STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035299	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northpark Health and Rehabilitation of Cascadia	2020 North 95th Avenue Phoenix, AZ 85037

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** 51124 Based on observation, clinical record review, facility documentation, interviews, and review of facility policies and procedures, the facility failed to ensure one resident (#34) received services according to professional standards regarding notification to a provider, required communication, and clarifying and following a physician's order. The deficient practice could result in residents not receiving adequate care and/or suffering from preventable injuries. -Findings Include: Resident #34 was admitted into the facility on [DATE], with diagnoses that included hypertension, diabetes mellitus, non-Alzheimer's dementia, syncope and collapse, and chronic right humeral fracture. Review of Resident #34's History and Physical notes from the discharging hospital dated August 25, 2024, revealed that the resident was being evaluated after a ground-level fall that date. A computerized tomography (CT) imaging study dated August 25, 2024, of Resident #34's head revealed no intracranial hemorrhage and no acute intracranial abnormality. Review of additional x-ray imaging studies dated August 25, 2025 revealed that the resident had a displaced angulated right humeral neck fracture, likely fractures of the right second and third ribs, and a possible fracture of the right femoral neck with recommendations to consider a CT image for further evaluation. Review of the resident's admission Minimum Data Set (MDS) assessment dated [DATE], revealed that the resident's Brief Interview for Mental Status (BIMS) assessment score was 03, indicating the resident had severely impaired cognition. Review of Section GG, revealed that the resident required moderate assistance for bed mobility and transfers from bed to chair. Section J revealed that the resident had a fracture related to a previous fall. The assessment also revealed that the resident was on an anticoagulant medication. Review of Resident #34's care plan revealed a focus initiated August 29, 2024 to address Impaired mobility with risk for falls due to History of falls, impaired functional mobility, pain, chronic humeral fx (fracture), and syncope. Interventions included to have the door of her room open as she allows unless during care, provide low bed, and to provide direct supervision when resident is toileting. (continued on next page)

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	Upon review of the physician orders, it was revealed that Resident #34 had an order dated September 11, 2024, indicating for the resident to Follow up with ortho for right humerus fracture, right femur fracture. An additional order dated September 13, 2024, indicated an Orthopedic Appointment on September 19, 2024, with the pick-up time noted as 2:20 PM and the appointment time noted as 3:00 PM. Review of a handwritten note that was provided to the facility's transportation driver (Driver/ Staff #2) from the orthopedic appointment on September 19, 2024 revealed that the resident was seen in our clinic for a proximal humerus fracture. The note indicated that the resident was alert and oriented to self only, with nobody from the facility accompanying the patient, the resident had right-sided ptosis (eyelid droop), and complaining of severe headache for past 24 hours. Review of an orthopedic appointment note signed September 19, 2024 at 4:18 PM by the orthopedic provider revealed that the facility received the note via fax on September 20, 2024 at 11:14 AM. The note indicated Resident #34 is unable to participate in examination. She has no caregivers accompanying her. Evidently patient fell about a week ago and sustained right proximal humerus fracture as evident on x-rays today. It does not appear she was ever taken to the emergency room . She is repeatedly complaining of severe 10 out of 10 headache pain. She has dilated pupils, right-sided ptosis. The note further indicated that She does have a driver from her facility with her. We instructed the driver to take her to the nearest emergency room for evaluation of intracranial bleed (brain bleed). Review of Resident #34's clinical record revealed there was no evidence that the instructions from the orthopedic appointment were followed or communicated to the resident's family, to the resident's physician, or to the facility's chief nursing officer. Additionally, there was no evidence of any follow-up communication to the orthopedic provider to clarify the instructions. Review of facility-provided copies of telephonic text messages dated September 23, 2024 at 4:48 PM, between a nursing staff and the nurse practitioner (NP/ Staff #134) revealed that the nurse notified the provider that Resident #34 had a fall into her mat in the room and that she had a hematoma