STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035297	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2024
NAME OF PROVIDER OR SUPPLIER: Surprise Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 14660 W Parkwood 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49325 Based on review of clinical records and policy, observations, and staff interviews the facility failed to ensure care and services related to a cervical collar was provided for one resident (#8). The deficient practice could result in resident needs not being met to attain and maintain the resident's highest practicable well-being. Findings include: Resident # 8 was admitted on [DATE] with diagnoses of unspecified displaced fracture of second cervical vertebra, subsequent encounter for fracture with routine healing, encephalopathy, acute kidney failure, and essential (primary) hypertension. Review of the Admission's Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 5 which indicated the resident had severe cognitive impairment. The hospital physician note dated June 12, 2024 included that the resident had the C-collar in place. Assessment included C2 cervical fracture. Per the documentation, the C-collar at all times except during showers and meals; and to follow-up in 8 weeks and reassess with new CT (computed tomography) scan of the cervical spine. The hospital discharge instruction dated June 12, 2024 included a discharge diagnosis of C2 cervical fracture. The documentation also included that the resident had repeat CT scan of the cervical spine without contrast. The admission note dated June 13, 2024 included that the resident arrived at the facility and was alert and oriented x1. The documentation did not include whether the resident had the C-collar on or not. The NP (nurse practitioner) progress note dated June 14, 2024 revealed that the resident was alert and oriented x 3, was frail and underweight. Assessment included C2 cervical fracture. Plan included for therapy evaluation and treatment and C-collar at all times x 8 except during showers and meals. The physician progress notes dated June 15 and 18, 2024 included a chief complaint of C2 cervical fracture; and that, the resident was to continue with C-collar at all times x 8 weeks except during showers and meals. Per the documentation, the C-collar was to be placed back on as the resident did not have it on when he came back from shower. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	However, clinical record revealed no care plan with goals and interventions in place to address the resident's primary diagnosis of displaced fracture of second cervical vertebra and use of the cervical collar. The care plan had a picture on the right lower corner of the page that showed a picture that the resident was wearing a collar on his neck. Despite documentation that the resident had cervical collar, there was no evidence of a physician order for the use cervical collar (C-collar) found in the clinical record; and that, the resident refused to wear the C-collar. The clinical record also revealed no evidence of a reason why the C-collar was not on; and that, the physician was notified. The Occupational Therapy (OT) note dated June 19, 2024 revealed that the resident was not able to maintain cervical and aspiration precautions while wearing cervical collar; and that, cervical collar was ill fitting and the resident's chin was tucking into collar when worn. The Physical Therapy (PT) services dated June 19, 2024 revealed that the resident's cervical brace had a poor fit; and that, cervical brace was not safe for wearing. The nursing note dated June 19, 2024 included that the resident was placed in the dayroom by therapy in eyesight of the nurse station dur to resident at risk of fall. Per the documentation, the staff last checked the resident at approximately 11:20 a.m. and was removed from the dayroom by his family at 12:00 p.m. via a wheelchair. The documentation also included that the resident's family called for assistance at 12:05 p.m. and the resident was found unresponsive and without a pulse. The recorded video footage from June 19, 2024 revealed that the resident was being wheeled in by a family member from the common room near the nursing station to his room and was not wearing the cervical collar. In an interview with Licensed Practical Nurse (LPN/staff #70) conducted on June 25, 2024 at 3:50 p.m., the LPN stated that in the morning of June 19, 2024, the resident appeared fine, had received medications in the room at about 8:00 a.m. and went to therapy after that. The LPN stated that after the therapy, the resident was brought and was left him in the common room sitting near the table. An interview was conducted on June 26, 2024 at 8:51 a.m. with an Occupational Therapist (OT/staff #33) who stated that he provided occupational therapy services to the resident twice i.e., the initial assessment and on the day of the resident's passing. The OT said that last OT session with the resident was on June 19, 2024, and after this session, the resident was left sitting in his wheelchair in