STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035273	A. Building B. Wing	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Splendido at Rancho Vistoso	13500 North Rancho Vistoso Blvd Tucson, AZ 85755

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48932 Based on clinical record review, interviews, review of facility policies and the State Agency (SA) complaint tracking system, the facility failed to use a two-person transfer, as identified by the comprehensive care plan, resulting in the resident #1's fall with injury. The deficient practice could result in increased risk of injury to the resident. Findings include: Resident #1 was admitted to the facility on [DATE] with diagnoses of unspecified dementia, degenerative disease of nervous system and repeated falls. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed a staff assessment for mental status indicating resident #1 had a memory problem with both short-term memory and long-term memory. It was also assessed that resident #1's cognitive skills for daily decision making to be moderately impaired. The same MDS assessment also indicated resident #1 was entirely dependent on staff for assistance or the assistance of 2 or more helpers required with sit to stand and bed-to-chair transfer. The MDS also revealed the resident was receiving hospice care. A review of the physician's orders revealed the following orders; Hoyer lift for transfers only, which was dated March 22, 2024. A review of a comprehensive care plan revealed a focus on the resident's risks of falls due to his use of psychotropic medications and fall risk score. An intervention was initiated on March 25, 2024 that indicated resident #1 was a two person assist with Hoyer lift with transfers. A review of the facility's assessment titled, Assessment Criteria for Safe Resident Handling and Movement, dated July 5, 2024 indicated resident #1 was not weight bearing as they did not have any bilateral upper-extremity strength. The same assessment also indicated resident #1 was a 2-person transfer by staff with a full body lift with full sling. (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 0689 Level of Harm - Actual harm Residents Affected - Few	A review of the progress notes for resident #1 revealed an entry dated September 2, 2024 that was created by Licensed Practical Nurse (LPN/Staff #147). The note revealed that staff #147 was summoned to resident #1's room by another staff member. The note continues to indicate that resident #1 was sitting on the floor with a CNA and that the CNA stated she slid him down to the floor when trying to transfer to (wheelchair). The note indicated that staff #147 and three other staff members assisted the resident into the wheelchair and vitals were taken. A review of another progress note for resident #1 which was dated September 3, 2024 and was created by LPN/Staff #53. The note indicated resident #1 was complaining of pain when he moved in bed and during peri-care. At this time, the resident was assessed and it was noted that there was bruising to the lateral right knee with some swelling. The note indicates that a new order for increased morphine and an x-ray was received. A review of the physician's orders revealed an order for an X-ray to the right knee and hip due to increased pain caused by a fall which was dated September 3, 2024. A review of a third progress note for resident #1, dated September 5, 2024 which was written by Registered Nurse (RN/Staff #138), revealed the results of the x-ray showed a comminuted distal perihardware fracture. The note also indicated that the medical doctor, hospice, and resident #1's spouse was notified of the results. A review of the intake information submitted by the facility to the SA complaint tracking system revealed a facility self-report was made on September 4, 2024 which stated resident #1 was being assisted by a Certified Nursing Assistant (CNA) (referring to staff #26) when resident #1 slid down with (the) CNA to the floor. At the time of the self-report, the facility was still awaiting results of the x-ray. A review of the intake information submitted by an anonymous reporter to the SA complaint tracking system on September 6, 2024 revealed resident #1 had a fall on September 2, 2024 when being transferred by a CNA (staff #26). This is the same event that was identified in the facility self-report. The information also indicated resident #1 complained of pain from the right knee to the right hip and received an x-ray on September 4, 2024. The report indicated the x-ray revealed a fractured right knee. An interview was conducted on September 10, 2024 at 10:30 AM, via phone, with staff #26. Staff #26 indicated that she has received training on resident transfer methods from the facility. Staff #26 also indicated that she usually gets updated resident information during shift change however, she indicated that she does not get a lot of information that she feels she needs. Based on her experience, the shift