STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035289	A. Building B. Wing	02/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Arrowhead, LLC	7201 W Camino San Xavier Ave Glendale, AZ 85308

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49399 Based on clinical record review, staff and resident interviews, facility documentation and policy review, the facility failed to ensure that an allegation of abuse for one resident (#6) was reported to the State Agency. The deficient practice places the resident at risk for continued abuse. Findings include: Resident #6 was admitted to the facility on [DATE], with diagnoses of acute respiratory failure with hypoxia, enterocolitis due to clostridium difficile, sepsis, depression and low back pain. A review of the Resident #6 admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderately impaired. In addition, Resident #6 mostly required assistance with everyday activities. A review of the care plan initiated on January 24, 2024 revealed a need assistance with transfers and toileting related to impaired mobility secondary to weakness and debility. The interventions included check frequently and assist with toileting as needed, keep call light within reach, and remind me to call for assistance. An interview was conducted with a Case Manager, (Staff #12), on February 13, 2024 at 11:55 AM. She stated that for an alleged abuse, they get information from the person reporting the abuse, and it gets elevated to the administrator. She further stated she has not received any information regarding Resident's #6 alleged abuse. She then stated that it might have been reported to the Assistant Director of Nursing (ADON/Staff #75) or the Director of Nursing (DON/Staff #65). On February 13, 2024 at 12:38 PM, an interview was conducted with ADON (Staff #75). Staff #75 stated that he was not aware or remembers any report of alleged abuse. He stated that allegations always go to the DON/Staff #65. On February 13, 2024 at 12:42 PM, an interview was conducted with DON (Staff #65) in her office. Staff #75 was also present. The DON stated that she does not have any recollection of a notification regarding an incident of alleged abuse of Resident #6. She further stated there was no mention to the physician, while she was looking at a 7-day look back at the physician progress notes. Staff #65 stated that she will be speaking to Resident #6 so she can interview resident, to obtain a description of the staff, and the timeframe so she can interview the staff. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On February 13, 2024 at 12:57 PM, Staff #100, the Clinical Services Resource staff, stated that the DON was on vacation last week. She also stated that the alleged abuse came on a report last week. She stated that met with Resident #6 and that Resident #6 declined an interview at first and then stated the staff are good. She then stated that Resident #6 thinks one person yelled at her, but was unable to describe the staff who yelled at her. The resident stated the staff asked her why her call light was on and what she needed. On February 13, 2024 at 12:59 PM, an interview was conducted with the Administrator (Staff #10). he was informed of the allegation of abuse by Resident #6. He further stated all the managers conduct angel rounds every morning and if there is a concern, then they determine if it is grievance or not. There was rounding for all patients and there were no concerns identified on February 8. He stated he will provide copy of the angel rounds for that week. On February 14, 2024 at 9:59 AM, a document about the alleged abuse of Resident #6 was received from Administrator/Staff #10. The document was returned to Staff #10 because it does not match the Resident #6's name on the provided document about the alleged abuse. On February 14, 2024 at 11:36 AM, a follow up interview was conducted with Staff #100. She stated that she was rounding in the hallway, where the resident is and on February 5, 2025, and she stopped by Resident #6 room to check on her, and Resident #6 stated that she thinks someone came in her room and asked her why her call light was on. Staff #100 asked Resident #6 if she can describe the incident and resident said no, she could not. Staff #100 stopped by the resident room approximately 10:00 AM. Resident #6 stated to that she felt the staff was rude and yelled at her but was unable to recall the time and who or describe the person. Staff #100 apologized to Resident #6. She then asked if resident feels safe and Resident #6 stated she feel safe and everyone is nice to her. Staff #100 conducted an interview with the night shift and day shift staffs and interviewed patients and no one heard yelling. Staff #100 further stated that the resident was visited during angel round. She then stated that Resident #6 stated she does not have concerns or complaints. She further stated that after investigating, there was no evidence to substantiate. She further added, the resident denied any feelings of intimidation or feeling of being unsafe. She then stated that the process is to do immediate investigate and interview. There was nothing to report about this alleged abuse, resident