to her right forehead. The messages revealed the resident was on plavix and aspirin, neuro checks intact to her baseline, brisk pupils, and the resident will be put on a change of condition status. Additionally, it was revealed that the NP responded with a message, Draw a circle around the hematoma and will monitor it. Review of the progress notes revealed that a nursing progress note dated September 23, 2024, at 5:42 PM, indicated that at 4:15 PM, Resident #34 was yelling out for help. The note indicated that Upon CNA entering room, patient was found seated on floor mat next to bed. Patient has hematoma to right forehead from bed rail. Neuro checks initiated and WNL (within normal limits). Daughter, CNO (chief nursing officer), and NP (nurse practitioner) on call notified. An order dated September 23, 2024 at 6:00 PM was placed indicating Change of Condition for a hematoma to right forehead from hitting head on bed rail. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the progress notes revealed that a nursing progress note dated September 24, 2024, at 5:49 AM revealed that the resident was on a Change of Condition for hematoma to right forehead from hitting head on bed rail. The note revealed that the Resident #34 was restless during shift, frequently yelling out for daughters. Patient placed in geri chair and sitting with nursing staff at nurse's station. Review of a nursing progress note dated September 24, 2024 at 7:41 AM, revealed that Resident #34's daughter was requesting patient to be sent out to the emergency room for further evaluation due to R (right) forehead hematoma. Provider contacted, order to be send out non-emergent for further evaluation was given. Daughter and CNO notified, will continue to follow plan of care. An order was dated September 24, 2024, indicating to send the resident with non-emergent transport to the emergency room to eval and treat. Review of the Trauma Surgery History and Physical from the hospital dated September 24, 2024, revealed that the resident was being evaluated after a ground level fall while at a rehab facility. The note indicated that the resident had a subdural hematoma (SDH/ brain bleed), a right radius fracture, a right ulna fracture, a right humerus fracture, and a right intertrochanteric femur fracture. Review of the Internal Investigation for Resident #34 dated September 25, 2024 revealed the investigation was initiated by the CNO on September 25, 2025 for the occurrence of not following MD orders from (the orthopedic provider). Upon review of personnel files, an employee termination letter, dated September 25, 2024, revealed that the Assistant Director of Nursing (ADON/ Staff #165) was terminated effective immediately for multiple reasons including failing to report information through proper channels, such as the Chief Nursing Officer. An additional employee termination letter, dated September 26, 2024, indicated that the Medical Records staff (MR staff/ Staff #200) was terminated effective immediately for multiple reasons including failure to communicate regarding Resident #34's faxed orthopedic visit notes on September 20, 2024. Additionally, an Employee Warning Notice dated September 26, 2024, for the Charge Nurse (Charge Nurse/ Staff #64), indicated a final warning for violation of safety rules and substandard performance regarding Resident #34 and the incident of her orthopedic visit on September 19, 2024. Review of the resident's Physician Progress Notes from the hospital dated September 28, 2024, indicated that the resident had underwent surgical repair of the right intertrochanteric femur fracture on September 25, 2025, and that hand surgery was consulted for the right radius and right ulna fractures and recommended a splint to the right upper extremity. The notes also revealed that orthopedic surgery recommended the resident to be non-weightbearing to the right upper extremity and weightbearing as tolerated to the right lower extremity, and to follow up in 2 weeks. Additionally, neurosurgery recommended conservative management for the SDH and to follow up in one month for a repeat scan. An order dated September 30, 2024, indicated for the resident to Admit to Skilled Nursing Facility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's facesheet revealed a list of diagnoses initiated on September 30, 2024, with multiple new diagnoses added to include: traumatic subdural hemorrhage without loss of consciousness, displaced intertrochanteric fracture of right femur, fracture of lower end of right radius, fracture of lower end of right ulna, and encounter for orthopedic aftercare. An observation was completed October 15, 2024 at 8:28 AM of the resident lying in bed in her room, with her daughter sitting at bedside. An interview was conducted at that time with the resident's daughter, due to the resident being unable to effectively communicate due to her cognitive status. The daughter stated that she was the resident's