STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035282	A. BUILDING _____ B. WING _____	09/19/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SANTE OF SURPRISE	14775 WEST YORKSHIRE DRIVE SURPRISE, AZ 85374

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and the Resident Assessment Instrument (RAI) manual, the facility failed to ensure a discharge Minimum Data Set (MDS) assessment was coded accurately for one of three sampled residents (#53). The deficient practice could result in inaccurate discharge tracking information. Findings include: Resident #53 was admitted to the facility on (MONTH) 24, 2019, with [DIAGNOSES REDACTED]. A review of a progress note dated (MONTH) 4, 2019 revealed the resident was discharged to an assisted living facility (ALF). Review of the discharge MDS assessment dated (MONTH) 4, 2019 revealed the resident was discharged to an acute hospital. During an interview conducted with the MDS Coordinator (staff #42) on (MONTH) 18, 2019 at 10:14 a.m., the MDS Coordinator stated that the resident was discharged to an ALF and that the discharge to an acute hospital was an error. During an interview conducted with the Director of Nursing (DON/staff #8) on (MONTH) 18, 2019 at 10:43 a.m., the DON stated that it is her expectation that MDS assessments are accurate. The RAI manual instructs to review the clinical record including the discharge plan and discharge orders for documentation of a resident's discharge location. The manual also included .the importance of accurately completing and submitting the MDS cannot be over-emphasized . and that Federal regulations require the assessment accurately reflects the resident's status.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, resident and staff interviews, and policy review, the facility failed to ensure two residents (#9 and #12) with wounds received treatment and care in accordance with professional standards of practice. The deficient practice could result in delayed healing of wounds. Findings include: -Resident #9 was readmitted to the facility on (MONTH) 12, 2019, with [DIAGNOSES REDACTED]. A quarterly Minimum Data Set (MDS) assessment dated (MONTH) 24, 2019 revealed the resident score a 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident had intact cognition. The assessment included the resident was receiving applications of ointments/medications for skin treatments. Review of the care plan regarding skin integrity dated (MONTH) 16, 2019, revealed the resident had a trauma wound to the dorsum of the left second toe. Interventions included administering treatment to the wound per physician order. The care plan did not include the resident had refused treatments. Review of the Initial Wound Review dated (MONTH) 16, 2019 revealed the resident had a trauma wound to the left second toe with an onset date of (MONTH) 16, 2019. The wound measured 0.3 centimeters (cm) x 0.5 cm, scab filled the wound bed, purpura to peri-wound, no drainage or odor, tender to touch, and wound edges are attached. Review of the physician orders [REDACTED]. inch netting daily. Review of Daily Skilled Nursing notes dated (MONTH) 18 and 21, 2019 revealed the left foot second toe was scabbed. A Weekly Wound Review dated (MONTH) 23, 2019 revealed the left second toe wound showed improvement. The Treatment Administration Record (TAR) dated (MONTH) 2019 revealed the treatment to the left second toe was provided as ordered. Review of the physician orders [REDACTED]. Continued review of the physician orders [REDACTED]. A review of the TAR for (MONTH) 2019 revealed the resident was provided the treatment on (MONTH) 28, 30, and 31 and refused the treatment on (MONTH) 27 and 29, 2019. A Medication Administration note dated (MONTH) 27, 2019 revealed wound care supplies were not available for the treatment to the left foot second toe. A Medication Administration note dated (MONTH) 29, 2019 revealed the resident refused the treatment because he was allergic to Mupirocin. The note included the left second toe was scabbed and remains open to air. Review of the TAR for (MONTH) 2019 revealed the resident was provided the treatment on (MONTH) 3, 11, 12, 13, and 14 and refused the treatments on (MONTH) 1, 2, 4 - 10, 15, and 16, 2019. Medication Administration notes dated (MONTH) 1 and 2, 2019 revealed the resident refused the treatments due to being allergic to Mupirocin. A daily skilled note dated (MONTH) 1, 2019 revealed the resident's left foot second toe was scabbed. A daily skilled note dated (MONTH) 5, 2019 revealed the scab was intact to the right foot second toe (not