STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035144	A. BUILDING _____ B. WING _____	**01/31/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PEORIA POST ACUTE AND REHABILITATION	**13215 NORTH 94TH DRIVE PEORIA, AZ 85381**

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 record reviews, staff interviews and review of policies and procedures, the facility failed to ensure that a fall with minor injuries for one resident (#3) were promptly reported to the physician and the resident's family member. The deficient practice had the potential for physician's and resident representatives not being informed of falls and changes in condition, which could result in prompt medical intervention for falls not being provided timely. Findings include: Resident #3 was admitted on (MONTH) 2, 2019 and readmitted on (MONTH) 11 2019 with [DIAGNOSES REDACTED]. A careplan for self care performance deficit related to impaired mobility and weakness dated (MONTH) 11, 2019 listed multiple interventions including to monitor/document/report to the physician PRN (as needed) any potential for improvement, reasons for self-care deficit, expected course and declines in function. A Fall Risk Evaluation dated (MONTH) 10, 2019 included that resident #3 was alert and oriented to time, place and person, had a history of [REDACTED]. The evaluation included a fall risk score of 11, which indicated that the resident was at high risk for falling. An X-Ray report dated (MONTH) 19, 2019 at 12:53 p.m. included that X-rays of the right elbow and right knee were negative for fracture or dislocation. A physician's progress note dated (MONTH) 19, 2019 at 9:07 p.m. included that the resident had fallen on the day prior to the note and was complaining of right knee pain. A nursing note dated (MONTH) 20, 2019 included that the physician had been notified of X-Ray results which were negative and that the resident was on change in condition status [REDACTED]. AN IDT (Inter-Disciplinary Team) note dated (MONTH) 20, 2019 at 12:42 p.m. included that the IDT Team had met to review a non-injury fall on (MONTH) 18, 2019 and that the careplan had been updated. A nursing note dated (MONTH) 20, 2019 at 11;35 a.m. included that the resident had been assisted onto the commode by a CNA (Certified Nursing Assistant) and had slipped off of the commode onto the floor. The note included that the resident had not reported pain to two CNA's mentioned in the note and quoted a statement from the resident that she had dropped onto the floor in the bathroom and was then put into a wheelchair. The note included that a skin assessment had been provided and the resident had abrasions to the right knee, right knuckles, right elbow and a laceration to the top right lip. The note included that a physician had been notified for an X-Ray, and that the resident had notified her daughter, when the daughter had visited. Continued review of the clinical record did not reveal any additional documentation regarding details of what had transpired immediately after the fall on (MONTH) 18, 2019 including when the resident's nurse, or when the resident's daughter and the physician had been notified of the fall with injuries. During an interview conducted on (MONTH) 29, 2020 at 11:20 a.m. with a family member of resident #3, she stated that she had been told by her mother that she had fallen in the bathroom and stated that staff had not notified her of the fall. The family member stated that she then asked the nurse about the fall, and that later that afternoon, the Director of Nursing called her and told her about the resident's fall. The family member stated that on past occasions when the resident has fallen, they always notify her that she has fallen. An interview was conducted on (MONTH) 29, 2020 at 11:35 a.m. with an LPN (Licensed Practical Nurse/staff #20) who stated that if a resident falls, the CNA is to report the fall immediately to the nurse, and the nurse assesses the resident for injuries immediately, then notifies the physician and the resident's family of the fall right away. During an interview conducted with the DON (Director of Nurses/#63) on (MONTH) 29, 2020 at 12:35 p.m. who stated that the CNA's did not report the resident's fall in the bathroom to the nurse when the resident fell . The DON reviewed an incident record and stated that the resident fell on (MONTH) 18, 2019 at 2:00 p.m. The DON stated that the resident's daughter called a unit manager the next morning (December 19, 2019) and asked about the resident's fall and that is when they found out that the resident had fallen on (MONTH) 18, 2019. An Incident Report dated (MONTH) 18, 2019 and revised on (MONTH) 20, 2019 was provided upon request. Review of the report revealed that the resident fell on (MONTH) 18, 2019 at 2:00 p.m., resident's family member was notified of the fall on (MONTH) 19, 2019 at 8:46 a.m. and the resident's physician was notified of the fall on (MONTH) 19, 2019 at 10:45 a.m. During an interview conducted on (MONTH) 29, 2020 at 2:52 p.m. with a CNA/staff #35 who stated that after the resident fell on (MONTH) 18, 2019 she did not tell the nurse that the resident had fallen because she thought the other CNA was going to tell the nurse about the fall. The CNA stated We made a mistake. I should have said something. A policy and procedure titled Change of Condition Reporting included a statement that it is the policy that all changes in resident condition will be communicated to the physician. The policy included that unusual signs and symptoms will be communicated to the physician promptly, and that all attempts to reach the physician and responsible party will be documented in the nursing progress notes. A policy and procedure titled Fall Management System included that it is the policy of the facility to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs. The policy included that when a resident sustains a fall, a physical assessment will be completed by a licensed nurse, with results documented in the Nursing Progress Notes. The policy included that the Attending Physician and family/responsible party shall be notified of the fall and the resident's status.

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.