STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035251	A. BUILDING ______ B. WING _____	**09/05/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NORTH CHANDLER PLACE - A CONTINUUM OF CARE COMMUN	**2555 NORTH PRICE ROAD CHANDLER, AZ 85224**

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** Based on facility documentation, clinical record review, staff interviews, and policy review, the facility failed to implement their policy, by failing to notify Adult Protective Services (APS) of an abuse allegation for one resident (#16) within 2 hours. The deficient practice could results in allegations of abuse being not reported to APS. Findings include: Resident #16 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. An annual Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident had intact cognition. The assessment included the resident required extensive assistance for transfers and toilet use. During an interview conducted with resident #16 on 9/3/2019 at 8:38 AM, resident #16 stated that approximately 6 months ago, a Certified Nursing Assistant (CNA) called her fatty and stated that she pees too much. The resident also stated the CNA was rough with her. Resident #16 stated that she did not know the CNA's name and that she did not report it at the time because she was afraid. The allegation of abuse was reported to the Director of Nursing at 9:20 AM on 9/3/19. Review of the facility investigation on 9/5/19 revealed the Ombudsman, the police and the State Agency were notified of the allegation, but did not include Adult Protective Services (APS) was notified. An interview was conducted with the Administrator (staff #51) on 9/5/2019 at 11:12 AM. Staff #51 stated that she did notify APS on 9/4/19 at around noon and that the notification to APS was late. An interview was conducted with the Director of Nursing (staff #52) on 9/5/2019 at 11:19 AM. Staff #52 stated that she did not notify APS of the allegation. She also added that she knows that it should have been reported but it must have been overlooked. A review of the facility's policy on Abuse, Neglect & Exploitation dated 7/20/16 revealed all alleged violations involving abuse, neglect, exploitation or mistreatment are to be reported to the State Survey Agency and Adult Protective Services immediately, but no later than 2 hours after the allegation was made.
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 facility documentation, clinical record review, staff interviews, and policy review, the facility failed to ensure an allegation of abuse for one resident (#16) was reported within the required timeframe to Adult Protective Services (APS). Findings include: Resident #16 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. During an interview conducted with resident #16 on 9/3/2019 at 8:38 AM, resident #16 stated that approximately 6 months ago, a Certified Nursing Assistant (CNA) called her fatty and stated that she pees too much. The resident also stated the CNA was rough with her. Resident #16 stated that she did not know the CNA's name and that she did not report it at the time because she was afraid. The allegation of abuse was reported to the Director of Nursing at 9:20 AM on 9/3/19. Review of the facility investigation on 9/5/19 revealed the Ombudsman, the police and the State Agency were notified of the allegation, but did not include Adult Protective Services (APS) was notified. An interview was conducted with the Administrator (staff #51) on 9/5/2019 at 11:12 AM. Staff #51 stated that she did notify APS on 9/4/19 at around noon and that the notification to APS was late. An interview was conducted with the Director of Nursing (staff #52) on 9/5/2019 at 11:19 AM. Staff #52 stated that she did not notify APS of the allegation. She also added that she knows that it should have been reported to APS but it must have been overlooked. A review of the facility's policy on Abuse, Neglect & Exploitation dated 7/20/16 stated that all alleged violations involving abuse, neglect, exploitation or mistreatment are to be reported to the State Survey Agency and Adult Protective Services immediately, but no later than 2 hours after the allegation was made.
F 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, and policy review, the facility failed to ensure the Activities of Daily Living (ADL) care plan was revised for one resident (#19). The deficient practice could result in inaccuracies regarding resident care. The census was 37. Findings include: Resident #19 was readmitted on [DATE] with a [DIAGNOSES REDACTED]. Review of the clinical record revealed a care plan revised 7/22/19, the resident had an Activities of Daily Living (ADL) Self-Care Performance Deficit. The goal was the resident will maintain her current level of function. Interventions included a fluid restriction of 1200 milliliters (mL) per day. A physician's orders [REDACTED]. Further review of the ADL care plan revealed it was not revised to reflect the order for a 1500mL fluid restriction per day. An interview was conducted with the Director of Nursing (DON/staff #52) at 11:18 AM on 09/05/19. She stated that care plans are updated with a change in the resident's condition or when a physician has a change in the plan of care. The facility's policy regarding Using the Care Plan revealed changes in the resident's condition must be reported to the Minimum Data Set (MDS) assessment coordinator so that a review of the resident's care plan can be made. The policy also included documentation must be consistent with the resident's care plan.
