STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035302	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diamondback Healthcare Center	3000 N 91st 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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50116 Based on documentation, observations, staff interviews and the facility policy and procedures, the facility failed to report an injury of unknown origin and complete a 5-day written investigation in accordance to their Abuse Policy's required timeframe for one resident (#2). The sample size was three. The deficient practice may result in residents being abused or receiving the appropriate treatment and care untimely. Findings include: Resident #2 was admitted on [DATE] with diagnoses of anoxic brain damage, respiratory failure, pleural effusion, epilepsy, gangrene and necrosis of lung. A review of the Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 99 which meant the resident did not have the BIMS assessment completed. The MDS assessment revealed that the resident was always incontinent of bladder and bowel. A review of the care plan revealed that the resident had a communication problem: rarely/never understood and rarely/never understands related to severe cognitive loss due to anoxic brain damage history, with an intervention to anticipate and meet needs, discuss with resident/family concerns or feelings regarding communication difficulty, ensure/provide a safe environment: call light in reach, adequate low glare light, bed in lowest position and wheels locked, avoid isolation. Resident #2 has potential impairment to skin integrity related to Activities of Daily Living (ADL) deficiencies, always incontinent of bowel and bladder, respiratory failure, epilepsy, anoxic brain damage, cognitive loss. The goal included that the resident will maintain or develop clean and intact skin by the review date. Interventions included to use a draw sheet or lifting device to move resident and use caution during transfers and bed mobility to prevent striking arms, legs and hands against any sharp or hard surface. A review of a skin assessment dated [DATE] revealed Resident #2 had no skin issues documented on the form. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the progress notes revealed that on November 18, 2024 the resident's spouse informed the nurse that there was a bruise on the resident's left dorsal foot below the 2nd toe. The spouse requested an X-ray. The nurse notified the hospice nurse and an order was received. Another progress note revealed that on November 19, 2024 the X-ray results were received from the hospice nurse that the resident's left foot had a fracture. The hospice nurse came to evaluate the resident and notify the spouse of the fracture. The spouse requested to send resident #2 to the emergency room to be evaluated and treated. Resident #2 was transported to the hospital. A review of a nursing skin assessment dated [DATE] revealed Resident #2 had bruising to the left foot near toes with known fracture. An interview was conducted with Certified Nursing Assistant (CNA/ staff #4) on January 7, 2025 at 11:00 a. m. who revealed that they did not care for resident #2 when the bruise was discovered. Staff #4 stated that any unusual marks are reported to the nurse. An observation was made on January 7, 2025 at 11:03 a.m. of resident #2's feet. Staff #8 (Wound Nurse) lifted the sheet and blanket off of Resident #2's feet while the resident was lying in bed. The resident was positioned slightly onto their right side. No padded side rails noted. The resident's left foot did not have any discoloration indicating a bruise. The toes did not appear straight or flat. They were bent at the joints. The left foot was resting on pillow that was between the right and left foot. An interview was conducted with Licensed Practical Nurse (LPN/ staff #5) on January 7, 2025 at 11:12 a.m. Staff #5 stated that when any unusual marks are reported, they go observe the mark, notify the Director of Nursing (DON), Assistant Director of Nursing (ADON), the doctor, family members, perform any orders received from the doctor, document in the chart, progress notes and the skin assessment tool. Staff #5 stated that the staff remembered the mark on resident #2. Staff #5 said that when the staff went to look at the area, the spouse was at the bedside and pointed it out. Staff #5 then called the doctor, notified hospice of what was observed. Then the staff stated the spouse requested an X-ray. Staff #5 stated an order for X-ray was then received but the spouse wanted the resident to be send out to the hospital instead of having the X-ray come out to the facility. Staff #5 stated the hospice nurse came and placed a soft boot on the toe to protect it in the meantime. Staff #5 stated the bruise was not on the toe but below, nickel sized, color was purplish blue in color. Staff #5 stated the resident winced in pain when the area was touched. Staff #5 stated the resident does not move on own and needs to be turned and repositioned every 2 hours. An interview was conducted with DON (staff #3) and Administrator (staff #6) on January 7, 2025 at 11:24 a. m. Staff #3 stated that when a resident has a bruise, area is assessed to see what is going on, an X-rays order is received and the nurse assesses and takes the next step. When asked what is your process for injuries of unknown origin is, Staff #3 stated an investigation is done and if needed to report it will be reported as well. When asked regarding what could happen if injuries are not reported and Staff #3 stated a wide variety can happen, absolutely nothing could heal, things could get worse, an open wound could get infected, depends on the type of injury. Staff #3 stated the facility did not report the incident as they did not think it was a reportable incident, understanding the patient's condition and Director of Operations (staff #9) said there was no open mark. Then staff #3 stated that in hindsight 5050 the incident should have been reported. Staff stated the family would massage the resident's feet and there were family dynamics. It was stated that the Hospice Nurse Practioner said that there was no suspected abuse. The staff stated as a provider this is very common, the way the fracture shows on Xrays and believed it was self-inflicted. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with staff #6 on January 7, 2025 at 12:48 p.m. who stated that no 5 day reports or list of reportables were available. Staff #6 stated that their first day was January 1 and gave it 24 hours when it was noticed that the shared files were gone (regarding the list of reportables and 5 day reports); and that, the shared files were wiped from the system. The policy Abuse Prevention, Identification, Investigation, and Reporting Policy was reviewed. The policy states: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Regulatory Definitions: Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Section VII. Reporting/Response, Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.