power of attorney. She stated that she was upset that her mother had a fall in the facility, and that the facility failed to call her right away. She stated that she received a phone call from the night nurse at approximately 11:30 PM on the day of the fall (September 23, 2024), however it was not mentioned that her mother had fallen. The daughter stated that she came into the facility at approximately 6:00 AM the following morning and noticed that her mother had a goose-egg on her head. She stated that she then insisted on the facility sending her mother to the hospital. She stated that while her mother was in the hospital, that her mother was diagnosed with a wrist fracture, a brain bleed, and a femur fracture that required surgery. The resident's daughter became tearful when stating the information. A telephonic interview was conducted on October 16, 2024 at 12:21 PM, with the former Medical Records staff (MR staff/ Staff #200), who was terminated September 26, 2024 and was no longer an employee of the facility. The MR staff was asked to recall the events surrounding Resident #34's orthopedic visit on September 19, 2024. The MR staff stated that the doctor's office wanted to send the resident to the emergency room . She further stated that it was her understanding of the facility's policy that she was trained in at the time of her hiring that if an outside doctor wants to send a resident to the hospital that they would be the ones who have to call 911. The MR staff stated that the orthopedic doctor had a handwritten note to send the resident to the ER and that the facility's driver (Staff #2) had messaged her saying that the doctor's office was stating that the resident needed to go to the hospital. She stated that the driver said that the resident seemed fine, she was just crying. The driver sent a picture of the handwritten note to the MR staff and the Charge Nurse (Staff #64). The MR staff further stated that the Charge Nurse instructed the driver to bring the resident back to the facility and the staff will assess the resident when she gets back to the facility. The MR staff stated that a call was placed to the ADON (Staff #165), and the ADON did not answer. The interview continued and the MR staff stated that she felt her actions had been adequate as she had relayed the information to the Charge Nurse, however, she stated that she was supposed to relay it to the Chief Nursing Officer (CNO/ Staff #150) and had failed to do so. The MR staff also stated that when she received the fax from the orthopedic visit the following day on September 20, 2024, that she failed to notify any nurse that it had been received and uploaded into the electronic medical record. The MR staff stated that she did not have a clinical background or clinical training, and that it was not her duty to read and interpret medical records. She stated that she failed to notify any nurse that the orthopedic notes were uploaded for review. The MR staff stated that she was subsequently fired for her failure to communicate in this incident. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A telephonic interview was conducted on October 16, 2024 at 12:36 PM, with the driver (Staff #2). The driver stated that he arrived at the orthopedic office for Resident #34's visit, and the resident appeared fine before the visit, as she wasn't screaming. The driver stated he waited in the lobby of the doctor's office for her. The provider then told him verbally that the resident needed to go to the emergency room , and that the resident's head was hurting. The provider gave him a small handwritten note, that the driver could not recall what was written, but that he believed vital signs were written on it. The driver stated that he was trained by the facility that he was not allowed to take residents to the emergency room , and so he called the ADON (Staff #165) who told him to bring the resident back to the facility. The telephonic interview was ended abruptly and unable to be reconnected at that time. An interview was conducted on October 16, 2024 at 1:25 PM, with the Charge Nurse/Licensed Practical Nurse (Charge Nurse/ Staff #64), who stated that on the day of Resident #34's orthopedic appointment, that it was the ADON (Staff #165) who told the driver to bring the resident back to the facility to assess her. The Charge Nurse stated that she was aware that the resident had an episode of higher blood pressure earlier that date before the appointment, and that she believed this could be the cause of the resident's headache. The Charge Nurse stated that she instructed the floor licensed practical nurse (LPN/ Staff #42) that when the resident comes back from the appointment, to check her blood pressure, and if it is still high, then staff could reach out to the provider and ask for a blood pressure medication. The Charge Nurse stated that after the resident returned to the facility, that nobody informed her if the resident's