| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **035286** | A. BUILDING _____ B. WING _____ | **03/05/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| **SANTE OF NORTH SCOTTSDALE** | **17490 NORTH 93RD STREET SCOTTSDALE, AZ 85255** |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0600<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on facility documentation, clinical record review, staff interviews, and policy review, the facility failed to ensure one resident (#353) was free from abuse by a caregiver. The deficient practice could result in other residents being abused. Findings include: Resident #353 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The resident was discharged [DATE]. Review of the admission Minimum Data Set assessment dated [DATE] revealed the resident's cognitive skills for daily decision making was severely impaired. The assessment included the resident could recall that he was in a nursing home facility and the location of his room. The facility's Investigation Report revealed that on October 16, 2019, a Registered Nurse (RN/staff #140) made the Director of Nursing (DON/#134) aware of an allegation of abuse. Staff #140 stated to the DON that today (October 16, 2019), the resident's family member stated to him that the resident told her the caregiver yelled at him, held him in bed, and struck him. The DON spoke with the family member. The report revealed the family member's statement to the DON included that on the night of October 15, 2019, she was explaining the situation with the caregiver to one of the Certified Nursing Assistants (CNA/staff #12) and that staff #12 stated to her that the caregiver appeared frustrated and that she heard the caregiver in a loud voice say Go to sleep. This is worse than taken care of a baby. The report included the caregiver's employer was contacted and that the caregiver was no longer allowed to provide services in the facility. The report also included the incident happened on October 14, 2019 at 11:00 p.m. The report revealed the resident had no injury that would suggest that he had been struck in the face and that there was no bruising or swelling to the side of his face where he bit his cheek. The witness statement from staff #12 dated October 16, 2019 included staff #12 witnessed the caregiver yelling at the resident. Staff #12 stated the caregiver was yelling repeatedly go to sleep and that when staff #12 asked the caregiver if everything was ok, the caregiver loudly stated this is worse than taking care of a baby. Staff #12's witness statement also included she informed the Licensed Practical Nurse (LPN/staff #136) that the caregiver was yelling at and being mean to the resident. A witness statement from staff #136 dated October 16, 2019 revealed staff #12 reported to her on the night shift on October 14, 2019, the caregiver was yelling at resident #353 to go to sleep. Staff #136 stated that she stood near the resident's door and did not hear anything. The statement also included staff #136 checked on the resident 3-4 times that night and did not hear yelling. The witness statement from staff #140 dated October 16, 2019 included that on October 15, 2019 at 7:30 a.m., the resident's family member informed him the resident's mouth was bleeding and that the resident had broken his tooth. Staff #140 stated the family member stated the caregiver had been texting her all night that the resident had been acting wild and out of character. Staff #140 stated he assessed the resident's mouth and observed dried and coagulated blood but not a broken tooth. Staff #140 stated the next day, October 16, 2019 around 7:30 a.m., the resident's family member reported him that the resident had told her the girl hit me. The family member also told staff #140 that staff #12 heard the caregiver making derogatory statements to the resident such as you're worse than a baby. The statement included that once the family member stated that the resident had said the caregiver hit him, staff #140 notified the DON. The statement from the family member dated October 16, 2019 revealed that later in the day on October 15, 2019, the resident was more alert and in less pain from his mouth when he told the family member the caregiver from the night before had hit him and yelled at him all night and kept hitting him. The family member stated that around 6:30 p.m. on October 15, 2019, staff #12 told her that she witnessed the caregiver screaming at the resident and saying this is worse than taking care of a baby. The facility's Investigation Report also revealed the DON contacted the caregiver's employer, and received a written witness statement from the caregiver as part of the investigation. The witness statement from the caregiver dated October 17, 2019 revealed the caregiver arrived for her shift on October 14, 2019 at 7:00 p.m. The caregiver stated the resident was yelling and trying to get out of bed during the night. The caregiver stated that she redirected the resident and did what she had to do to keep the resident from being on the floor. The statement also included the caregiver stated that she did not put her hands on the resident or handle the resident in a rough way. The caregiver stated a CNA helped her that morning and that they did not see any blood on the resident or on the resident's linens. Staff #12's personnel file was reviewed and included that staff #12 received training on abuse and neglect, including identification and reporting, on July 16, 2019. Staff #12's personnel file also included a written disciplinary action dated October 16, 2019 for failure to report verbal abuse of a resident. Staff #136's personnel file was reviewed and included that staff #136 received training on abuse and neglect, including identification and reporting, on September 17, 2019. An