the left foot second toe). A Weekly Skin Check note dated (MONTH) 6, 2019 revealed the resident's right second toe (not the left foot second toe) was scabbed with no redness or drainage noted. The note included the toe was cleansed, [MEDICATION NAME] was applied (not Mupirocin), and the toe was covered with a dry dressing. However, review of the clinical record revealed no evidence the physician was notified of the refusals that the resident was allergic to Mupirocin until a handwritten provider note dated (MONTH) 7, 2019. The note revealed the provider was notified by the nurses that the resident refused the treatment to the foot due to being allergic to Mupirocin. A copy of the care plan provided by the facility now included the resident has refused treatments to the left foot second toe initiated (MONTH) 7, 2019. The interventions now included explaining the risks and benefits of refusals and continued refusal of treatments and to involve the physician as necessary initiated (MONTH) 6, 2019. During a wound treatment observation conducted on (MONTH) 18, 2019 at 9:08 a.m. with the wound nurse (staff #20), the left foot second toe was observed to have no wound. The right foot second toe wound was observed with a scab-like area that was mostly dark brown and the area around the wound was observed reddened. The wound nurse did not provide a treatment to the right foot second toe. Immediately following the observation, an interview was conducted with the wound nurse (staff #20). The wound nurse stated the resident had told her that she was allergic to Mupirocin and is wary of putting antibiotic cream on the toe. The wound nurse also stated that the resident often refuses the treatment. Staff #20 stated that the resident has never had a wound on her left second toe and that the wound being treated is the wound on the right second toe. Staff #20 also stated that the orders were incorrect regarding the left toe.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) An interview was conducted with the Interim Administrator (staff #220) on (MONTH) 19, 2019 at 09:02. Staff #220 stated the expectation is that if a treatment is refused, other approaches will be tried, the refusal will be documented, and the physician and wound nurse will be notified. Staff #220 also stated any refusals or changes of treatment would be documented in progress notes, daily nursing notes, or the wound review notes. -Resident #12 was readmitted to the facility on (MONTH) 27, 2019, with [DIAGNOSES REDACTED]. A PPS (Prospective Payment System) 30-day MDS assessment dated (MONTH) 24, 2019 revealed a score of 13 on the BIMS which indicated the resident was cognitively intact. The assessment also included the resident had a skin tear and was receiving applications of ointments/medications for skin treatment. Review of the care plan regarding skin integrity revealed the resident had a skin tear to the left knee. Interventions included administering treatment to the skin impairment per physician order. The physician's orders [REDACTED]. Review of the TAR for (MONTH) 2019 revealed the treatment was provided on (MONTH) 1, 4, 7, and 10. Continued review of the TAR for (MONTH) 2019 revealed the treatment for [REDACTED]. However, review of the nursing notes for (MONTH) 13, 2019 revealed no information regarding the treatment to the left knee. Further review of the notes revealed a Medication Administration Note that the treatment to the left knee was due on (MONTH) 14, 2019. However, review of the TAR for (MONTH) 2019 revealed no documentation the left knee treatment was provided on (MONTH) 14, 2019 but did include the treatment was provided on (MONTH) 16, 2019. During an interview conducted with the resident on (MONTH) 16, 2019 at 09:35 a.m., the resident was observed with a bandage to the left knee dated (MONTH) 11, 2019. The resident stated the bandage had not been changed for a few days and that he expected the bandage to be changed a while ago. During an interview conducted with the wound nurse (staff #20) on (MONTH) 18, 2019 at 9:08 a.m., the wound nurse stated that the floor nurses provide the day to day treatments. An interview was conducted with the Director of Nursing (DON/staff #8) and Interim Administrator (staff #220) on (MONTH) 19, 2019 at 09:02 a.m. The DON stated that she expects dressing changes to be provided timely. Staff #220 stated the expectation is that the nurses provide treatments per the physician orders. An interview was conducted with a Licensed Practical Nurse (LPN/staff #17) on (MONTH) 19, 2019 at 9:43 a.m. The LPN stated that the nurses