

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 09/06/2024
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 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49199</p> <p>51159</p> <p>Based on clinical record review, interview, review of policies and procedures, the facility failed to notify the ombudsman of transfer or discharge. The deficit practice would result in residents not being able to inform the ombudsman being unaware for any transfer or discharge.</p> <p>Resident # 70 was admitted to the facility on [DATE] with diagnoses that include adult failure to thrive, HTN, BPH, Anemia. Resident # 70 was discharged [DATE].</p> <p>Resident # 70 needs supervision or touching assistance with: eating, oral hygiene, and personal hygiene. Resident # 70 needs substantial/maximal assistance with: upper body dressing, lower body dressing, putting on/taking on foot wear, roll left and right, sit to lying, chair/bed-to-chair transfer. The care plan revealed Resident #70 was monitored for any change of conditions. If any change were to occur it would be reported to their provider. Resident # 70 is at risk for altered fluid balance r/t Poor intake, feeding tube. Resident # 70 has oral thrush and antifungal.</p> <p>Progress notes on June 14, 2024 revealed Resident # 70 is progressing with their therapy and was going to be discharged to an acute rehab center. There was no date or time that resident discharge was completed in progress notes or that the ombudsman was notified.</p> <p>Staff #66 Care Manager LPN said the resident was the main point of contact for plan of care and discharge plan. Resident # 70 was provided admission orders, baseline care plan and discussion held on Resident # 70 goals, expectation, and treatment. Resident #70 was informed of their treatment orders, dietary orders, medications, and therapy services. If there are any changes care plan will be notified to Resident # 70. Resident # 70 had verbalized in understanding their care plan and agreed to the care plan.</p> <p>Interview with staff # 167 Care Manager Licensed Practical Nurse (LPN) on 09/05/2024 at 8:44AM revealed Resident # 70 was transferred to an acute rehab unsure of the reason. Since this was an emergency transfer there were no documents signed by resident or on the resident behalf of this transfer.</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 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with staff # 66 Care manager Licensed Practical Nurse (LPN) on 09/05/2024 at 9:17AM revealed an Ombudsman would only be notified if there is a problem. Since this is not a discharge a discharge packet was not given to resident #70. This was a skilled nursing facility to a skilled nursing facility transfer. An email or fax of everything needed would have be given to the receiving facility.</p> <p>On 09/06/2024 at 8:44AM the Administrator said the process of discharge would normally be if a resident had requested for a change in facility they would give the resident a list of facilities. With this list we will help residents pick out a facility that they would like. In this case this Resident # 70 wife wanted to go to a different facility prior to coming to this facility. At the time Resident # 70 was not qualified for that particular facility. Resident # 70 would start off with a lower level rehab to build on their strength like this facility. During Resident # 70 times here, they were recovering quite well. Resident # 70 wife requested this transfer and we had sent out a referral which was approved. During this process case managers and resource nurses are involved. There should have been a note that the patient was discharged in the progress notes. There was no discharge packet given.</p> <p>On 09/05/2024 2:58PM documentation the ombudsman being notified of transfer and discharge was requested but the documentations was not provided. Social Services Staff # 172 stated they were not aware that the ombudsman needed to notify.</p> <p>Review of the policy Transfer or Discharge facility revealed that the Ombudsman would be given a notice of transfer or discharge and resident and representatives.</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>51159</p> <p>Based on the reviewing of staff list, census, record review and interview facility failed to ensure that a Registered Nurse (RN) severed 8 consecutive hours in the day. The deficit practice would result resident care not being properly given in need of a registered nurse.</p> <p>Reviews of daily staff revealed that an RN was not present during the 8 hours in the day for 8 different dates. On May 19, 2024 the Census was 58 no RN coverage for day and night. On July 01, 2024 Census was 68 no RN coverage for the day for 8 hours. At the August 05, 2024 census there was 68 no RN coverage for the day for 8 hours. On August 06, 2024 census was 66 for the day for 8 hours, August 12, 2024 the census was 69 and no RN coverage for 8 hours of the day. August 19, 2024 census 67 no RN coverage for the day for 8 hours. August 27, 2024 census 64 no RN coverage for the day for 8 hours. September 01, 2024 census 59 no RN coverage for 8 of the day.