

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  035280	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/17/2024
NAME OF PROVIDER OR SUPPLIER  Sante of Mesa		STREET ADDRESS, CITY, STATE, ZIP CODE  5358 East Baseline Road Mesa, AZ 85206	

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 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47341</b></p> <p>Based on observation, clinical record review, staff interview, and facility documentation, policy and procedure, the facility failed to ensure dialysis assessments were completed and transportation to dialysis appointments was arranged for one of three sampled residents (#4). The deficient practice could result in the resident missing dialysis treatment and developing renal complications.</p> <p>Findings include:</p> <p>The facility's contract with the Dialysis Facility, signed and dated 10/18/2023, it included that the facility shall be responsible for arranging transportation of residents to and from Dialysis Facility, including all transportation costs and expenses. Long term care facility shall be responsible for ensuring that residents are (i) medically stable to undergo such transportation, (ii) medically suitable to receive treatment at Dialysis Facility, and (iii) timely transported to and from Dialysis Facility.</p> <p>Resident (#4) was admitted [DATE] with diagnoses of type 2 diabetes mellitus with diabetic chronic kidney disease (CKD), CKD with Heart Failure and Stage 5 CKD or end stage renal disease</p> <p>A physician order dated April 8, 2024 included for dialysis three times a week on Mondays, Wednesdays, and Fridays; and, the chair time would be from 11:50am to 3:20pm with an arrival time of 11:30am.</p> <p>Another physician order dated April 8, 2024 revealed an order to complete pre-dialysis and post-dialysis assessments every day shift on every Monday, Wednesday, and Friday.</p> <p>A progress note dated April 9, 2024 included that the care manager met with the resident and family for an admission intake review that covered review of all medications, treatment orders, dietary orders, therapy services and all other interventions or services ordered at the time of admission.</p> <p>A review of the Treatment Administration Record (TAR) for April 2024 included that a post dialysis assessment was documented as completed on April 10 and 12, 2024.</p> <p>However, the documentation from the dialysis center revealed that the resident did not receive dialysis on April 10, 2024.</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 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A progress note dated April 10, 2024 revealed that the resident was sent to the emergency room (ER) at 2:45 p.m.</p> <p>The progress note dated April 11, 2024 revealed that the resident returned to the facility at 12:05 a.m. Per the documentation, the family were upset because resident #4 was not scheduled for dialysis on April 11, 2024. Further, the documentation included that the family took the resident to the dialysis center on April 11, 2024 at 5:00 a.m.; and that, the facility agreed to schedule transport to pick the resident from dialysis to return to the nursing facility.</p> <p>Further review of the clinical record revealed no documentation of reason why transportation to dialysis appointment was not arranged for resident #4.</p> <p>In an interview with the licensed practical nurse (LPN/staff #90) conducted on April 17, 2024 at 3:00 p.m., the LPN (#90) stated that they did not complete any post dialysis assessment for resident #4 even if it was on the TAR. LPN (#90) stated that pre- and post- dialysis assessments were completed in the assessment section of the electronic health record. A review of the clinical record was conducted with the LPN (#90) during the interview. The LPN stated that there were no dialysis assessments completed for resident #4.</p> <p>An interview with the Director of Nursing (DON/staff #88) was conducted on April 17, 2024 at 4:31 p.m. The DON stated that the clinical record of resident #4 did not have dialysis assessments completed for resident #4.</p> <p>During an interview with the unit clerk (staff #76) conducted on April 17, 2024 at 2:45 p.m., the unit clerk stated that they were responsible for scheduling transportation for all residents; and that, if they had already left for the day when a resident gets admitted, the care management or the transportation director will have to set it up the appointments. Staff (#76) said that if the facility were notified that a resident was not picked up at the facility, they will follow up immediately with the dialysis center to see if the resident person can still be seen for dialysis. They stated that if the center does not have any chairs available for later time that same day, they will schedule a special chair for the resident for the next day; and that, they would make the appointment for them to be seen outside their regularly scheduled time. Staff (#76) stated that if the facility was advised that it was an urgent case, the facility will take the resident to the hospital to be dialyzed. Regarding resident #4, staff (#76) stated that resident #4 did not have dialysis completed on April 10, 2024 at 11:30 a.m. because the staff who completed the resident's admission did not inform her that the resident needed transportation to dialysis. Staff (#76) said that they found out that the resident did not go to his dialysis appointment when they received a call from the resident's family at approximately 10:00 a.m. and reported that family was at the dialysis center but resident #4 was not. Staff (#76) said they called the dialysis center to see if the resident could be seen that day, but she was told no. Staff (#76) stated that the resident was then scheduled on April 11, 2024 at 5:00 a.m. and they notified the family. However, the unit clerk said that on April 10, the resident had an accident and was sent out to the ER. Further, Staff (#76) said that they cancelled the resident's transportation to dialysis for April 11, 2024 at 5 a.m. because she did not know if the resident would be back to the nursing facility from the ER. The Staff (#76) said that the resident returned at the facility on April 11, 2024 at 12:00 a.m.