attempt to interview staff #12 via telephone on March 3, 2020 at 12:15 p.m. was unsuccessful. An attempt was made to interview staff #136 via telephone on March 3, 2020 at 12:21p.m.; however the number was no longer in service. During an interview conducted with the DON on March 5, 2020 at 8:34 a.m., the DON stated she was notified of the allegation of abuse on October 16, 2019, almost 48 hours after the incident occurred. The DON stated that she immediately notified the caregiver's employer so they could also begin an investigation. The DON stated that she conducted an investigation and substantiated verbal abuse and that the caregiver is no longer allowed back in the facility. The DON stated education and disciplinary action was provided to staff #12. The DON also stated education was provided to staff #136 and that staff #136 told her that she did not think the resident was abused and that she would not be returning to work at the facility. Review of the facility's policy on abuse revealed that as part of the resident abuse prevention, the administration will protect residents from abuse by anyone including staff from other agencies. The policy also revealed verbal abuse includes mocking, insulting, ridiculing, and yelling. |
| F 0609<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on facility documentation, clinical record review, staff interview, and policy review, the facility failed to ensure an allegation of abuse regarding one resident (#353) was reported to the State Survey Agency within the required timeframe. The deficient practice could result in further allegations of resident abuse not being reported within the required timeframes. Findings include: Resident #353 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident was discharged [DATE]. Review of the facility's Investigation Report revealed that on October 16, 2019, the Director of Nursing (DON/staff #134) was made aware of an allegation of abuse. A Registered Nurse (RN/staff #140) stated to the DON that today (October 16, 2019), the resident's family member stated to him that the resident told her the caregiver yelled at him, held him in bed, and struck him. The DON spoke with the family member. The report revealed the family member's statement to the DON included that on the night of October 15, 2019, she was explaining the situation with the |

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

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.

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| F 0609<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 1)<br>caregiver to one of the Certified Nursing Assistants (CNA/staff #12) and that staff #12 stated to her that the caregiver appeared frustrated and that she heard the caregiver in a loud voice say Go to sleep. This is worse than taken care of a baby. An investigation was initiated. The report included the caregiver's employer was contacted and that the caregiver was no longer allowed to provide services in the facility. The report also included the incident happened on October 14, 2019 at 11:00 p.m. However, review of the State complaint data system revealed the allegation of abuse was not reported to the State Agency until October 16, 2019 at 9:06 a.m. An interview was conducted on March 5, 2020 at 8:34 a.m. with the DON. The DON stated that she was notified of the allegation of abuse on October 16, 2019, almost 48 hours after the incident occurred. The DON stated that she initiated an investigation and reported the allegation of abuse to all the necessary entities. The DON also stated that staff #12 and staff #136 were provided education on reporting allegations of abuse. The facility's policy on abuse revealed suspected abuse will be reported within two hours to the State licensing/certification agency responsible for surveying/licensing the facility. |
| F 0684<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide appropriate treatment and care according to orders, resident's preferences and goals.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on clinical record review, resident and staff and the resident's family member interviews, and policy review, the facility failed to ensure one resident (#202) received treatment and care in accordance with professional standards of practice, by failing to implement the bowel protocol orders. The deficient practice could result in residents having complications from constipation. Findings include: Resident #202 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. During the initial part of the survey, an interview was conducted with resident #202 on March 2, 2020 at 9:30 a.m. The resident stated that he had not had a bowel movement in 5 days. Review of the Admission Evaluation Summary dated February 27, 2020 revealed the resident's usual bowel evacuation pattern was every 2 days. The Summary also included the resident was alert and oriented to person, place and date and did not require assistance with decision making. The physician's orders [REDACTED]. ounces by mouth every 24 hours as needed for constipation if no results from the [MEDICATION NAME] suppository. A physician consultation note dated February 28, 2020 revealed the resident was at risk for constipation due to narcotic pain medications. The Daily Skilled Nursing Note Summary dated March 1, 2020 revealed the resident required limited assistance of one person with toilet use and was frequently incontinent of urine and bowel. The Care Conference meeting summary and notes dated March 2, 2020 revealed the resident reported he had not had a bowel movement since February 25, 2020. Review of the Bowel Continence and Bowel Movement log revealed no evidence the resident had a bowel movement from February 27, 2020 to March 3, 2020. Review of the Medication Administration Record [REDACTED]. Further review of the MAR indicated [REDACTED]. During an interview conducted with the resident and the resident's family member on March 4, 2020 at 1:12 p.m., the resident stated that he had not had a bowel movement in a while. The resident's family member stated that it was last Wednesday (February 26, 2020). Both stated that the resident was administered a stool softener that morning with no results. An interview was conducted with a licensed practical nurse (LPN/staff #64) on March 4, 2020 at 1:09 p.m. She stated that they monitor bowel movements by asking the resident or the Certified Nursing Assistants (CNAs) if the resident is having regular bowel movements. The LPN stated that this information is passed on when the census sheet is updated at shift change. She stated that the facility has standing orders for a bowel program. At 2:34 p.m., staff #64 stated the resident had a bowel movement on February 29, 2020 and that they felt the resident was within parameters. After reviewing the Bowel Continence and Bowel Movement log, the LPN stated that she had misread the log. In an interview conducted with a CNA (staff#57) on March 4, 2020 at 1:47p.m., the CNA stated that she monitors a resident's bowel movements by asking the independent resident if he/she has had a bowel movement and for the resident that is dependent, she will know when the resident has a bowel movement. The CNA stated she report residents' bowel movements to the nurse. She stated that it was reported to her at shift change, resident #202 had a bowel movement on the 29th. She also stated the resident is continent, but needs extensive assistance. During an interview conducted with the Director of Nursing (DON/staff #134), the DON stated her expectation is that the bowel protocol should have been followed for resident #202. The facility's policy titled Bowel (Lower Gastrointestinal Tract) Disorders-Clinical Protocol revised September 2017 revealed staff and the physician will identify risk factors related to bowel dysfunction and will address complications due to bowel dysfunction. |
| F 0697<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Provide safe, appropriate pain management for a resident who requires such services.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on clinical record review, staff interviews, and policy review, the facility failed to ensure one sampled resident (#35) was provided pain management consistent with professional standards of practice, by failing to administer pain medications within the ordered parameters. The deficient practice could result in residents' pain not being relieved and/or residents receiving more pain medications than they require. Findings include: Resident #35 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of the care plan initiated February 10, 2020, revealed the resident had the potential/actual alteration in comfort/pain related to a recent hospitalization . The goal was that the resident would have relief from discomfort or pain. Interventions included administering pain medications as ordered and observing for and reporting breakthrough pain. The admission Minimum Data Set assessment dated [DATE] revealed a Brief Interview Mental Status score of 15, indicating the resident was cognitively intact. Regarding [MEDICATION NAME]: Review of the physician orders [REDACTED]. Review of the Medication Administration Record [REDACTED]. [MEDICATION NAME] was administered for a pain level of 0 on February 15 at 3:36 p.m.; for pain levels of 4 on February 12 at 4:34 a.m., February 20 at 5:37 a.m., February 21 at 4:32 a.m., and February 28 at 4:55 a.m.; for pain levels of 5 on February 11 at 10:41 a.m., February 13 at 12:20 a.m. and 9:18 p.m., February 19 at 6:48 p.m., February 20 at 7:39 p.m., February 21 at 11:01 a.m., February 23 at 8:46 p.m., and February 27 at 10:08 p.m. Regarding [MED] Extra Strength: A physician's orders [REDACTED]. Review of the MAR for February 2020 revealed [MED] Extra Strength was administered to the resident on February 28 at 8:00 p.m. for a pain level of 8 and on February 29 at 2:00 p.m. and 8:00 p.m. for a pain level of 0. Further review of the clinical record revealed no documentation why the pain medications were administered outside of the ordered parameters and/or that the physician was notified. An interview was conducted on March 5, 2020 at 10:47 a.m. with a Registered Nurse (RN/ staff #31 ), who stated that if a pain medication is not effective, she would notify the physician and document the notification and the physician's instructions in a progress note. After reviewing the MAR indicated [REDACTED]. An interview was conducted on March 5, 2020 at 11:08 a.m. with the Director of Nursing (DON/staff #134), who stated that if a resident is requesting pain medication outside of the ordered parameters, the nurse must follow the ordered parameters. The DON stated the expectation is that the nurse would notify the physician for authorization to administer the pain medication outside of the parameters. She also said that if a pain medication is administered outside of the ordered parameters without notifying the physician, the nurse needs to notify the physician a med error has occurred and document the notification in the daily skilled notes or progress notes. After reviewing the pain medication errors documents, the DON stated there was no documentation the physician was notified regarding resident #35's pain medications. Review of the facility's policy for administering pain medications revised December 2010, revealed the purpose of the procedure is to provide guidelines for assessing the resident's level of pain prior to administering [MEDICATION NAME] pain medication. The policy also revealed pain medications are to be administered as ordered. |
