STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035250	A. BUILDING _____ B. WING _____	**06/20/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
IMMANUEL CAMPUS OF CARE	**11301 NORTH 99TH AVENUE PEORIA, AZ 85345**

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 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on staff and family interviews, record review and review of policies and procedures, the facility failed to ensure that one resident's (#1) representative was immediately informed of a significant change in condition. The sample size was one resident. Findings include: Resident #1 was admitted on (MONTH) 13, 2019 with [DIAGNOSES REDACTED]. An Admission Record dated (MONTH) 13, 2019 located in the paper clinical record contained a space for contact information including the name of the contact, relationship to the resident and address and phone number. The spaces were blank with a notation that read No Data Found. A baseline care plan dated (MONTH) 13, 2019 included that resident #1 was alert and oriented and was recovering from a recent ORIF (Open Reduction Internal Fixation) surgical procedure to correct the fracture of her left elbow. Review of the Admission Record located in the electronic clinical record revealed that a family member of resident #1 had been added to the contacts list and was designated as Emergency Contact #1. The contact information included the family member's phone number. An SBAR (Situation, Background, Assessment, Recommendation) communication form dated (MONTH) 16, 2019 at 6:29 a.m. revealed that resident #1 had fallen, had a decrease in consciousness and was being transported to the hospital for evaluation of altered mental status and possible [MEDICAL CONDITION] activity. The form included that the resident's nurse practitioner was notified. Continued review of the SBAR form revealed a space designated that read Name of family/Health Care Agent Notified and included in the space was a notation that read none listed. A health status note dated (MONTH) 16, 2019 at 10:25 a.m. included that resident #1 had been found on the floor,b examined for injury, and no injuries were found. The note included that resident #1 was unresponsive, and had slight convulsive movements of hands and legs and that the resident was transferred to the hospital for evaluation. Review of the clinical record did not reveal any additional documentation that the resident's responsible party had been notified of the resident's change in condition and subsequent transfer to the hospital on (MONTH) 16, 2019. An interview was conducted on (MONTH) 20, 2019 at 11:45 a.m. with a medical records staff #128. The staff reviewed the electronic record for resident #1 and stated that on (MONTH) 14, 2019 at 12:46 p.m. the Admission Record had been updated by an LPN (Licensed Practical Nurse/staff #30) to include contact information for resident #1's family member. An interview was conducted on (MONTH) 20, 2019 at 12:00 p.m. with the family member/emergency contact for resident #1. During the interview, the family member stated that he had been informed that resident #1 had a significant change in condition and had been admitted to the hospital the day after she had been admitted (June 17, 2019) when the hospital notified him by phone, and that the nursing facility did not notify him that resident #1 had been hospitalized until two days later (June 18, 2019) when they notified him by phone. During an interview with the Director of Nursing (#121) conducted on (MONTH) 20, 2019 at 1:25 p.m. the Director stated that when a resident has a change in condition the nurse is to notify the physician, and family as soon as possible, and that the notifications should be within two hours. The Director stated that the nurse is to check the paper clinical record, or the electronic clinical record to obtain the phone number to contact a resident's family for a significant change. During an interview conducted with staff #30 on (MONTH) 20, 2019 at 1:58 p.m. the staff stated that she had updated the resident's contact information on (MONTH) 14, 2019 to include the family member's phone number in case of emergency, and that she had updated the information into the electronic clinical record. However, the staff stated the paper clinical record was not available to her at the time because it was being audited, and that she had not been able to update the paper record at that time. A facility policy titled Change in a Resident's Condition or Status included that the facility shall promptly notify the resident, his or her attending physician and representative of changes in the resident's medical/mental; condition or status. The policy included that unless otherwise instructed by the resident, a nurse will notify the resident's representative when there is a significant change in the resident's physical, mental or psychosocial status, and when a decision has been made to discharge the resident from the facility; and/or it is necessary to transfer the resident to a hospital.

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.