blood pressure was high or not. The Charge Nurse stated that she then clocked out for the day. She also stated that she did not call the facility provider, nor did she have knowledge of any staff calling the provider about the resident's condition in this incident. The interview with the driver (Staff #2) was continued in-person on October 16, 2024 at 1:32 PM. The driver stated that at the end of the resident's orthopedic appointment, that Resident #34 was yelling and crying. The driver repeated that he called the ADON (Staff #165) who instructed him to bring the resident back to the facility and that the nurses will assess the resident. The driver stated that he gave the handwritten note from the orthopedic provider to the MR staff (Staff #200). A follow-up interview was conducted on October 16, 2024 at 2:51 PM, with Resident #34's daughter. When asked if she had received any update from the facility regarding the incident or results surrounding her mother's orthopedic appointment on September 19, 2024, she stated I can say absolutely not, I was not called and updated on anything. She additionally stated that over the course of her stay at the facility, she has noted changes in her mother, that she's more scared now, that she has high anxiety now, and that she's in a panic anytime I leave. On October 16, 2024 at 3:04 PM, a telephonic interview was conducted with the resident's nurse practitioner (NP/ Staff #134). When asked if he recalled receiving a call from the nurse on September 23, 2024 regarding Resident #34 having a fall, the NP stated I can't recall any of this and no, I don't recall telling the nurse to circle the hematoma. He further stated that he was never informed by any staff from the facility regarding the orthopedic incident and the results of it. When the resident's orthopedic visit note from the September 19, 2024 appointment was reviewed together with the NP, the NP stated that it would be inappropriate that the facility's staff failed to notify the provider in this incident. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On October 17, 2024 at 9:16 AM, an interview was conducted with the LPN (Staff #42). The LPN confirmed that she was the resident's day nurse at the time the resident was at the appointment and when she was brought back to the facility. The LPN stated that while the resident was still at her appointment, that the Charge Nurse (Staff #64) called and said she was not sure if the resident was going to be returning to the facility or going to the hospital. The LPN stated that the resident arrived back to the facility at the end of her shift around 6:30 or 7:00 PM, and was brought onto the unit by the driver. The LPN stated that the resident returned with an envelope from the doctor's office and there was a handwritten note inside with little scribbles. The LPN stated that the Charge Nurse had sent her a text message earlier with a picture of the handwritten note. The LPN stated that the ADON (Staff #165) had instructed for the resident to come back to the facility. The LPN further stated that when the resident returned from the orthopedic appointment, it was unclear to me whether it was a doctor's order or not to send the resident out to the hospital, and that she did not call the doctor's office at that time to clarify because the Charge Nurse said she was going to call the doctor's office to clarify. The LPN additionally stated that she felt the issue was going to be resolved because the Charge Nurse directly stated that she was going to call the doctor's office for clarification. The LPN also stated that she was not sure if the Charge Nurse actually called or not because the Charge Nurse left the unit. The LPN stated that no neuro checks or formal assessments were done on the resident other than vital signs. Finally, the LPN stated that it was her insight that if the provider was not informed of the incident involving the orthopedic appointment, that this would be a gap in care. A telephonic interview was conducted on October 17, 2024 at 8:06 AM, with the facility's Medical Director/attending physician (MD/ Staff #149). The MD stated that she was familiar with Resident #34 as she has seen her to provide care. When asked if anyone from the facility called on September 23, 2024 regarding the resident's fall, the MD stated no, because she was not on call that day. She further stated that she was not aware of any provider on her team that was called that evening of September 23rd, 2024 when the resident fell . She did state that on September 24th, she was on call, and she received a message while driving into the facility. She stated that she talked to the nurse. The MD further stated that when she arrived at the facility, she saw the resident, and sent her out to the hospital for evaluation. When reviewing the orthopedic visit note from October 19, 2024 together, the MD stated firmly that the providers on her team were definitely not notified of