are informed of treatments that need to be provided by the orders that pop up daily in the treatment section in the electronic clinical record. Another interview was conducted with the DON (staff #8) on (MONTH) 19, 2019 at 12:44 p.m. The DON stated that the night nurse told her that the treatment was provided to the resident on (MONTH) 14, 2019. However, the DON acknowledged that the resident's bandage to the left knee had the date (MONTH) 11, 2019 written on the bandage. A review of the facility's policy for Skin Tears - Abrasions and Minor Breaks, Care of, revealed the purpose is to guide the prevention and treatment of [REDACTED]. Review the resident's care plan and current orders and check the treatment record. Documentation in the clinical record will include the treatment was provided and how the resident tolerated the procedure or if the resident refused the treatment with the reason for the refusal. Physician notification may be routine (that is, non-immediate) if the abrasion is uncomplicated or no associated with significant trauma. The policy also included reporting other information in accordance with professional standards of practice. A review of the facility's policy for Wound Care revealed the purpose is to provide guidelines for the care of wounds to promote healing. The date and time the wound care was given or if the resident refused the treatment and the reason(s) why should be recorded in the clinical record. Notify the supervisor if the resident refuses the wound care. The policy also revealed reporting other information in accordance with professional standards of practice.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 observations, staff interviews, and policy review, the facility failed to ensure the environment was free from accident hazards by failing to ensure safe water temperatures were maintained in multiple residents' (including residents #15, #47, and #153) rooms and failed to ensure one resident (#26) who had a fall received adequate supervision and assistance. The deficient practice could result in residents [MEDICAL CONDITION] to hot water temperatures and potentially falling. Findings included: -Resident #15 was admitted to the facility on (MONTH) 20, 2019, discharged return anticipated to the hospital on (MONTH) 5, 2019, and readmitted to the facility on (MONTH) 7, 2019 with [DIAGNOSES REDACTED]. The admission Minimum Data Set (MDS) assessment dated (MONTH) 27, 2019 and the discharge MDS assessment dated (MONTH) 5, 2019, revealed the resident had no cognitive impairment and required extensive assistance with most Activities of Daily Living (ADLs). The admission assessment also included the resident used a wheelchair for mobility. The water temperature from this resident's bathroom sink was tested on (MONTH) 16, 2019 at 10:30 a.m. and found to be 130.7 degrees Fahrenheit (F). -Resident #47 was admitted on (MONTH) 1, 2019 with [DIAGNOSES REDACTED]. The admission MDS assessment dated (MONTH) 8, 2019 revealed the resident scored a 13 on the Brief Interview for Mental Status (BIMS), indicating he was cognitively intact. The assessment included the resident required extensive 1-2 person assistance for most ADLs and utilized a wheelchair and a walker to aid in mobility. On (MONTH) 16, 2019 at 10:30 a.m., the water temperature in this resident's bathroom sink was tested and was found to be 130.7 degrees F. -Resident #153 was admitted on (MONTH) 10, 2019 with [DIAGNOSES REDACTED]. The admission MDS assessment dated (MONTH) 17, 2019 revealed the resident scored a 7 on the BIMS, indicating he was severely cognitively impaired. The assessment included the resident required two-person assistance for most ADLs and utilized a wheelchair to aid in mobility. The water temperature from the resident's sink in the resident's bathroom was tested on (MONTH) 16, 2019 at 10:30 a.m. The temperature was 130.7 degrees F. Due to the elevated hot water temperatures, additional hot water temperatures were checked in 10 other residents' room bathrooms. Those hot water temperatures ranged from 121 degrees F to 128.7 degrees F. An interview was conducted with the Director of Maintenance (staff #6) regarding the elevated hot water temperatures on (MONTH) 16, 2019 at 11:30 a.m. The Director of Maintenance stated that she would adjust the mixing valve to turn the hot water temperature down. On (MONTH) 16, 2019 at 11:51 a.m., the Assistant Director of Maintenance (staff#32) was observed to obtain hot water temperatures in residents' rooms. The hot water temperature in resident #15's room was 128.1 degrees F, 