

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035282	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Sante of Surprise		STREET ADDRESS, CITY, STATE, ZIP CODE 14775 West Yorkshire Drive Surprise, AZ 85374	
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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, and the facility's policies and procedures, the facility failed to ensure that one resident's (#7) representative was notified of a change in condition. The sample size was three. The deficient practice could lead to the responsible party not being informed and not being able to participate in the resident's care. Findings include: Resident #7 was admitted to the facility on [DATE] with diagnoses that included radiculopathy in the lumbar region, chronic diastolic heart failure, and acute kidney failure. The discharge Minimum Data Set (MDS), dated [DATE], indicated that Resident #7 did not participate in a Brief Interview for Mental Status (BIMS). The MDS assessment also noted that Resident #7 had 1 fall with major injury while residing at the facility. The Care Plan, created on March 31, 2026, revealed there was a focus on Resident #7's risk for falls and fall related injuries due to a decline in her independent functioning and weakness related to her medical conditions. Interventions included having the bed in a low position, frequent checks of the resident, notifying the Medical Doctor (MD) and responsible party if a fall were to occur, and to obtain oxygen saturations and vitals post fall. The clinical record had a late entry incident note, dated April 23, 2026 at 9:55 A.M. created by Licensed Practical Nurse (LPN/Staff #19), noted that Resident #7 was being transferred from the bed to her wheelchair when her knees buckled and she was lowered to the floor by a Certified Nursing Assistant (CNA). The same note also noted that the resident's vitals were taken and she had no injuries. There was no indication that Resident #7's representative was notified of the fall. Additional review of the clinical record revealed a change in condition evaluation dated April 23, 2026 at 5:10 P.M., created by Staff #19. This evaluation documented that the resident was complaining of bilateral hip pain. The Nurse Practitioner (NP) was notified, and orders were given for bilateral hip x-rays. However, the record contained no evidence that the resident representative was notified about the fall that led to the resident's onset of hip pain. A radiology report, dated April 23, 2026 at 8:22 P.M., noted that x-rays of bilateral hips and the pelvis were taken. It further noted that there was no radiographic evidence of an acute fracture or dislocation. An Incident Report (IR), dated April 23, 2026, noted that a CNA was transferring Resident #7 from the bed to the wheelchair when her knees buckled and she was lowered to the floor. It also noted there were no injuries noted. The IR also noted that the facility's Administrator, ADON, DON, Charge Nurse, and the provider was notified. There was no indication that the resident's representative was notified of the fall. An interview was conducted on July 27, 2026 at 1:23 P.M. LPN/Staff #13. Staff #13 described a change in a resident's condition as a change of status in their mental and physical condition. Staff #13 agreed that a fall would be a change in condition for a resident. Staff #13 explained that when a resident has a fall, she would notify the provider, the resident's family, the Assistant Director of Nursing (ADON), or the Director of Nursing (DON). Staff #13 further shared that she documents the notifications on the (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	change of condition form and on the resident's risk assessment form. Staff #13 shared that if the resident's responsible party was not notified of a fall, they would not be informed of the cares the resident might need. An interview was conducted on July 27, 2026 at 1:36 P.M. with LPN/Staff #4. Staff #4 described a change in a resident's condition as anything that is different from their baseline. Staff #4 agreed that a fall would be considered a change in their condition. Staff #4 explained that when a resident has a fall, she would notify the family, the doctor, the DON or ADON, and the charge nurse. She further explained that she would document the notifications of the change in condition form and the risk management form. However, Staff #4 was not sure if the risk management form was part of the clinical record or the facility's record. Staff #4 further shared that there was no reason why a resident's representative shouldn't be notified of a change in condition and if it was not documented, that means the notification was not done. An interview was conducted on July 27, 2026 at 1:54 P.M. with the DON/Staff #9. Staff #9 described a change in a resident's condition as anything that is different from the resident's baseline. She also agreed that a fall would be considered a change in their condition. Staff #9 explained that when a resident has a fall, she expected staff to notify the clinician, the physician, herself, the ADON, and family/emergency contact. Staff #9 further explained that the notifications are documented in the incident report or in a progress note. Staff #9 reviewed Resident #7's clinical record and shared that she had three falls while at the facility. Staff #9 further shared that on April 23, 2026, Resident #7 was being transferred from the bed to her wheelchair when her knees buckled and she had an assisted fall. Staff #9 explained that the resident was not wearing grip socks and was wearing regular non-grip socks which could have contributed to the fall. After consulting with Resident #7's clinical chart, Staff #9 stated that she did not see documentation that the resident's family was notified. She further stated that Resident #7 was alert and oriented and had the right to not have us notify her family. However, Staff #7 also stated that she did not see any documentation that the resident did not want family to be notified of the fall. Staff #9 added that she would expect a note in the clinical record to indicate that the family was notified of the fall or if the resident did not want the family to be notified. Staff #9 stated that by not notifying the family/representative posed no risk to the resident because the resident was alert and oriented. She further stated that the x-rays had come back negative so there was nothing concerning that needed to be related to the resident's representative. She added that if the x-ray was different, then she would be more concerned about not notifying the representative. On July 27, 2026 at 2:15 P.M. the facility's Administrator (Staff #1) notified surveyor that LPN/Staff #19 was on a leave of absence. Review of the facility's policy and procedure (P&P), titled Change in a Resident's Condition or Status, indicated it was last revised in May 2017. The P&P explained that the facility is to promptly notify the resident's representative of changes in the resident's medical condition. It further explains that unless instructed by the resident, a nurse will notify the resident's representative when the resident is involved in any accident or incident that results in an injury. Review of the facility's P&P, titled Charting and Documentation, indicated it was last revised in July 2017. It explained that documentation of procedures and treatments will include care-specific details which included the notification of family.		