged that on November 14, 2023, she did not know how long the hospital was going to keep the resident or if the resident was being admitted , but knew that the resident was in the incubation period, so was not admitted back to the facility. She stated that the facility was able to isolate residents with Covid-19 by room, but did not have staff to care for the residents. She wouldn't have hired registry staff to provide one to one care for residents with Covid-19 because it is not practical for financial reasons, but doesn't have any documentation of trying to find additional staff or telling AZDHS that this was not feasible. An interview was conducted on November 8, 2023 at 9:04 AM with a Registered Nurse/Critical Nurse Manager (RN/staff #25), who stated that she was responsible for discharge planning and any family concerns. She stated that if a resident was Covid-19 positive in 2021 and symptomatic, the resident was transferred to the hospital if ordered by the physician. During the interview, she reviewed facility documentation and stated that she didn't have any notes regarding the resident's discharge. She stated that it was her understanding that the facility did not have a Covid unit and she followed facility protocol, which was to transfer the Covid-19 positive residents to the hospital or another facility. During an interview conducted on November 8, 2023 at 9:12 AM with the Administrator (staff #90), she stated that resident #86 would not have been given the resident a bed-hold policy because the facility wasn't going to accept the resident back due to being Covid-19 positive. An interview was conducted on November 8, 2023 at 10:20 AM with the Administrator (staff #90) and the Director of Nursing (DON/staff #81). Both staff stated that they developed a plan for Covid positive residents, but didn't implement the plan. Staff #90 stated that they were a Covid-19 free facility and wanted to remain that way. The facility's Covid-19 Emergency Plan, Location of Confirmed Patients with SARS-CoV-2 states to identify space in the facility that could be dedicated to care for residents with confirmed Covid-19. This could be a dedicated floor, unit, or wing in the facility or a group of rooms at the end of the unit that will be used to cohort residents with Covid-19. Determine the location of the Covid-19 care unit and create a staffing plan before residents or HCP with Covid-19 are identified in the facility.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581 Based on facility documentation, the facility failed to ensure two residents (#86, #26) were notified in writing regarding the reason for transfer and a copy was sent to the ombudsman. Findings include: Resident #86 was admitted to the facility on [DATE] with diagnoses that included periprosthetic fracture around internal prosthetic left knee joint, acute and chronic respiratory failure with hypoxia, and chronic pain syndrome. The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 13 indicating the resident was cognitively intact. A progress note dated November 14, 2021 at 4:17 PM revealed that the resident had a rapid Covid test and tested positive earlier today. The resident complained of shortness of breath, with wet cough. The physician was notified and the resident was transferred to the emergency department (ER) via ambulance for further medical management. The family was notified about the hospital transfer and the resident's belongings were sent along with her. A progress note dated November 14, 2021 at 10:08 PM revealed that the resident's daughter called the facility to report on the resident regarding the ER admission and discharge. The daughter was notified about the facility Covid-19 positive patient protocol. Despite being educated, the concerned family member was audibly upset due to the fact the resident cannot be readmitted into this facility with a positive Covid-19 status. -Resident #26 was admitted to the facility on with diagnoses that included benign prostatic hyperplasia without lower urinary tract symptoms, hypertensive heart disease with heart failure, and an anxiety disorder. The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 12 indicating the resident had a mild cognitive impairment. During an interview conducted on November 6, 2023 at 9:24 AM with resident #26, he stated that he did not receive a written statement regarding the reason for going to the hospital or a bed hold policy when he was transferred to the hospital. An interview was conducted on November 8, 2023 at 8:27 AM with the Director of Nursing (DON/staff #81), who stated that the nurse/charge nurse informs the resident and family verbally regarding the reason for transport to the hospital. She also stated that the ombudsman is notified of the transfer at the end of the month, but the reason for discharge is not included. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on November 8, 2023 at 10:20 AM with the Administrator (staff #90) and the (DON/staff #81). , Interview with 1. Administrator and 2. DON, Staff #81 stated that the facility did not give the residents a written reason for being transferred to the hospital, so the ombudsman did not receive a copy. She stated that the facility has never been provided the resident with a reason for transfer in writing and is currently looking at how to develop a process. Staff #90 stated that when she was at a conference, she heard other facilities talking about notifying the ombudsman about the reason for the transfer, but didn't know what they were talking about. The facility's policy Admission, Transfer, Discharge Rights (F-Tag) states that before a facility transfers or discharges a patient, the facility will notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. Subject to the resident's agreement, the facility must send a copy of the notice to a representative of the Office of the State Long Term Care Ombudsman.