has no complaints or concerns. She stated if no one has heard it, and they can not identify anything or anyone, and resident does not want anything further done about, so no report was required. On February 14, 2024 at 12:08 PM, received a four paged document titled Conclusion to Concern: abuse investigation interviews dated February 5, 2024 from Staff #100. On February 14, 2024 at 12:21 PM, Staff #100 stated that a customer service in-service was conducted on February 5, 2024 and Staff #100 provided a copy of the in-service sign in sheet. However further review of the facility's investigation revealed no evidence that the allegation of abuse was reported to the State Agency. Review of the facility policy titled, Abuse and Neglect Prohibition with a revised date of October 12, 2022 revealed that each resident has the right to be free from abuse. Any observations or allegations of abuse must be immediately reported to the Administrator. Reporting and Response section 1 (a) states, if the eventes that caused the allegation involved abuse or serious bodily harm, a report is made not later than 2 hours after the management becomes aware of the allegation.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48814 Based on clinical record review, staff interviews, and facility policy and procedures, the facility failed to ensure one resident (#55) receive trimming of toe nails. The deficient practice could result in resident discomfort with pain and infection. Findings include: Resident # 55 was admitted to facility on January 9, 2024 with diagnosis included unspecified fracture of upper end of left humerus, subsequent encounter for fracture with routine healing, subsequent encounter, sepsis, unspecified organism, contusion of left elbow, subsequent encounter, essential (primary) hypertension, alcohol abuse, uncomplicated, gastro-esophageal reflux disease without esophagitis, muscle weakness (generalized), difficulty in walking, not elsewhere classified. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating that the resident is cognitively intact. The MDS also indicated that the resident was dependent on toileting and lower body dressing. Review of the care plan initiated on January 9, 2024 revealed that resident have actual/potential decline in his ability to perform his activities of daily living. Intervention included therapy evaluation and provide assistance as needed with grooming, bathing, and personal hygiene and per patient's preferences. Review of the resident task sheets for bath and nail care from January 16, 2024 to February 13, 2024 showed that resident is schedule for bathing every Tuesday and Friday. The following dates were reviewed for resident nail care: January 16, 2024: no nail care offered; January 19 - February 6, 2024: resident refused once and no follow up made on another shift; January 30 - February 13, 2024: no nail care offered or follow-up made on different shift Review of resident progress note on February 3, 2024 from Licensed Practical Nurse (LPN, staff # 106) revealed that patient had concerns about his toe nails not being cut. During an initial interview on February 12, 2024 at 12:15 a.m., resident stated that he wanted his nail to be clipped and staff ignores his request for podiatrist consult. An observation was made on resident toe nail on February 12, 2024 at 12:15 AM, both toe nails were big, thick and greenish in color. During an interview, resident stated that his toe nail is growing to his foot and his big nails hurt, he did not remember when was that last cut. An interview was conducted with certified nursing assistant (CNA, staff # 56) on February 14, 2024 at 9:57 AM, and she stated that by looking at the resident toe nails, she never asked him to cut his nails. She further stated that she notified the wound nurse couple weeks ago but did not follow-up. She also stated that she did not remember resident asking her to cut his toe nails. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with wound care nurse (staff # 54) on February 14, 2024 at 9:57 AM, and she stated that she is competent to do podiatry. She further stated that for non-diabetic residents' regular nurses provide cares and those with diabetes, she provides their care. She also stated that the resident is not diabetic and she is not sure whether he requested for nail care or not. An interview was conducted with Director of Nursing (staff # 65) on February 14, 2024 at 9:57 AM, she stated that if resident is diabetic then the nurse will provide nail care, if they are not diabetic then a CNA will do that. She further stated that facility does not have a podiatrist, if they need podiatrist then wound care nurses or doctor can do that. She also stated that if the nail is really thick then she does not recommend CNA to do that. About risk, she stated that it may cause infection and skin damage if nails were not cut. Review of facility policy on Activities of Daily Living (ADLs) revised on February 8, 2021, stated that patients shall receive assistance with activities of daily living every shift, as appropriate and ADLs include: bathing, grooming, dressing, eating, oral hygiene, ambulation, toilet activities and trimming of toe nails.