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	10/31/2024

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 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** 51124 Based on observation, interview, review of facility documentation, and review of facility policy, the facility failed to ensure that care and services were provided according to professional standards for one of one sampled resident (#42). The deficient practice could result in care not being provided to accepted standards of practice, leading to harm to a resident. -Findings include: Resident #42 was admitted to the facility on [DATE] with diagnoses that included traumatic hemorrhage of cerebrum, Alzheimer's disease, dysphagia, and protein-calorie malnutrition. The admission minimum data set (MDS) assessment dated [DATE] revealed that the resident's brief interview for mental status (BIMS) score was 03, which indicated resident was severely cognitively impaired. Moreover, revealed the resident required substantial assistance for bed mobility and was totally dependent on staff for transfers from bed to chair. The assessment also indicated the resident had one unstageable unhealed pressure wound. An Admission Evaluation dated September 30, 2024, revealed moisture associated skin damage (MASD) to the resident's sacrum. Additionally a section indicated, Wound team to complete skin assessment. Review of medical records revealed no evidence of measurements. A physician order dated October 01, 2024, for wound care to coccyx pressure injury, to cleanse with cleansing wipes, pat dry, apply triad, leave open to air, every day shift and as needed with peri care. A Skin Check dated October 01, 2024 revealed that the assessment was marked, Skin warm & dry, skin color WNL (within normal limits), turgor normal. The resident was not assessed/ no information for risk of developing pressure ulcers/injuries. Further, the resident was not assessed/ no information for the presence of one or more unhealed pressure ulcers. An Initial Weekly Wound Evaluation dated October 01, 2024, revealed resident #42 had an unstageable pressure wound on the coccyx extending to buttocks, present upon admission. The wound was measured as follows: 7 cm by 5.5 cm, and unable to determine depth of wound. The wound was described as maroon discoloration with normal skin surrounding. (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A care plan revised October 01, 2024 revealed that Resident #42 was at risk for impaired skin integrity, with a goal that the resident will maintain clean and intact skin, and interventions to Identify / document potential causative factors and eliminate / resolve where possible and to Keep skin clean and dry. A review of the certified nursing assistant (CNA) task log for October 2024 revealed that the resident had Loose / Diarrhea bowel movement on the following dates and times: 10/03/2024: 14:30 10/04/2024: 4:49 17:29 22:38 10/05/2024: 17:29 10/06/2024: 15:05 19:59 10/07/2024: 17:29 10/08/2024: 17:29 21:18 21:19 10/09/2024: 17:09 23:18 23:18 10/10/2024: 5:28 9:43 21:00 10/11/2024: 17:29 10/12/2024: 17:29 20:25 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/13/2024: 2:58 14:40 10/14/2024: 20:05 10/15/2024: 5:16 12:49 10/16/2024: 8:53 10/17/2024: 13:42 22:55 10/18/2024: 12:30 10/19/2024: 17:00 10/20/2024: 12:16 10/21/2024: 10:55 10/22/2024: 14:58 10/23/2024: 5:19 9:07 10/24/2024: 5:19 10/25/2024: 17:13 A Skin Check dated October 08, 2024 revealed that the assessment was marked Skin warm & dry, skin color WNL (within normal limits), turgor normal. The resident was marked as having no external devices (cast, prosthetic, brace). No evidence of any other markings was on the form. A Weekly Wound Evaluation dated October 10, 2024, revealed that the coccyx wound present on admission had increased in size to 8 cm x 7.5 cm, and that the maroon discoloration had begun to denude (open) with red/pink tissue present in open areas. The note revealed that the size of wound increased due to patient having repeated loose stools. Further, the note indicated that the, tube feeding orders were changed and patient is on Imodium for loose stools. A physician order dated October 10, 2024, indicated for Imodium 2 mg oral tablet, to give one tablet via NG (nasogastric) tube, every 6 hours as needed for loose stools. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Weekly Wound and Nutrition Interdisciplinary Team (IDT) meeting minutes for the week dated October 10, 202 through October 16, 2024 revealed that Resident #42's unstageable coccyx wound, described as a pressure injury, had increased in size. The increase in wound size was, due to patient having repeated loose stools. A Nurse Practitioner Visit note dated October 11, 2024 revealed the nurse reported Resident #42 was having diarrhea, and, will offer PRN (as needed medication). Review of the Medication Administration Record (MAR) for October 2024 revealed that the resident was administered Imodium one time, on October 21, 2024 at 9:56 AM. However, from the time the Imodium was ordered, until the first time it was given, the resident had daily episodes of loose stool, totaling 16 episodes. A Skin Check dated October 13, 2024 revealed that the assessment was marked Skin warm & dry, skin color WNL (within normal limits), turgor normal. The resident was marked as having no external devices (cast, prosthetic, brace). The note indicated under the section Skin Issues excoriation to coccyx and buttocks, resident only had one episode of loose stool on 10/12 and none for today. However, the CNA task log revealed 2 episodes of loose stools on October 12, 2024. An additional Nurse Practitioner Visit note dated October 14, 2024, revealed that no additional diarrhea was reported for Resident #42, despite the CNA task log indicating that the resident had 6 episodes of loose