</p> <p>Upon further review of the daily staffing list provided to the surveyor, Director of Nursing or Assistant of Director of Nursing are not listed on the daily staffing list.</p> <p>Interview with staff # 52 Certified Nurse Assistant CNA September 05, 2024 1:35PM. Typically I would get 11-12 residents under my care. I don't stay over time when working. If my coverage isn't here on time we would document and report our task and care that we have given to residents. This will help the next person taking over when we leave for the day. We can communicate with staff verbally and put reports within the chart. Call devices are given to residents and they can put them on their neck or they can have it near them on the table. We have in-service training and staff meetings to help us learn.</p> <p>Interview with Staff # 34 Director of Nursing (DON) on September 06, 2024 at 2:29 PM, the DON stated if we don't have an RN 8 hours of the day, the Director of Nursing or Assistant Director of Nursing would cover during those days. The Director of Nursing would work Monday - Friday. Our coverage is not based on the census, and if someone calls off the Director of Nursing or Assistant Director of Nursing would cover. We do what we can with what we have.</p> <p>Policy review of staffing had revealed 24 hours of the day a Licensed Nurses need to be able to provide direct resident services .</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48932</p> <p>Based on clinical record review, staff interviews, and the facility policy and procedures, the facility failed to ensure pain medications were administered in accordance with the physician's orders for one resident (#15). The deficient practice could result in the resident receiving unnecessary medication and being overmedicated.</p> <p>Findings include:</p> <p>Resident #15 was admitted to the facility on [DATE] with diagnoses of a fracture of shaft of right fibula, fracture of shaft of right tibia, and acquired absence of left hip joint.</p> <p>A review of the quarterly Minimum Data Set (MDS) assessment, dated June 20, 2024 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident is cognitively intact.</p> <p>A physician's order dated May 9, 2024 indicated Oxycodone HCl (narcotic analgesic) Oral Tablet 5 milligrams (mg) was to be given by mouth every 4 hours as needed for pain between 6-10 on a 0-10 pain scale.</p> <p>A review of the July and August medication administration record (MAR) revealed that oxycodone was not being administered within the pain parameters established by the physician.</p> <p>For the month of July 2024, oxycodone was administered below the required pain rating of 6-10 thirty-three times. For the month of August 2024, oxycodone was administered below the required pain rating of 6-10 thirty-two times.</p> <p>The clinical record revealed no documentation of the reason why oxycodone was administered outside of the parameters established by the physician's orders and that the physician was not notified.</p> <p>An interview was conducted with staff #110 (Registered Nurse) on September 6, 2024 at 9:58 AM. Staff # 110 indicated that pain medications are given to residents after a pain assessment is done. During the pain assessment a resident identifies how much pain they are having using a pain scale to determine if they are eligible to take the specific pain medication. Staff #110 explained that she will look at the medication order and it would specify when to give the medication to the resident. Staff #110 reviewed the August MAR for resident #15 and indicated that the oxycodone was not administered within parameters. When asked what the risk would be to the resident when administering oxycodone outside of parameters, staff #110 indicated that they would not be doing what would be best for the resident and they would not be treating the pain as prescribed by the physician.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on September 6, 2024 at 10:31 AM with staff #34 (Director of Nursing). Staff #34 indicated that when a resident asks for pain medications, the nurse is to ensure there is an order then ask the resident what they rated their pain as, and then identify the symptoms that indicates the resident is in pain. When reviewing the August MAR for resident #15, staff # 34 stated they saw multiple administrations being done outside of the ordered parameters. Staff #34 indicated that the nurse did not administer pain medication according to her expectation as she expected staff to follow the orders. When asked what the risk to the resident would be when oxycodone is administered outside of the ordered parameters, staff #34 explained that it could make the resident sleepy and it would enhance their fall risk. Staff #34 continued by stating their goal is not to make them dependent on narcotics.</p> <p>A review of the facility policy titled Administering Medications, revised on December 2012 indicated that medications are to be administered according to orders.</p> <p>A review of the facility policy titled Pain Assessment and Management, revised on March 2015 states Addiction to narcotic analgesics is not likely if used appropriately for moderate to severe pain.</p>		