| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 035279 | A. Building<br>B. Wing | 12/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Acacia Health Center | 4555 East Mayo Blvd<br>Phoenix, AZ 85050 |

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 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>(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 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, and facility documentation and policy the facility failed to ensure that medical records accurately documented skin impairments identified for resident #024. The deficient practice could result in medical records that do not accurately and completely reflect the care and services provided. The sample size was 3, and the facility census was 75. Findings Include:Resident # 024 was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease with acute exacerbation, hypertensive heart disease with heart failure, paroxysmal atrial fibrillation, and generalized muscle weakness. The resident was discharged from the facility on December 18, 2024. A provider's order dated November 22, 2024, directed staff to cleanse the right second toe with wound cleanser, apply betadine, and cover with a Band-Aid daily.A provider's order dated November 23, 2024, directed staff to cleanse the open area of the left knee with wound cleanser, apply a medical-grade honey dressing, cover with a petrolatum gauze dressing and gauze, and wrap with a rolled gauze dressing, secured with tape and a stockinette.A review of the admission Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident was cognitively intact. Further review of the MDS indicated that Resident #74 had two venous/arterial ulcers and skin tears present. The MDS identified skin condition treatments included pressure-reducing devices for chair and bed, nutrition and hydration interventions, application of nonsurgical dressings, ointments or medications, and application of dressings to the feet with or without topical medications. The MDS also identified that the resident and representative were active participants in the assessment process and that the overall goal was discharge to the community. A provider's order dated December 16, 2024, directed staff to cleanse the right first toe with wound cleanser, pat dry, apply betadine, and leave open to air daily . A review of the Skin and Wound Evaluation dated December 16, 2024, revealed that the front of the left knee had a skin tear with complete tissue loss, and treatment orders were in place for the application of a medical-grade honey dressing.A review of the Skin and Wound Evaluation dated December 16, 2024, revealed the following: the arterial ulcer on the first digit of the left dorsum was treated with sodium hypochlorite, debrided with an autolytic, and covered with calcium alginate and foam dressings; and the arterial ulcer to the right first digit (hallux) was circular in shape and had an area with 70% slough and 30% non-granular tissue, that was circular in shape. A review of the Skin and Wound Evaluation dated December 16, 2024, described the arterial ulcer on the right dorsum as scabbed, circular in shape, with no surrounding redness. Further review revealed that the ulcer was cleansed with sodium hypochlorite and dressed with an antimicrobial dressing.A review of the Transition of Care and Discharge summary, dated [DATE], revealed that the discharge summary instructions received by the resident's representative and present in the electronic record were inconsistent with the resident's clinical record, due to omissions related to the resident's skin impairments.A provider's order dated December 17, 2024, directed staff to cleanse the left lateral hallux wound with wound cleanser.A review of the Home Health Care Referral Form dated December 17, 2024, revealed special instructions to include wound care.A review of the Health Services Concern and Comment form, dated February 28, 2025, indicated that the resident's representative expressed concern regarding the resident's wound care and the discharge wound care process. According to the document, the facility's investigation determined that incorrect documentation related to the resident's wound care was submitted on the discharge assessment. Further review of the document revealed that the facility provided education to licensed nursing staff regarding wound care documentation, discharge documentation, and communication.An interview was conducted on October 28, 2025, at 9:08 a.m., with the resident's representative. The representative expressed concern regarding insufficient communication from the facility to the consulting provider about the resident's wounds. The representative reported receiving written discharge instructions but indicated dissatisfaction that the discharge paperwork did not accurately reflect active skin impairments. The representative stated feeling equipped to manage the wounds but emphasized a desire that facility staff had communicated the condition of the wounds more accurately.An interview was conducted on October 28, 2025, at 9:42 a.m., with Certified Nursing Assistant (CNA) Staff #21. Staff #21 stated that any changes in a resident's skin integrity are immediately reported to the nurse. Additionally, Staff #21 explained that on resident shower days, it is their responsibility to document any abnormalities on the shower sheet and submit the completed form to the nurse. Staff #21 emphasized that accurate documentation and communication are essential to advocate for |