F 0698 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Past noncompliance - remedy proposed** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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 0698 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) Based on clinical record review, staff interviews, and policy review, the facility failed to ensure one sampled resident (#19) who required [MEDICAL TREATMENT] received such services, consistent with professional standards of practice. The deficient practice could result in [MEDICAL TREATMENT] related complications not being identified and treated timely. Findings include: Resident #19 was readmitted on [DATE] with a [DIAGNOSES REDACTED]. Review of the clinical record revealed a physician order [REDACTED]. The Significant Change in Status Minimum Data Set assessment dated [DATE] revealed the resident was receiving [MEDICAL TREATMENT]. The care plan revised 8/20/2019 revealed the resident was receiving [MEDICAL TREATMENT]. Interventions included monitoring the [MEDICAL TREATMENT] site and vital signs as ordered. Review of the clinical record revealed more than 10 Follow-Up Instruction for Health Care Institution forms from the [MEDICAL TREATMENT] center regarding the resident [MEDICAL TREATMENT] visits. The facility's [MEDICAL TREATMENT] Communication Forms dated 7/27/19, 8/21/19, and 8/28/19 revealed pre [MEDICAL TREATMENT] assessment documentation. Review of nursing progress notes dated 7/31/19, 8/11/19, and 8/18/19 revealed the resident returned from [MEDICAL TREATMENT], vital signs were obtained, and/or the dressing to the [MEDICAL TREATMENT] site was clean, dry and intact. However, further review of the clinical record from 7/25/19 to 9/2/19 did not reveal the resident was consistently assessed pre and post [MEDICAL TREATMENT]. An interview was conducted with two Registered Nurses (RN/staff #85 and staff #61) at 8:57 AM on 9/5/19. Staff #61 stated that the [MEDICAL TREATMENT] assessments are kept in a book that goes with the resident to the [MEDICAL TREATMENT] center and comes back with the resident when the resident returns to the facility. Staff #61 stated that the pre and post assessments for resident #19 will be in the resident's [MEDICAL TREATMENT] book. Staff #85 stated she had not seen resident #19's [MEDICAL TREATMENT] book for over 2 weeks. Staff #85 also stated that the [MEDICAL TREATMENT] center faxes over the assessments completed at [MEDICAL TREATMENT]. An interview was conducted with the Director of Nursing (DON/staff #52) at 11:18 AM on 9/5/19. Staff #52 stated that a pre and post assessment should be completed when a resident is receiving [MEDICAL TREATMENT]. The DON stated the assessment would include vital signs and assessment of the [MEDICAL TREATMENT] site. She stated that the communication paperwork faxed from the [MEDICAL TREATMENT] center includes labs, weights, vital signs, and an assessment. The DON stated that the resident's [MEDICAL TREATMENT] book is where assessments are kept for both the facility and the [MEDICAL TREATMENT] center. The DON also stated that the [MEDICAL TREATMENT] assessments should be in the [MEDICAL TREATMENT] book and should be documented in the electronic record. The facility's policy regarding [MEDICAL TREATMENT] Care revised 12/2015 revealed routine shunt care included documenting the shunt/catheter condition pre and post [MEDICAL TREATMENT] in the clinical record. The policy included pre [MEDICAL TREATMENT] information will be communicated to the [MEDICAL TREATMENT] center using the Skilled Nursing [MEDICAL TREATMENT] Center Communication Form. The policy also included the outpatient [MEDICAL TREATMENT] center will communicate the resident's status while at the center upon the resident's return to the facility.