132.1 degrees F in resident #47's room, and 128.1 degrees F in resident #153's room. Hot water temperatures were rechecked in residents' rooms on (MONTH) 16, 2019 at 2:20 p.m. The hot water temperature in resident #15's room tested at 112.2 degrees F, at 123.3 degrees F in resident #47's room, and at 119.6 degrees F in resident #153's room. An interview was conducted with the Director of Maintenance (staff #9) on (MONTH) 17, 2019 at 8:01 a.m. Staff #9 stated the last time residents' room water temperatures were obtained was yesterday (September 16, 2019) evening at approximately 8:00 p.m. She said the average hot water temperature was about 102 degrees F. Staff #9 stated water temperatures are checked in two random residents' rooms, the kitchen, and the laundry room every day, including weekends. The Director of Maintenance stated water temperatures in residents' rooms were obtained this morning (September 17, 2019) and that the hottest water temperature was 98 degrees F. Review of the water temperature log provided by staff #9 on (MONTH) 17, 2019 at 12:42 p.m., revealed the morning hot water temperatures in residents' bathrooms obtained that morning were under 120 degrees F. The hot water temperature in resident #47's bathroom that morning was 102.2 degrees F.

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) An interview was conducted with the Interim Administrator (staff #220) on (MONTH) 18, 2019 at 10:45 a.m. Staff #220 stated there had been no complaints about the hot water temperatures. She stated that if staff or residents had complaints about the hot water temperatures, her process would be to investigate the complaint immediately. Staff #220 stated she would test the hot water temperature and that if the hot water temperature was too hot, she would put up a sign requesting that no one use the hot water. She stated she would notify maintenance to adjust the mixing valve and retest the hot water temperature to ensure hot water temperatures are at a safe temperature. Staff #220 stated their policy states hot water temperatures should not exceed 120 degree F. The facility's policy regarding the Safety of Water Temperatures revealed water in the facility shall be kept within a temperature range to prevent scalding of residents. The policy included water heaters that service resident rooms, bathrooms, common areas, and tub/shower areas shall be set to temperatures of no more than 120 degrees F, or the maximum allowable temperature, per state regulation. The policy also included direct-care staff shall be informed of risk factors for scalding/burns that are more common in the elderly, such as decreased skin thickness and sensitivity, [MEDICAL CONDITION], reduced reaction time, and decreased cognition, mobility, and communication. -Resident #26 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Admission Evaluation dated 8/27/2019 included a fall risk assessment which contained documentation the resident had not had a fall anytime in the last 6 months prior to admission. Review of the physician orders [REDACTED]. Review of the care plan initiated 8/28/2019 revealed the resident was at risk for falls and fall related injuries due to decline in independent function, deconditioning, and weakness. The goal was that the resident will be free of falls and fall related significant injury. Interventions included anticipating and meeting basic needs, not leaving the resident alone in the bathroom, keeping needed personal and care items, water etc., in reach, and providing Orange You Special universal communication identifiers. The care plan regarding activities of daily living (ADLs) initiated 8/28/2019 revealed the resident had a self-care deficit as evidenced by the need for assistance with ADLs related to muscle weakness. Interventions included the resident required 1-2 staff participation with personal hygiene/oral care, toilet use, transfers, and re-positioning. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed a score of 13 on the Brief Interview for Mental Status which indicated the resident was cognitively intact. The assessment included the resident had visual impairment and did not use corrective lenses or other visual aids during the vision assessment. The assessment also included the resident did not have a fall 6 month prior to admission or since admission. The assessment revealed the resident required extensive assistance of two plus staff for transfer and toilet use. The assessment further revealed the resident was not stable when moving on and off the toilet and was only able to stabilize with human assistance. Review of the care plan revealed the resident had impaired vision related to right eye [MEDICAL CONDITION] initiated (MONTH) 6, 2019. The goal was that the resident would remain safe and accept assistance in daily routine. Interventions included placing personal items within reach and ensuring the room is free from clutter. During an observation conducted of the resident's room on 09/16/2019 at 8:07 AM, resident #26 was observed in the bathroom on the commode with the bathroom door open. No wheelchair was observed in the bathroom. After exiting the resident's room, it was two minutes later that the resident could be heard from the hallway two rooms down yelling out for help. The call light above the door of the resident's room was observed on. At 08:12 AM, a Central Supply/Scheduler (staff #3) walked past the resident's room and did not enter the room or acknowledge the call light. At 8:13 AM, a Case Manager (Licensed Practical Nurse/staff #20) walked past the resident's room and did not stop to see why the resident had her call light on. A few seconds later the resident was heard again calling for help. At 8:16 AM a Licensed Practical Nurse (LPN/staff #153) wheeling a medication cart stopped in front of resident's room. The LPN was heard asking, What happened. After entering the room, the resident was observed by the surveyor on the floor of the bathroom and a wheelchair was observed in the doorway of the bathroom. A nursing noted dated 9/16/2019 written by staff #153 at 2:02 PM revealed the resident was found lying on the bathroom floor. The resident stated that she was trying to reach the cap of the toothpaste on the floor. The resident stated the wheelchair moved and she fell . The note included staff #153 and two other staff members assisted the resident into her wheelchair. No injuries notes, the resident denied pain or discomfort. The note included neuro checks were initiated and the physician, Administrator, Director of Nursing, and family were notified. Review of the fall investigation report dated 9/16/2019 revealed that on 9/16/2019 at approximately 8:10 AM; the resident wheeled herself to the bathroom, saw a toothpaste cap on the floor, reached for the cap and fell on the floor. The resident activated her call light for assistance. The report included the resident stated she forgot to lock the wheelchair. An observation was conducted of the resident's room on 09/17/2019 at 11:50 AM. The resident was observed sitting in her wheelchair on the left side of her bed with her necklace call pendent around her neck. The bedside table with a water cup and tissue box on it was at the end of the bed out of the resident's reach. At this time, an interview was conducted with the resident. The resident stated that she fell while reaching for the cap to her toothpaste. The resident stated she was in the bathroom alone and that usually staff do not allow her to be alone in the bathroom. The resident also stated she fell on her bottom and that today the right side of her bottom hurts. Another observation was conducted on 09/17/2019 at 3:30 PM of the resident's room. The bedside table containing water and tissues was observed on the right side of the bed and the resident was observed on the left side of the bed sitting in her wheelchair. The resident was observed with the necklace call pendant around her neck. An interview was conducted on 09/18/2019 at 8:06 AM with a Certified Nursing Assistant (CNA/staff #215) who was caring for the resident. She stated if a resident is a fall risk, she checks on the resident frequently. The CNA stated resident #26 can stand but someone needs to be on standby assist because sometimes the resident falls. The CNA stated the resident is on the Orange You Special program so the resident should not to be left alone in the restroom. She also stated that if the resident wanted privacy, she would stand outside the bathroom door, stay in the room, or stay right outside the room in the hallway. During an interview conducted on 09/18/2019 at 9:50 AM with staff #3, she stated that if she had seen the call light on she would have answered it. She stated that if a resident was calling out from the bathroom she would go into bathroom to see what was wrong. An interview was conducted with staff #20 on 09/18/2019 at 12:17 PM. He stated that he did not see resident #26's call light on when he walked by the resident's room. The LPN stated that it is everyone's responsibility to answer call lights. The LPN also stated that he is observant and always looks to see if any call lights are on as he walks down