the common room in front of nurses' station, and without his cervical collar. The OT said that he recalled the cervical collar was too big so resident's head rolled and ended up getting his chin tucked. The OT stated that the purpose of the cervical collar was to keep the resident's neck in alignment; however, there were no explicit orders regarding the use of the resident's cervical collar. Further, the OT said that other therapists had similarly noticed chin tucking. During the interview, the OT showed a screen shot of the recorded video footage from June 19, 2024 at 12:07 p.m. that showed that resident #8 was in his wheelchair being pushed by a female individual. The resident was wearing dark colored clothes, had a bonnet on but was not wearing a cervical collar. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on June 26, 2024 at 09:19 AM with Physical Therapist Assistant (PTA/staff # 42), who stated that she conducted the OT session for resident #8 with the OT on June 19, 2024. The PTA stated that the resident was not wearing his cervical collar when she arrived into the room to provide services; and that, the resident's cervical collar was on the resident's dresser. The PTA stated that the resident's cervical collar was poor fitting, too big, and if the resident moved his chin at all, his chin would tuck in. Further, the PTA said that she did not take any action on this issue because she assumed that staff knew the cervical collar was big for resident #8; and that, the purpose of the cervical collar was for the resident's comfort. In an interview with Physical Therapist (PT/Staff # 53) conducted on June 26, 2024 at 9:39 a.m., the PT stated that she provided physical therapy services to resident #8; and that, the cervical collar that the resident had was too big. The PT stated that she attempted and would attempt to put the cervical collar on resident #8, but the resident would often complain of discomfort; and, was likely the reason why the resident was refusing to wear the cervical collar. The PT said that in one instance when she arrived in the resident's room, the resident did not have the cervical collar which was observed laying on the resident's nightstand. During the interview, the PT showed a screen shot of the recorded video footage from June 19, 2024 at 12:07 p.m. that showed that resident #8 was in his wheelchair being pushed by a female individual. The resident was wearing dark colored clothes, had a bonnet on but was not wearing a cervical collar. An interview with Certified Nursing Assistant (CNA/staff #22) was conducted on June 26, 2024 at 11:14 a.m. The CNA stated that on June 19, 2024, the therapy staff had left the resident in front of the nurse's station; and that, the resident was not wearing the cervical collar. During an interview conducted with Director of Nursing (DON/staff #4) on June 27, 2024 at 8:22 a.m., the DON stated that regardless whether the cervical collar was needed, recommended, or used as needed, it should have been worn by resident #8. An interview was conducted on June 27, 2024 at 9:54 a.m. with Licensed Practical Nurse (LPN/staff #16) who stated that her role as an admission nurse was to assist with the admissions process of new residents that included obtaining orders, checking for devices like braces and looking for anything that residents were supposed to be wearing and to be added onto the resident's care plan. The LPN also said that medical records were reviewed and anything that was needed by residents will be brought up; and, the role of an admitting nurse was to input medications, care plan and goals, and interventions. In an interview with Medical Doctor (MD/staff #50) conducted on June 27, 2024. The MD stated that she would expect that a physician order and a care plan was in place for a resident who was admitted with a neck brace from a discharging facility. Review of the facility's policy titled, Specialized Rehabilitative Services (reviewed April 2024) revealed, it is the policy of this facility to provide rehabilitative services to residents as determined by their comprehensive plan or care to assist them to attain, maintain or restore their highest practicable level of physical, mental, functional and psycho-social well-being; specialized rehabilitative services include the following: physical therapy and occupational therapy. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy titled, Physician Orders reviewed in August 2023 included that admission orders are reviewed with the physician upon admission based on the discharge instruction from the discharging facility and are transcribed accordingly. The facility policy on Comprehensive Person-Centered Care Planning with a review date of February 2024 revealed that it is their policy that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical nursing, mental and psychosocial needs that are identified in the comprehensive assessment; within 48 hours of the resident's admission, the facility will develop and implement a baseline care plan that includes instruction needed to provide effective and person-centered care.