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 _____	**01/03/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, staff interviews, and policy review, the facility failed to ensure one resident (#132) was free from neglect. Findings include: Resident #132 was admitted to the facility on (MONTH) 17, (YEAR), with [DIAGNOSES REDACTED]. Review of the care plan initiated (MONTH) 18, (YEAR) revealed the resident had a self-care deficit related to impaired mobility. Interventions included the resident needed the assistance of 1-2 staff for toilet use. A daily skilled nurse note dated (MONTH) 20, (YEAR) revealed the resident was alert and oriented to person, place, and time. The note also included the resident required extensive assistance for toileting. Review of nurse progress notes dated (MONTH) 21, (YEAR) around 12:00 a.m., revealed the resident was left on the bedpan for approximately 3 hours. The note included the resident took herself off the bed pan and spilled urine all over the floor and the bed. The note also included that there was no redness or skin breakdown to the buttocks. The facility's investigation report dated (MONTH) 27, (YEAR) revealed that at approximately 9:15 p.m. on (MONTH) 20, (YEAR) a Certified Nursing Assistant (CNA/staff #151) put the resident on the bedpan and that she reported to the oncoming CNA (staff #102) that the resident was on the bedpan. At approximately 11:45 p.m. staff #102 heard the resident yelling for help and entered the resident's room. The resident stated that staff #151 put her on the bedpan and did not return. The resident stated that she took herself off the bedpan, however the bedpan was found halfway off her bottom. The Licensed Practical Nurse (LPN/staff #63) conducted a skin check that revealed there was no redness or bruising, open areas, or areas of concern. The report included the LPN statement that the white dot that is put on the outside door frame to alert staff that a resident is on the bedpan was not on the door frame. The report also included the resident stated that she had put her call light on and yelled out for help and that it seemed like it took a long time for someone to come and help her. An interview was conducted with a CNA (staff #83) on (MONTH) 2, 2019 at 11:47 AM. Staff #83 stated that the maximum time she leaves a resident on a bedpan is 10 minutes but that she tries to take the resident off the bedpan as soon as possible. Staff #83 stated that a CNA should never leave a shift with someone on the bedpan or toilet that the CNA needs to stay until the resident is done. An interview was conducted on (MONTH) 2, 2019 at 1:13 PM with a CNA (staff #39). She stated that if a resident is on a bedpan and the resident has not put their call light on after 5 minutes that she will check on the resident. Staff #39 stated that there is a white dot that is placed on the doorframe of a room that alerts staff the resident is on a bedpan. The CNA also stated that if she received a report at shift change that a resident was on a bedpan that she would go to that room right away. During a telephone interview conducted with the LPN (staff #63) on (MONTH) 3, 2019 at 9:28 AM, the LPN stated that the resident had put her call light on and that he and staff #102 took the resident off the bedpan. He stated that the resident was upset that she had been left on the bedpan for a long time but that the resident could not say specifically how long. The LPN stated that the resident did not have any injuries or pain from the bedpan. During a telephone interview conducted with the CNA (staff #102) on (MONTH) 3, 2019 at 9:50 AM, the CNA stated that when she checked on the resident, the resident never said anything about being on the bedpan. An interview was conducted with the Director of Nursing (DON/staff #50), Clinical Operations (staff #152) and the Administrator (staff #53) on (MONTH) 3, 2019 at 12:58 PM. The DON stated that neglect is not necessarily a purposeful act but could be something that was forgotten. The DON also stated that examples of neglect would include not changing a resident, not giving a resident a shower, or not administering a medication. The DON included that she was not employed by the facility at the time of the incident. Staff #152 stated she was involved with the incident. She stated that the resident was capable of using the call light. She also stated that during a medication administration, the resident did not say anything about being on a bedpan. Attempts to contact staff #151 (CNA) for an interview were unsuccessful. Review of the facility's abuse policy revealed that neglect is defined as failure of the facility, its associates or service providers to provide goods and services to a guest that are necessary to avoid physical harm, pain, mental anguish or emotional distress. The policy included examples of situations that can imply Guest neglect: a. Avoiding or ignoring Guests. b. Not responding to requested needs in a timely manner. c. Not providing interventions and treatments in a timely manner.
