

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  035272	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/27/2024
NAME OF PROVIDER OR SUPPLIER  VI at Grayhawk, A VI and Plaza Companies Community		STREET ADDRESS, CITY, STATE, ZIP CODE 7501 East Thompson Peak Parkway Scottsdale, AZ 85255	

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47341</b></p> <p>Based on observation, staff interviews, and review of facility documentation, the facility failed to ensure one resident's (#27) oxygen tubing was safely secured. The deficient practice could result in a preventable accident.</p> <p>Findings included:</p> <p>Resident #27 was admitted to the facility on [DATE] with diagnoses of acute and chronic respiratory failure with hypoxia, gastro-esophageal reflux disease without esophagitis, and chronic obstructive pulmonary disease.</p> <p>Review of the MDS (minimum data set) assessment dated [DATE] revealed a BIMS (brief interview of mental status) score of 11 indicating moderate cognitive impairment.</p> <p>A care plan dated 09/28/2023 revealed resident was at risk for incontinence due to advanced aging process, new surroundings, debility related to activity intolerance and weakness complicated by acute on chronic respiratory failure. Interventions included to assist and offer to toilet frequently and as needed and encourage independence. The care plan also revealed resident was in need of assistance with self-mobility and functional tasks due to debility from recent illness, advancing age with comorbidities and interventions included 1/4 side rails to bedside as appropriate to encourage/foster mobility independence.</p> <p>The physician order report revealed an order dated 11/15/2023 for oxygen at 2 liters (L) to 4 L via nasal cannula for diagnosis of chronic obstructive pulmonary disease.</p> <p>An observation was conducted on 02/21/2024 at 10:13 A.M. The oxygen concentrator inside the resident's room was located between the door to the hallway and the door to the bathroom. The bathroom was located between the concentrator and the resident's bed. The resident was observed wearing the nasal cannula and the oxygen tubing connected to the oxygen concentrator was placed above the bathroom door frame with the bathroom door open.</p> <p>A follow up observation on 02/22/2024 at 11:37 A.M. revealed the oxygen tubing connected to an oxygen concentrator remained above the door frame of the bathroom door.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the progress note dated 01/20/2024 revealed resident was on continuous oxygen via nasal cannula at 3 L and displayed shortness of breath with minimal exertion. The note on 2/14/2024 revealed resident reported feeling like he can't get air. On 2/20/2024 in was noted that resident reported increased dyspnea.</p> <p>An interview was conducted with Licensed Practical Nurse (LPN\staff #280) on 02/23/2024 at 9:47 A.M. at which time she observed the oxygen tubing over the resident's bathroom door, staff #280 stated that maintenance/engineering fixed it that way to prevent resident from tripping and keeping it out of the way. Staff #280 stated it needed a top right corner bracket to keep the door from closing and clamping the tubing. During the interview, staff #280 opened and closed the door several times and the tubing fell in between the door and the door frame. The LPN started to close the door but stopped just before the door clamped the tubing which she acknowledged would prevent the resident from receiving oxygen.</p> <p>In an interview with the Director of Nursing (DON) on 02/23/2024 at 10:05 A.M. she stated that the facility used oxygen tubing clips above the doorway, that it was standard procedure so residents do not trip over their door. When the DON was informed of resident #27's oxygen tubing she stated she did not see it because maintenance had already added another bracket to secure the tubing.</p>