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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** 40581 Based on facility documentation, the facility failed to ensure two residents (#86, #26) were notified were made aware of the bed-hold policy upon transfer to the hospital. Findings include: Resident #86 was admitted to the facility on [DATE] with diagnoses that included periprosthetic fracture around internal prosthetic left knee joint, acute and chronic respiratory failure with hypoxia, and chronic pain syndrome. The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 13 indicating the resident was cognitively intact. A progress note dated November 14, 2021 at 4:17 PM revealed that the resident had a rapid Covid test and tested positive earlier today. The resident complained of shortness of breath, with wet cough. The physician was notified and the resident was transferred to the emergency department (ER) via ambulance for further medical management. The family was notified about the hospital transfer and the resident's belongings were sent along with her. A progress note dated November 14, 2021 at 10:08 PM revealed that the resident's daughter called the facility to report on the resident regarding the ER admission and discharge. The daughter was notified about the facility Covid-19 positive patient protocol. Despite being educated, the concerned family member was audibly upset due to the fact the resident cannot be readmitted into this facility with a positive Covid-19 status. Review of the clinical record did not reveal a bed-hold policy signed and dated by the resident or a family member. -Resident #26 was admitted to the facility on with diagnoses that included benign prostatic hyperplasia without lower urinary tract symptoms, hypertensive heart disease with heart failure, and an anxiety disorder. The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 12 indicating the resident had a mild cognitive impairment. A progress note dated September 10, 2023 revealed that the resident was transported to the hospital as per physician's orders for possible sepsis at approximately 6:40 a.m. The vital signs were taken prior to transport and were as follows: 112/57 blood pressure, 121 heart rate, 72% oxygen on 1 liter., 102.7 temperature, and 22 respiratory rate. There was an attempt to contact the resident's daughter, but there was no answer. The nurse sent the face sheet and orders to transport. Review of the clinical record did not reveal a bed-hold policy. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted on November 6, 2023 at 9:24 AM with resident #26, he stated that he did not receive a written statement regarding the reason for going to the hospital or a bed hold policy when he was transferred to the hospital. An interview was conducted on November 8, 2023 at 8:27 AM with the Director of Nursing (DON/staff #81), who stated that the the resident is given a bed-hold policy when he/she is transported to the hospital if it is feasible. If the situation is emergent, the bed hold policy is discussed with a family member, who would decide if he/she wanted to pay the rate required. She stated that she was not sure if the conversation regarding the bed hold policy with the family member is documented in a progress note. She also, stated that if the bed-hold form was used, she would expect that it was signed and dated by the resident or family member. During an interview conducted on November 8, 2023 at 9:12 AM with the Administrator (staff #90), she stated that resident #86 would not have been given the resident a bed-hold policy because the facility wasn't going to accept the resident back due to being Covid positive. The facility's policy Admission, Transfer, Discharge Rights (F-Tag) states that before a patient is transferred to a hospital or goes on therapeutic leave, the facility will provide written information to the patient, a family member or resident representative specifying the duration of the bed-hold policy during which the patient is permitted to return and resume temporary residence in the facility.

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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** 40581 Based on observation, clinical record, staff interviews and the facility policy and procedures, the facility failed to use appropriate hand hygiene practices and PPE when providing wound care for one resident (#18). The deficient practice could result in infection. Findings include: Resident #18 was admitted to the facility on [DATE] with diagnoses that included dementia, fracture of left femur, and abnormalities of gait and mobility. A care plan dated October 9, 2023 for an actual impaired skin integrity related to admitted with surgical incision left hip. admitted with deep tissue injury on (DTI) on right buttock and left heel. The resident admitted with a stage II pressure ulcer to sacrum. -October 11, 2023 DTI right buttock is resolved. -October 11, 2023, stage II sacrum is now an unstageable pressure ulcer on her sacrum. -October 20, 2023, sacrum ulcer is resolved. -November 6, 2023, left heel is now stage III. Interventions include to treat left heel per order. Wound order dated November 3, 2023 revealed skin prep, okay open to air daily, float heels in bed, offload wound, reposition per facility protocol, offloading mattress. November 6, 2023 wound note revealed a facility acquired left heel non-blanchable redness -October 9, 2023: 3 cm length x 3 cm width -November 6, 2023: 0.8 length cm x 0.5 cm width On November 7, 2023 at 10:31 a.m. observed a Registered Nurse/Clinical Nurse Manager (RN/staff #1) clean a pressure ulcer on left heel. Staff #1 was observed: -sanitzing hands -donning gown and gloves -placing a paper towel below resident's left foot (foot was elevated by a pillow and did not touch the paper towel -removed the resident's sock and bandage/gauze -bandage/gauze was placed on the paper towel (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-cleansed the left heel with clean gauze and then placed gauze on the paper towel -doffed dirty gloves and placed them on the paper towel -reached under her gown and pulled out another pair of gloves from her pocket and did not sanitize hands prior to donning the gloves -Collagen pad was applied and covered -doffed gloves and washed hands An interview was conducted on November 8, 2023 at 11:10 AM with (RN/staff #1), who stated that she doesn't necessarily need to sanitize her hands after doffing soiled gloves and before donning the new gloves because she has already cleaned her hands prior to beginning wound care. She acknowledged that she didn't sanitize her hands after doffing the soiled gloves and donning a new pair of gloves when she cleaned the resident's wound on November 7, 2023. She also, stated that it would not be appropriate to take new gloves from her pocket beneath her gown because the gown could be contaminated and she acknowledged that she pulled her gloves from underneath her gown when providing wound care on November 7, 2023. An interview was conducted on November 8, 2023 at 11:22 AM with the Director of Nursing (DON/staff #81), who stated that when wound care is provide, the nurse should doff her gloves after removing the bandage, sanitize hands, and don new gloves. She stated that the hands should be sanitized because the old gloves may be contaminated. She also stated that the inside of the gown has the potential to be contaminated because it is touching the staff's clothing, so reaching underneath the gown to get gloves from the pocket creates the potential for contamination. The facility's policy Isolation Procedures and Universal Precautions states that hand washing is considered the single most important procedure for preventing infections. Hand washing is necessary before and after removal of gloves and barriers.