STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **035243**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **05/16/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIFESTREAM AT SUN RIDGE	**12215 WEST BELL ROAD SURPRISE, AZ 85378**

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 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** > Based on clinical record review, staff interviews, facility documentation, and policy review, the facility failed to report an allegation of abuse within 2 hours to the State Agency for one sampled resident (#40). The deficient practice could result in the potential for further abuse. Findings include: Resident #40 was admitted on (MONTH) 10, (YEAR) with [DIAGNOSES REDACTED]. Review of the facility investigative report dated (MONTH) 8, 2019, revealed resident #40 reported to the Administrator (staff #13) and the Director of Social Services (staff #11) that on (MONTH) 7, 2019, the evening nurse (staff #57) did not provide proper care to her. The resident alleged staff #57 purposely put her feeding machine on pause making it beep. The report included the resident stated that when she asked staff #57 to turn the machine off, staff #57 said shut up and did not turn the machine off. The report did not include the abuse allegation was reported to the State Agency. Review of the State Agency data base revealed the abuse allegation was not reported to the State Agency until (MONTH) 13, 2019 at 10:42 AM. An interview was conducted with the Administrator (staff #40) on (MONTH) 13, 2019 at 8:50 AM. The Administrator stated that he was aware that resident #40 believed/stated she had been verbally abused by staff #57. He stated they did not treat the allegation as abuse because there was a witness in the room who overheard the conversation and never heard staff #57 tell the resident to shut up. During an interview conducted with the Director of Nursing (DON/staff #37) on (MONTH) 16, 2019 at 1:42 PM., the DON stated that if a resident makes an allegation of abuse, she would report the allegation within the timeframe required. The DON stated that she spoke with resident #40 on (MONTH) 8, 2019 and that the resident did not report to her an allegation of abuse. The facility's policy titled Abuse Prevention Program revised (MONTH) 22, (YEAR), revealed the facility will report any allegations of abuse within timeframes as required by federal requirements.
F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on clinical record review, staff interviews, facility documentation, and policy review, the facility failed to submit the results of an abuse investigation to the State Agency within 5 days for one sampled resident (#40). The deficient practice could result in the potential for further abuse. Findings include: Resident #40 was admitted on (MONTH) 10, (YEAR) with [DIAGNOSES REDACTED]. Review of the facility investigative report dated (MONTH) 8, 2019, revealed resident #40 reported to the Administrator (staff #13) and the Director of Social Services (staff #11) that on (MONTH) 7, 2019, the evening nurse (staff #57) did not provide proper care to her. The resident alleged staff #57 purposely put her feeding machine on pause making it beep. The report included the resident stated that when she asked staff #57 to turn the machine off, staff #57 said shut up and did not turn the machine off. The report also included a Certified Nursing Assistant (CNA) was present who stated that when staff #57 unhook the feeding tube, the machine started beeping and the resident started yelling at staff #57. The CNA stated that staff #57 attempted to explain calmly why the machine was beeping but the resident kept screaming at staff #57. The report did not reveal the CNA heard staff #57 tell the resident to shut up. The report also did not include the results of the investigation was reported to the State Agency within 5 days. An interview was conducted with the Administrator (staff #40) on (MONTH) 13, 2019 at 8:50 AM. The Administrator stated that he was aware that resident #40 believed/stated she had been verbally abused by staff #57. He stated they did not treat the allegation as abuse because there was a witness in the room who overheard the conversation and never heard staff #57 tell the resident to shut up. The facility's policy titled Abuse Prevention Program revised (MONTH) 22, (YEAR), revealed the facility will investigate and report any allegations of abuse within timeframes as required by federal requirements.
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on clinical record review, staff interviews, and policy review, the facility failed to ensure one sampled resident (#94) did not sustain an injury by failing to ensure the resident's environment was free of an accident hazard. The deficient practice could result in others residents being at risk for injury. Findings include: Resident #94 was admitted to the facility on (MONTH) 14, 2019, with [DIAGNOSES REDACTED]. The resident was discharged (MONTH) 1, 2019. Review of a care plan initiated (MONTH) 15, 2019 revealed the resident had an activities of daily living deficit related to weakness. Interventions included the resident required extensive assistance of one staff for transfers. The admission Minimum Data Set assessment dated (MONTH) 21, 2019, revealed a Brief Interview of Mental Status score of 15 which indicated the resident had no cognition impairment. The assessment also included the resident required extensive assistance of two staff for transfers. Review of a nurse progress note dated (MONTH) 24, 2019, revealed the resident sustained [REDACTED]. The note included the resident bled profusely and that a pressure dressing was applied to stop the bleeding. The note also included the resident stated My skin is so fragile, I just bumped it. The family and physician were notified. Review of the facility's Incident Follow-up and Recommendation Form dated (MONTH) 24, 2019, revealed the resident sustained [REDACTED].#12) from the bed to a wheelchair. It was noted that the end cap was not on the bed fame and included the edges were not jagged. The form included the resident stated that she just bumped it and my skin is so fragile. The incident form also included the end cap was replaced on the bed and treatment was provided to the skin tear. Additional review of the form revealed the predisposing environmental factor was furniture.

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 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) An interview was conducted with the CNA (staff #12) on (MONTH) 15, 2019 at 8:27 a.m. Staff #12 stated that she was transferring the resident from the bed to a wheelchair when the resident sustained [REDACTED]. The CNA stated that part of the bed is usually covered. She stated the skin tear was large and the resident was bleeding. The CNA stated she notified the nurse and maintenance and that maintenance fixed the bed immediately. The CNA stated that she did not know if beds were checked regularly for safety but that if she observes something wrong with the bed, she will notify staff so that it can be fixed. During an interview conducted with a Licensed Practical Nurse (LPN/staff #85) on (MONTH) 15, 2019 at 2:33 p.m., the LPN stated that she was the nurse on duty when the resident sustained [REDACTED]. She stated that the skin tear was caused by an area on the bed frame that was missing the cover. The LPN stated that the physician was notified and treatment was provided. Staff #85 also stated she called maintenance so that the uncovered part of the bed frame could be fixed. An interview was conducted with the Director of Nursing (DON/staff #37) on (MONTH) 16, 2019 at 11:38 a.m. She stated a CNA was transferring resident #94 when the resident hit her leg on a protruding part of the bed that was not covered with a protective cap. The DON stated the resident sustained [REDACTED]. The DON also stated that the protruding part of the bed that was not covered with the end cap caused the skin tear. Staff #37 stated that after the incident, the protective cap was immediately replaced on the protruding part of the bed. An interview was conducted with the Maintenance Director (staff #86) on (MONTH) 16, 2019 at 11:26 a.m. Staff #86 stated that after the incident with resident #94 on (MONTH) 24, 2019, all the beds in the facility were checked for safety. The Maintenance Director stated that not having the protective cap on that part of the bed created a safety hazard. Staff #86 stated it was facility policy to check all the beds annually for safety. Staff #86 also stated all staff have been informed to report any unsafe resident equipment right away so that it can be repaired. The Maintenance Director stated that he did not recall staff reporting the missing protective cap for resident #94's bed frame part. The facility's policy regarding Bed Inspections revealed it is the policy of this facility to conduct regular inspections of all bed frames as part of a regular maintenance program. The policy also included that if bed equipment is found to be outside of the manufacturer's requirements for any reason, the facility staff will perform maintenance to the bed equipment or remove it from use.