| F 0732<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Post nurse staffing information every day.**<br><br>Based on observation, staff interviews and policy review, the facility failed to ensure nursing staff information was posted daily. The deficient practice could result in staffing information not being readily available to residents and visitors. The facility census was 60 residents. Findings include: An observation was conducted on March 2, 2020 at 7:38 a.m., of the nursing staff posting information which was at the front desk of the facility. The nursing staff posting was dated February 27, 2020, with a resident census of 55. An interview was conducted with the Human Resources Director/Staffing Coordinator (staff #133) on March 3, 2020 at 11:46 a.m. She said she normally receives the final resident census number at approximately 7:00 p.m. or 8:00 p.m., and that she would use the census to determine the staffing levels for the following day. She stated the receptionist/concierge would then post the staffing information each morning when she arrives, which is normally between 8:30-9:00 a.m. Staff #133 also stated there was a weekend concierge who was responsible for posting the nursing staff information on the weekends. An interview was conducted with a concierge (staff #44) on March 3, 2020 at 11:54 a.m. She stated she normally works Tuesdays through Fridays. Staff #44 stated that when she arrives in the |

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| F 0732<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 2)<br>mornings, she obtains the staffing sheet from the nursing station and creates the nursing staff posting for the day. She said she normally posts the staffing information by 9:00 a.m. She said she did not work Friday (February 28, 2020), and that she did not know who posted the nursing staff information that day. Staff #44 said there is another concierge who posts the staffing information on Saturday, Sunday and Monday mornings. She stated the Administrator's assistant also assists with posting nursing staff information. Review of the facility's policy for posting direct care staffing numbers revealed the facility would post on a daily basis the number of nursing personnel responsible for providing direct care. The posting would be typed or handwritten, posted in a prominent location, and posted in a clear and readable format. |
| F 0775<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Keep complete, dated laboratory records in the resident's record.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on clinical record review, staff interview and policy review, the facility failed to ensure a laboratory report was filed in one resident's (#351) clinical record and reported to the receiving facility. The deficient practice could result in failure to identify and initiate treatment for [REDACTED].#351 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of the physician's orders [REDACTED]. Review of the Treatment Administration Record (TAR) for September<br>2019 revealed the order to obtain a urinalysis was documented as completed on September 26, 2019. Review of the clinical record revealed the resident was discharged with home health to a group home on September 26, 2019. Further review of the clinical record revealed no evidence of the results from the urinalysis that was collected prior to discharge. An interview was conducted with the Director of Nursing (DON/staff #134) on March 3, 2020 at 2:26 p.m. The DON stated that they did not have any record of the resident's urinalysis results. She said the lab was contacted, and they did not have any record of the urinalysis results either. She said they could not provide confirmation that the lab results had been sent to the receiving facility. Review of the facility's policy for requests for diagnostic services revealed that all requests for diagnostic services must be ordered by the resident's attending physician. All orders for diagnostic services would be entered into the resident's medical record and signed by the physician. Orders would be promptly carried out as instructed by the physician's orders [REDACTED]. tests shall be reported in writing to the facility or the resident's attending physician. Should the results be reported to the facility, the DON or charge nurse receiving the results would be responsible for promptly notifying the physician of the results. Signed and dated reports of all diagnostic services would be made a part of the resident's medical record. |
| F 0812<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.**<br><br>Based on observations and staff interviews, the facility failed to ensure unclean items were stored in accordance with professional standards for food service safety. The deficient practice could place residents at risk for foodborne illness. Findings include: Regarding the unclean pans: During an observation conducted with the Nutrition and Culinary Consultant (staff #135) of the kitchen on March 2, 2020 at 7:42 a.m., two circular pizza pans and one stainless steel steam table pan were observed with black, crusty debris on them. Further observation revealed these pans were stored in the clean dishes area. An interview was conducted with staff #135 during this observation. Staff #135 stated that he was not sure why these items were stored in the clean area. He stated the pans should be removed and rewashed. Regarding the beverage in the area of clean pots and pans: An observation was conducted of the kitchen with the Culinary Service Director (staff #37) on March 4, 2020 at 11:25 a.m. A beverage with a straw was observed on a shelf between clean pots and pans. An interview was conducted with staff #37 immediately following this observation. Staff #37 stated the beverage should not be in that area and he removed the beverage. |