change report is quick and sometimes they will say to just check in with the nurse on the floor. Staff #26 indicated they were familiar with resident #1 and she indicated that in the past she would use the bear hug (stand pivot transfer) and she was not aware that he was to be using a Hoyer lift for transfers. Staff #26 continued to explain that she was transferring resident #1 by the bear hug and then his legs were giving out and so staff slid the resident down to the floor. Staff #26 indicated resident #1 went down on his right side and she called for a co-worker (staff #57) who was walking by. During the interview, staff #26 had indicated this shift was her first shift back from an extended absence as she had not worked since June of 2024. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted with Certified Nursing Assistant (CNA/Staff #57) on September 10, 2024 at 10:51 AM. Staff #57 explained that she utilizes the Kardex to identify how a resident is transferred and the facility provides training on transfer methods which includes the gait belt, Hoyer and Saralifts. Staff #57 indicated that updated resident information is shared with her during shift change and for any information that is not provided to her, she will look at the Kardex for additional information. Staff #57 indicated that on September 2, 2024 she was walking another resident to the dining hall when she passed the room of resident #1 and saw staff #26 with the resident in his room and at that time, she could not see resident #1's position. She indicated that she asked staff #26 if she needed assistance because resident #1 was a Hoyer transfer and staff #26 responded that she did not. Staff #57 indicated that after she had assisted the other resident to the dining room, she walked back down the hallway and at that time staff #26 asked for help. Staff #57 indicated that staff #26 explained that resident #1 did not fall but slid down. Staff #57 then went to retrieve staff #147 and staff #116 (CNA) for assistance. An interview was conducted with staff #116 on September 10, 2024 at 11:18 AM. Staff #116 explained that resident transfer methods are listed on the Kardex or the shift cheat sheet that she uses. She indicated the cheat sheet has basic resident information on there such as their diagnoses and transfer methods. Staff #116 stated that the cheat sheet is available for all CNAs in a binder at the nurses' station. Staff #116 explained that she was working on September 2, 2024 when staff #147 asked for her help with resident #1 and she observed him in his room with half of his body on the floor. Staff #116 stated that staff #26 told her that the resident did not fall but slid down. Staff #116 revealed the resident was in a lot of pain and was very agitated however the resident did not identify where the pain was. After the fall, 15-minute neuro checks were implemented according to staff #116. A phone call was placed to staff #147 on September 10 at 11:53 AM but was not returned during the course of the investigation. An interview was conducted with the Director of Nursing (DON/Staff #99) on September 10, 2024 at 1:31 PM. Staff #99 indicated that it was his 5th day working at the facility at the time of the interview. When asked how do staff know what type of transfers a resident might need, he explained that the easiest way to get this information was to look at the Kardex in Point Click Care (electronic health record application). An interview was conducted with the facility's Administrator (ADM/Staff #93) on September 10, 2024 at 1:45 PM. Staff #93 explained that information that is to be relayed between incoming and outgoing staff during shift change should include fall precautions, reviewing the Kardex together, talking about skin integrity and follow-up items that need to be done. Staff #93 pointed out that they are mostly reviewing the Kardex together to ensure staff receive the most up-to-date information because resident needs are constantly changing. Staff #93 explained that the interim DON, at the time, was notified that resident #1 had a fall and that the LPN on duty (staff #147) conducted a pain assessment and no injuries were noted at the time. However, the resident was in a lot of pain the next day when hospice saw resident #1 and an order for an x-ray was placed. Staff #93 indicated that she discussed the results of the x-ray, which indicated a fracture, with resident's spouse, son and physician and they had decided against surgery because of his age. When asked if staff met her expectations on how resident #1 is to be transferred, staff #93 stated everyone did it correct except for (staff #26). The situation was avoidable if she had just waited for staff to assist her. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of a facility policy titled Safe Resident Handling and Movement, last revised on April 2024, indicated that the type of assistance a resident might need for moving and positioning is documented in the resident's record.