the orthopedic visit and the instruction from the orthopedic provider to send the resident to the emergency roiagnom on [DATE]. She stated, Nobody on my team was notified and I believe the staff member who was responsible for making the decision to not send the resident to the hospital is no longer working at the facility. An interview was conducted with the facility's Administrator (Staff #181) on October 17, 2024 at 11:48 AM. The Administrator stated that his expectation for staff is that they follow physician orders, and that if staff was not clear on a physician order, that they reach out to their supervisor or the doctor for clarification. In an interview conducted on October 17, 2024 at 12:10 PM, the CNO (Staff #150) stated that it is her expectation that her staff follows physician orders, whether they are verbal, written, or telephone orders. She further stated that if staff was unclear about physician orders that her expectation for staff would be that they come to the ADON, the Charge Nurse, or myself for clarification, and that the nursing management would then call the physician to clarify. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The interview continued with the CNO, and when asked about her understanding of the step-by-step events regarding Resident #34 on the day of her orthopedic visit on September 19, 2024, the CNO stated that the MR staff (Staff #200) told the driver (Staff #2) to bring the resident back to the facility and the ADON (Staff #165) would assess the resident. She stated that the ADON then saw the resident when she returned to the facility and told the floor nurse (Staff #42) not to call the facility doctor. She stated that no staff member called the orthopedic provider to clarify the order to send the resident to the emergency room . She also stated no staff called the facility's provider team for clarification. The CNO also stated that the following day, September 20, 2024, the MR staff received the fax with the orthopedic visit notes and failed to notify any nurses that the visit notes were uploaded for review, despite her training to bring any information that comes in to the unit nurse. The interview with the CNO continued, and the CNO stated that the outcome for Resident #34 is that she's doing well. She stated that the resident had an old intracranial bleed that did not get worse. Further, when asked if the resident suffered any new fractures, the CNO initially stated, No, then stated that she needed to re-read the notes. A telephonic interview was conducted on October 17, 2024 at 2:29 PM, with the ADON (Staff #165). The ADON stated that she resigned when the Administrator called her to tell her he was putting in her resignation. When asked about the incident involving Resident #34 and her orthopedic appointment on September 19, 2024, the ADON stated I was not involved in that case, and that the Charge Nurse (Staff #64) did not notify me, nobody notified me about that resident or her ortho appointment. She additionally stated that I didn't have anything to do with that patient and the Charge Nurse made the call to bring the patient back to the facility, the LPN (Staff #42) read the note and she didn't notify the provider. I was not notified. The ADON additionally stated that the CNO was also not notified of the incident at that time. She finally stated that, It wasn't until about 1 week later that the nurse on the floor was reviewing the resident's notes in the chart and said that this resident should have went out to the emergency room for evaluation. Review of the facility's policy titled Physician Orders, revised August 01, 2023, revealed that if there is a question regarding physician orders, seek clarification from the physician and document response/directives. Review of the facility policy titled Advance Directives/ Health Care Decisions, revised October 01, 2017 revealed that the facility defines and clarifies medical issues and presents the information regarding relevant healthcare issues to the resident and/or his/her legal representative, as appropriate. Review of the facility policy Resident Change of Condition revised November 28, 2017, revealed that upon recognition of a potentially life-threatening condition or significant change in status, the nurse should communicate with other health care providers to meet the needs of the resident. Under the subcategory Immediate Notification the policy indicated that the physician should be informed at the time the event occurs as soon as possible. Further, the facility is to immediately inform the resident, consult with the resident's physician, and notify the resident representative (consistent with his or her authority) when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention and also when there is a significant change in the resident's physical, mental, or psychosocial status. Additionally, the facility is to notify family members/responsible party of the resident's condition.