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In another interview with the LPN (staff #90) conducted on April 17, 2024 at 3:00 p.m., the LPN stated they were responsible for setting up transportation to dialysis appointments for residents; and that, the facility provided all transportation, so it is very unlikely for transportation not showing up. Staff (#90) said that if the transportation did not come, they would call the dialysis center to let them know and work to reschedule the resident for later time that day or as soon as possible. Further, Staff (#90) stated that the provider at the dialysis center will either say the resident was okay to skip that day's session and attend their next appointment as scheduled; or, they will need to come in as soon as possible.</p> <p>In an interview with the nurse care manager (staff #65) conducted on April 17, 2024 at 3:12 p.m., they stated a 'meet and greet' with new admissions where they would go over things like transportation needs and dialysis appointments; but, the unit clerk or maintenance director will set up the actual transportation. Regarding resident (#4), staff (#65) said that after completing the intake with resident #4 and his family, they told the staff (#76) that resident (#4) would need transportation set up for his Monday, Wednesday, Friday dialysis appointments. Staff (#65) said that there was no transportation set up to take the resident to his April 10, 2024 11:30 a.m. appointment; and that, after the resident was sent out for his fall on April 10 (same day as the scheduled dialysis), an appointment was made for 5:00 a.m. on April 12, 2024. Staff (#65) further stated that she made sure transportation had been set up for that one as well as a return car for 10:00 a.m.</p> <p>In an interview with the DON conducted on April 17, 2024 at 3:55 p.m., the DON stated that the expectation was for the facility to always offer to transport residents to dialysis appointments whether they use the facility driver or a third-party vendor to do so. The DON said that if transportation does not show up, staff were expected to check if they can get the resident's dialysis set up again immediately; and, for staff to call the dialysis center and see if the resident can be accommodated, or as a last resort to go to the hospital if needed. The DON further stated that her expectation was for nursing staff to do an assessment before and after dialysis appointments for residents. At 4:03 p.m., the Assistant Director of Nursing (ADON/staff #43) joined the interview and stated that that transportation had been set up for resident #4 on April 10, 2024 but the resident had a fall and ended up going to the ER due to head gash. Staff (#43) said that the hospital refused to dialyze the resident him while he was in the hospital; and that, transportation had been cancelled and rescheduled to 5:00 a.m. on April 12, 2024 because it was not clear at the time if the resident would be back in the facility in time. The Staff (#43) also said that the resident's family agreed to take the resident to dialysis. During the interview, a review of the clinical record was conducted with both the DON and the Staff (#43). The review revealed that the resident's appointment was scheduled for 11:30 a.m. on April 10, 2024 and the resident did not have a fall until 2:35 p.m. on April 10, 2024. Staff (#43) was not able to explain why the resident did not go to his 11:30 a.m. appointment.</p> <p>A facility policy on Transportation, Diagnostic Services or Medical Appointments included that the facility will assist residents in arranging transportation to/from diagnostic or medical appointments when necessary. Should it become necessary for the facility to provide transportation, the Social Service Designee or Concierge staff will be responsible for arranging the transportation through the business office. Requests for transportation should be made as far in advance as possible.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy on Pre-Dialysis and Post-Dialysis Assessment Procedure revealed that upon return to the facility, staff is to Ensure guest is comfortable and safe upon return, obtain report from dialysis center or Review any dialysis records upon return to the facility, Complete an evaluation/Assessment that may include vital signs, mental status, body systems assessment, access site assessment (i.e. dressing, caps, access site, bruit, thrill), pain/discomfort, complete post-transport assessment, and report any significant findings or abnormalities during the evaluation/assessment to the physician and carry out any orders received.</p>		