stool / diarrhea from October 11 to October 14, 2024. A Skin Check dated October 15, 2024 revealed that the assessment was marked Skin warm & dry, skin color WNL (within normal limits), turgor normal. The resident was marked as having no external devices (cast, prosthetic, brace). No evidence of any other markings was on the form. A Weekly Wound Evaluation dated October 19, 2024, revealed the coccyx wound had no evidence of measurements recorded on the evaluation. The note indicated that the, maroon discoloration is fading and the, open denuded areas are improving and the, wound edges are intact. Also, the wound bed had red granulation tissue present. The note further indicated that, loose stools due to tube feed have began to decrease in amount. A review of the Weekly Wound and Nutrition Interdisciplinary Team (IDT) meeting minutes for the week dated October 16, 202 through October 22, 2024 revealed that the unstageable coccyx wound, described as a pressure injury, had increased in size. The wound size was noted as 2 cm x 1.5 cm x .1 cm. The wound was described as 50% granulation tissue and 50% slough. An additional order dated October 20, 2024, indicated for wound care to coccyx pressure injury, to cleanse with wound cleaner, pat dry, apply medihoney followed by calcium alginate, and cover with dry dressing, every day shift and as needed if soiled or dislodged. A Skin Check dated October 22, 2024 revealed that the assessment was marked Skin warm & dry, skin color WNL (within normal limits), turgor normal. The resident was marked as having no external devices (cast, prosthetic, brace). No evidence of any other markings was on the form. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Surgical Note dated October 24, 2024, by the wound physician, revealed that the provider was asked to see this patient for my opinion on how to manage the wound found on the left buttock. The note indicated that the cause of the wound was, moisture associated skin damage. Further, the note indicated that the resident underwent a debridement of the wound with a surgical excision of devitalized tissue. The size of the wound pre-operatively was 3.0 cm x 5.0 cm and unable to determine depth of the wound, and the post-operative size of the wound was 3.0 cm x 5.0 cm x 0.1 cm. A physician order dated October 25, 2024, indicated for wound care to moisture associated skin damage (MASD) on the left buttock, to cleanse with wound cleaner, pat dry, apply medihoney followed by calcium alginate, and cover with dry dressing, every day shift and as needed if soiled or dislodged. An observation was conducted on October 28, 2024 at 10:47 AM of the resident sitting up in a wheelchair in her room, and her daughter seated beside her. The resident was unable to communicate. A wound care observation was conducted on October 30, 2024 at 11:21 AM, of the resident receiving a treatment consisting of medihoney alginate and a foam dry dressing for the left buttock, provided by a wound nurse / licensed practical nurse (Staff #63). The wound was located on the resident's left buttock, to the left of the bony prominence of the coccyx. The skin over the coccyx appeared healed. The open area of the left buttock wound had a dry, non-serosanguinous wound bed, and irregular borders. An interview was conducted on October 28, 2024 at 10:47 AM, with the resident's daughter. The daughter stated that while at the facility, her mother, ended up with a bedsore that she didn't have before. She stated that her mother had a lot of diarrhea that caused the wound. On October 29 2024 at 10:12 AM, an interview was conducted with a CNA (Staff #74) who stated that the resident has a pressure wound on her bottom, and that it usually has a dressing on it. She stated that the resident is dependent on staff for all care. An interview was conducted on October 29, 2024 at 10:15 AM, with a CNA (Staff #292). The CNA stated that she normally works on the unit with Resident #42, that she first started working with the resident about two weeks ago, and that the resident had loose stools every time, and needed to be changed approximately every two hours. She stated that the resident had a small wound on her bottom, that they put barrier cream and a dressing on it. She also stated that the dressings would get soiled, the CNA staff would remove the dressings when changing the resident, and let the nurse know so that the nurse could replace the dressing in between the times that the CNA staff changed the resident. An interview was conducted on October 29, 2021 at 10:21 AM, with a wound nurse / licensed practical nurse (LPN / Staff #73) who stated that when Resident #42 first admitted to the facility, that the resident had an unstageable wound that was dark around the coccyx. The unstageable wound then resolved, and moisture associated skin damage (MASD), showed up on her left buttock. She stated that there were no open areas of the wound when the resident first admitted , and that the MASD open area on the left buttock was first noticed on October 19, 2024. She stated that the resident was first referred to the wound physician for evaluation on October 24, 2024. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An additional interview with another wound nurse / LPN (Staff #63) was conducted on October 30, 2024 at 11:21 AM. The LPN said he was familiar with the resident as he had been taking care of the wound since the first week. He stated that at the time of the resident's admission, there were no open wound areas on the resident's bottom, that there was just maroon discoloration. The LPN stated that the resident was having loose stools multiple times an hour where the new areas of wound had opened on the left buttock. When asked to clarify what exactly caused the open areas of the wound, the LPN stated that, if the stool was better managed, so it wasn't loose and watery, then she would not have the denuded areas. He stated that when the loose stools were noted, that the resident was started on Imodium to address the loose stools. When the MAR for October 2024 was reviewed together with the LPN, the LPN stated that the Imodium for loose stool had only been given once, on October 21, 2024. On October 230, 2024 at 1:30 PM, an interview was conducted with the registered dietician (RD / Staff #260) who stated that she was part of the weekly IDT review for Resident #43. The RD stated that she was, looped into her care almost immediately after admission; and that, the resident has, had loose stools ever since she's been here. She further stated that, anytime anyone is on tube feed, everyone always looks at tube feeding as the cause of loose stools, but half the time it is, half the time it isn't. The RD stated that, it's hard to say whether the type of tube feed was contributing to the resident's loose stools; and that, she had switched the type of tube feed on October 07, 2024, however the resident continued to have loose stool. The RD stated that during the weekly IDT meeting on the week of October 10 - 16th, 2024, that she remembered it was brought up in the meeting that the wound was deteriorating and a causative factor was the resident's repeated loose stool. The RD stated that an attempt had been made to switch the resident's diet to puree food to replace the tube feed on October 14, 2024, however the tube feed had to be restarted three days later due to concerns of poor intake by the resident. An interview was conducted on October 31, 2024 at 9:41 AM with an LPN (Staff #152). The LPN stated that she normally works on Resident #42's hallway and provides care for her. The LPN stated that if a resident had loose stool for some time that they would administer medication as ordered, and if no medication was ordered, that she would call the physician and get some. She stated that if the resident had a PRN (a needed) medication ordered for loose stool, that she would then give it. The LPN stated that she could not think of any non-pharmacological options to address loose stool. The LPN stated she was familiar with Resident #42 and had only given her Imodium once to address loose stool on October 21, 2024 when the resident's daughter had asked for it. She stated that she had never witnessed Resident #42 having loose stool before, and that neither the CNA staff nor the resident's family had made her aware of any loose stool prior to October 21, 2024. She also stated that the wound nurses had not communicated with her that Resident #42 was having loose stool. On October 31, 2024 at 9:48 AM, an interview was conducted with the resident's other daughter. The daughter stated that her mother could not control her bowel and that she needed to be changed approximately every 1-2 hours, because she was having loose stool and diarrhea. She stated that her mother had been having ongoing diarrhea that did not stop until within the last week. The daughter stated that she had left for vacation on October 18, 2024, and up to that point, her mother had back to back diarrhea the whole time, and that she started to be more vocal about the diarrhea to facility staff. (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 on October 31, 2024 at 10:17 AM, with the Director of Nursing, (DON / Staff #10). The DON stated that the facility's process if a resident has ongoing loose stool or diarrhea is to address it, we talk with the patient, talk with the staff, we look into non-pharmacological interventions, then whatever the doctor's orders are. He further stated that we would not let it continue, we address it. The DON further clarified that non-pharmacological options for loose stool could be adjusting the type of tube feed, patient education, and holding medications that might cause diarrhea. If all the options are exercised and the resident is still having diarrhea, then we address it with the doctor. The DON stated that if a resident is experiencing loose stool or diarrhea, that the nurse would assess to see if it truly was diarrhea. He stated it would not meet his expectation if a nurse did not go to the resident to assess the loose stool daily. He stated the nurse should investigate and assess and resolve the issue. The DON confirmed that in the case of Resident #42's ongoing diarrhea, the CNAs were documenting continued loose stools and the Imodium was not administered that could have helped resolve the loose stool issue. The DON stated that the importance of effective communication between the CNAs and nurses is huge, and if everybody is not on same page, then medication may be missed or there might be a possibility of all people on the care team not being able to resolve something in a timely manner. Review of the facility's policy titled, Change in Resident Condition, revised July 04, 2024, revealed that a licensed nurse will accurately document, in the Daily Nurses Notes, information relevant to changes in the resident's medical condition. Documentation is to include assessment of the resident's medical status, subsequent monitoring of interventions and their effectiveness, and communication to all involved parties. Review of the facility's policy titled, Incontinence Care, revised July 04, 2024, revealed that Nursing Assistants will check the resident at least very two hours and assist with toileting as needed. The unit nurse and charge nurse will monitor and oversee incontinence care. The facility's policy titled, Abuse Prevention, Identification, Investigation, and Reporting, revised July 04, 2024, revealed that staff will ensure that basic medical, functional, and psychosocial needs are being met and that potentially preventable or treatable conditions affecting function and quality of life are addressed appropriately.