the hallways. An interview was conducted with the Director of Nursing (DON/staff #8) and the Assistant Director of Nursing (ADON/staff #64) on 09/18/2019 at 12:45 PM. The ADON stated there is an intervention on the resident's care plan stating she is not to be left in the bathroom alone. The DON stated she is not sure why someone would place that specific intervention on the resident's care plan and that it should have been removed. The DON stated the resident has the right to be in the bathroom by herself if she wants and the staff can stand outside her bathroom door. The ADON stated it is her expectation that the staff make regular observations in the hallways to identify any issues with the residents. The ADON stated it is facility standards to look for call lights that are on and answer them in a timely manner. The DON stated the staff can stand outside the bathroom door or in the hallway if there is a concern with the resident being in the bathroom alone. An interview was conducted with the Interim Administrator (staff #220) on 09/18/2019 at 1:18 PM. She stated the resident is ultimately responsible for her safety. Staff #220 stated if a resident falls and staff are not present and the resident is able to make their own choices, then the staff are not responsible. An interview was conducted with the resident #26 and a Certified Occupational Therapy Assistant (COTA/staff #147) on 09/19/2019 at 8:31 AM. The resident stated that every time she uses the toilet, she needs help moving onto the commode. She stated that on Monday morning, 9/16/2019, one of the staff members did help her onto the toilet but she could not remember which one. Resident #26 stated that she leaned over to get a toothpaste cap off the floor and that is when she fell . She stated she hit the call light after she fell on the floor. Staff #147 stated she was not aware the resident had fallen on Monday. Review of the facility's policy titled Falls - Clinical Protocol revised (MONTH) 2012 revealed that as part of the initial assessment, the clinical staff with the help of the physician will identify risk factors for subsequent falling. Staff will document risk factors in the resident's clinical record and discuss the resident's fall risk. Risk factors for subsequent

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) falling include gait and balance disorders and illnesses affecting the central nervous system. The physician will identify medical conditions affecting fall risk (for example, a recent stroke). The policy included falls often have medical causes; they are not just a nursing issue. Based on the assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** Based on observation, staff interviews, and policy review, the facility failed to ensure that a glucometer designed for multi-resident use was disinfected after a resident use. The deficient practice could result in indirect contact transmission of infectious agents. Findings include: An observation was conducted on (MONTH) 19, 2019 at 8:47 a.m. of a Registered Nurse (RN/staff #172) using a glucometer to perform a blood glucose test on a resident. When the test was completed, the RN cleaned the glucometer with alcohol wipes and placed the glucometer on top of the medication cart to dry. On (MONTH) 19, 2019 at 8:53 a.m., an interview was conducted with the RN (staff #172). She stated that she had five residents who required blood glucose testing each morning. The RN stated that she usually cleans the glucometer with alcohol wipe between each resident use or just uses what is in her medication cart. The RN also stated there is a red-topped container with wipes by the nurses' station that she can use. She said she was not sure what the facility's policy states. During an interview conducted with the Director of Nursing (DON/staff #8) on (MONTH) 19, 2019 at 11:51 a.m., she stated that the glucometers are supposed to be cleaned between each resident use by using a Sani wipe. The DON stated that glucometer should be allowed to dry for several minutes, depending on the required dry-time listed on the container. The facility's policy titled Blood Sampling - Capillary (Finger Sticks) revealed the purpose of the procedure is to guide the safe handling of capillary-blood sampling devices to prevent transmission of bloodborne diseases to residents and employees. The policy also revealed blood glucose meters intended for reuse are cleaned and disinfected between resident uses using an approved Environmental Protection Agency (EPA) registered disinfectant for cleaning the sampling device (glucometer).