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(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** 50116 Based on documentation, observations, staff interviews and the facility policy and procedures, the facility failed to report an injury of unknown origin within required timeframe for one resident (#2). The sample size was three. The deficient practice may result in residents being abused or receiving the appropriate treatment and care untimely. Findings include: Resident #2 was admitted on [DATE] with diagnoses of anoxic brain damage, respiratory failure, pleural effusion, epilepsy, gangrene and necrosis of lung. A review of the Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 99 which meant the resident did not have the BIMS assessment completed. The MDS assessment revealed that the resident was always incontinent of bladder and bowel. A review of the care plan revealed that the resident had a communication problem: rarely/never understood and rarely/never understands related to severe cognitive loss due to anoxic brain damage history, with an intervention to anticipate and meet needs, discuss with resident/family concerns or feelings regarding communication difficulty, ensure/provide a safe environment: call light in reach, adequate low glare light, bed in lowest position and wheels locked, avoid isolation. Resident #2 has potential impairment to skin integrity related to Activities of Daily Living (ADL) deficiencies, always incontinent of bowel and bladder, respiratory failure, epilepsy, anoxic brain damage, cognitive loss. The goal included that the resident will maintain or develop clean and intact skin by the review date. Interventions included to use a draw sheet or lifting device to move resident and use caution during transfers and bed mobility to prevent striking arms, legs and hands against any sharp or hard surface. A review of a skin assessment dated [DATE] revealed Resident #2 had no skin issues documented on the form. A review of the progress notes revealed that on November 18, 2024 the resident's spouse informed the nurse that there was a bruise on the resident's left dorsal foot below the 2nd toe. The spouse requested an X-ray. The nurse notified the hospice nurse and an order was received. Another progress note revealed that on November 19, 2024 the X-ray results were received from the hospice nurse that the resident's left foot had a fracture. The hospice nurse came to evaluate the resident and notify the spouse of the fracture. The spouse requested to send resident #2 to the emergency room to be evaluated and treated. Resident #2 was transported to the hospital. A review of a nursing skin assessment dated [DATE] revealed Resident #2 had bruising to the left foot near toes with known fracture. An interview was conducted with Certified Nursing Assistant (CNA/ staff #4) on January 7, 2025 at 11:00 a. m. who revealed that they did not care for resident #2 when the bruise was discovered. Staff #4 stated that any unusual marks are reported to the nurse. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation was made on January 7, 2025 at 11:03 a.m. of resident #2's feet. Staff #8 (Wound Nurse) lifted the sheet and blanket off of Resident #2's feet while the resident was lying in bed. The resident was positioned slightly onto their right side. No padded side rails noted. The resident's left foot did not have any discoloration indicating a bruise. The toes did not appear straight or flat. They were bent at the joints. The left foot was resting on pillow that was between the right and left foot. An interview was conducted with Licensed Practical Nurse (LPN/ staff #5) on January 7, 2025 at 11:12 a.m. Staff #5 stated that when any unusual marks are reported, they go observe the mark, notify the Director of Nursing (DON), Assistant Director of Nursing (ADON), the doctor, family members, perform any orders received from the doctor, document in the chart, progress notes and the skin assessment tool. Staff #5 stated that the staff remembered the mark on resident #2. Staff #5 said that when the staff went to look at the area, the spouse was at the bedside and pointed it out. Staff #5 then called the doctor, notified hospice of what was observed. Then the staff stated the spouse requested an X-ray. Staff #5 stated an order for X-ray was then received but the spouse wanted the resident to be send out to the hospital instead of having the X-ray come out to the facility. Staff #5 stated the hospice nurse came and placed a soft boot on the toe to protect it in the meantime. Staff #5 stated the bruise was not on the toe but below, nickel sized, color was purplish blue in color. Staff #5 stated the resident winced in pain when the area was touched. Staff #5 stated the resident does not move on own and needs to be turned and repositioned every 2 hours. An interview was conducted with DON (staff #3) and Administrator (staff #6) on January 7, 2025 at 11:24 a. m. Staff #3 stated that when a resident has a bruise, area is assessed to see what is going on, an X-rays order is received and the nurse assesses and takes the next step. When asked what is your process for injuries of unknown origin is, Staff #3 stated an investigation is done and if needed to report it will be reported as well. When asked regarding what could happen if injuries are not reported and Staff #3 stated a wide variety can happen, absolutely nothing could heal, things could get worse, an open wound could get infected, depends on the type of injury. Staff #3 stated the facility did not report the incident as they did not think it was a reportable incident, understanding the patient's condition and Director of Operations (staff #9) said there was no open mark. Then staff #3 stated that in hindsight 5050 the incident should have been reported. Staff stated the family would massage the resident's feet and there were family dynamics. It was stated that the Hospice Nurse Practioner said that there was no suspected abuse. The staff stated as a provider this is very common, the way the fracture shows on Xrays and believed it was self-inflicted. An interview was conducted with staff #6 on January 7, 2025 at 12:48 p.m. who stated that no 5 day reports or list of reportables were available. Staff #6 stated that their first day was January 1 and gave it 24 hours when it was noticed that the shared files were gone (regarding the list of reportables and 5 day reports); and that, the shared files were wiped from the system. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The policy Abuse Prevention, Identification, Investigation, and Reporting Policy was reviewed. The policy states: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Regulatory Definitions: Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Section VII. Reporting/Response, Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.