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 ensure one allegation of neglect involving one resident (#132) was reported to the State Agency in a timely manner. Findings include: Resident #132 was admitted to the facility on (MONTH) 17, (YEAR), with [DIAGNOSES REDACTED]. The facility's investigation report dated (MONTH) 27, (YEAR) revealed that at approximately 9:15 p.m. on (MONTH) 20, (YEAR) a Certified Nursing Assistant (CNA/staff #151) put the resident on the bedpan and that she reported to the oncoming CNA (staff #102) that the resident was on the bedpan. At approximately 11:45 p.m. staff #102 heard the resident yelling for help and entered the resident's room. The resident stated that staff #151 put her on the bedpan and did not return. The resident stated that she took herself off the bedpan, however the bedpan was found halfway off her bottom. The report included the Licensed Practical Nurse (LPN/staff #63) conducted a skin check that revealed there was no redness or bruising, open areas, or areas of concern. The report also included the State Agency was notified by voicemail of this incident on (MONTH) 21, (YEAR) at 7:45 a.m. During an interview conducted with the LPN (staff# 63) on (MONTH) 3, 2019 at 9:28 AM, the LPN stated that he notified the Director of Nursing immediately after the incident and that he notified the charge nurse when she arrived that morning. An interview was conducted with the Director of Nursing (DON/staff #50), Clinical Operations (staff #152) and Administrator

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 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) (staff #53) on (MONTH) 3, 2019 at 12:58 PM. The DON stated that it is their policy for the administrator or herself to notify the State Agency. She stated that staff should report any incidents to her right away even if it is the middle of the night. The DON also included that she was not employed by the facility at the time of the incident. The administrator stated that she received a phone call about the incident on the morning of (MONTH) 21, 2019 between 7:00-7:30 AM and that she left a message for the State Agency at 7:45 AM. Review of the facility's policy regarding abuse revealed all alleged violations involving abuse, neglect, exploitation, or mistreatment will be reported by the facility administrator, or his/her designee to the State Agency, Ombudsman, and the Guest representative of record. The policy also included that suspected abuse, neglect, exploitation or mistreatment will be reported within two hours.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of personnel records, staff interviews, and review of policies and procedures, the facility failed to ensure two employees (staff #146 and staff #63) had evidence of freedom from infectious [MEDICAL CONDITION]. Findings include: A review of personnel records conducted on (MONTH) 3, 2019 at 1:00 p.m. revealed the following: - A full time COTA (Certified Occupational Therapy Assistant/staff #146) that was hired on (MONTH) 21, (YEAR) had a history of [REDACTED]. A form titled Annual [MEDICAL CONDITION] Sign/Symptoms Screening completed on (MONTH) 15, (YEAR) revealed the employee did not have symptoms of [MEDICAL CONDITION], and was signed by the employee and a physician. However, there was no additional documented evidence that the employee had been screened or evaluated for freedom from [MEDICAL CONDITION] after (MONTH) 15, (YEAR). - A full time LPN (Licensed Practical Nurse/staff #63) that was hired on (MONTH) 4, (YEAR) had a form titled TB Questionnaire that had been completed on (MONTH) 31, (YEAR). The form included that the employee had a past history of a positive TB ([MEDICAL CONDITION]) test in (YEAR), did not have symptoms of [MEDICAL CONDITION], and was signed by the employee and a physician. There was no additional documented evidence that the employee had been screened or evaluated for freedom from [MEDICAL CONDITION] after (MONTH) 31, (YEAR). An interview was conducted on (MONTH) 3, 2019 at 2:02 p.m. with the Human Resource Coordinator (staff #145). Staff #145 stated that employees are supposed to have annual TB ([MEDICAL CONDITION]) testing and clearance. Staff #145 stated that it was her error that she failed to obtain TB clearance for staff #146 and staff #63. A facility's policy and procedure titled [MEDICAL CONDITION], Employee Screening for, included a statement that read The need for annual testing shall be determined by the annual TB risk classification or as per State regulations. The section of the policy titled Serial testing of Employees included that employees with positive baseline (TB) tests or those who convert to positive will have an annual symptom screening.