STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035205	A. BUILDING _____ B. WING _____	**09/19/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SUNCREST HEALTHCARE CENTER	**2211 EAST SOUTHERN AVENUE PHOENIX, AZ 85040**

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 0689 **Level of harm -** 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 observation, clinical record reviews, staff interviews, facility documentation and policies and procedures, the facility failed to ensure care and services were provided to one resident (#166) who was identified as high risk for falls, and failed to ensure one resident (#28) who has cognitive impairment was thoroughly and accurately assessed for safe smoking. The deficient practice could place residents at increased risk for injuries. Findings include: -Resident #166 was admitted to the facility on (MONTH) 1, 2019, with [DIAGNOSES REDACTED]. According to the admission observation form dated (MONTH) 1, 2019, the resident was alert and oriented to person and place, was a 2 person assist with transfers and had weakness to both lower extremities. The Fall Risk assessment dated (MONTH) 1, 2019 included the resident was a high fall risk and required assistance/supervision with mobility, transfers or ambulation. An initial care plan dated (MONTH) 1, 2019 included the resident was a fall/safety risk. A goal was for the resident to have no injury or harm. Interventions included for use of the call light, instruct on safety measures and assess for causal factors; such as orthostatic blood pressure, urge to void, medications and ambulatory gait. A Fall care plan with a start date of (MONTH) 2, 2019 included the resident was a fall risk. A goal was for the resident to maintain current level of mobility, with minimal risk of injury. Interventions were to assist resident to a standing position, keep bed in low position with brakes locked, instruct/encourage safety measures to prevent falls and injury and for staff to perform frequent monitoring and observation to determine safety and prevent falls. A physician progress notes [REDACTED]. Per the note, the resident needed assistance with ADLs (activities of daily living) and needed a CNA (certified nursing assistant) to get him up and out of bed. A progress note written by case management as a late entry dated (MONTH) 24, 2019, revealed it was reported that the resident had a fall from the wheelchair and had an ice pack to his forehead. Review of the fall incident report dated (MONTH) 24, 2019 revealed the resident had a fall from a wheelchair and had an ice pack on his forehead. The incident report did not include what type of injury the resident sustained [REDACTED]. Further review of the fall incident report revealed there were areas to document if the resident exhibited or complained of pain, the resident's level of consciousness, pupil size and response, speech, mental status, upper and lower extremity movement/grasps, vital signs, possible contributing factors, interventions implemented, notifications made and physician orders. However, none of these areas were addressed on the incident report. Despite documentation the resident fell , there was no evidence that the facility had thoroughly investigated the fall and determined any possible causes of the fall. There was also no evidence of any additional interventions which were implemented after this fall, in order to prevent further falls. In addition, there was no clinical record documentation regarding the type of injury that the resident sustained [REDACTED]. A nursing note dated (MONTH) 15, 2019 at 8:20 a.m., included the resident was lying on the floor in his room, with his wheelchair behind him. The note included the resident had a laceration on the top of his head and that interim wound care was provided. Resident #166 was assisted back to his wheelchair and was on neuro check monitoring. The physician was notified and an order was obtained to monitor for any change. Another nursing note dated (MONTH) 15, 2019 at 9:45 a.m. included the resident was lethargic and was bleeding from the laceration, even when pressure was applied. The physician was notified and orders obtained for the resident to be transferred to the hospital. A physician's orders [REDACTED]. Review of the fall incident report dated (MONTH) 15, 2019 included the resident had an unwitnessed fall in their room and sustained a laceration to the top of the head. The resident exhibited confusion of new onset. Interventions included first aid and direct pressure to the wound. Per the report, these interventions were somewhat effective and the injury was not resolved. According to the hospital emergency room records dated (MONTH) 15, 2019, the resident presented with fall forward out of wheelchair and sustained a [MEDICAL CONDITION] from hitting head on dresser. The resident had a stellate laceration overlying the top of the head. CT (Computed [NAME]ography) of the head as well as the cervical spine was done and revealed evidence of C1 (Cervical-1) ring fracture. A nursing note dated (MONTH) 18, 2019 included the resident was admitted to the ICU (intensive care unit). The resident had a C1 cervical fracture right sided ring break and was on spinal precautions, and was on a ventilator. It also included the resident was not arousable, with fair movement in the upper extremities. An interview was conducted on (MONTH) 17, 2019 at 10:18 a.m. with the CNA (staff #85), who was caring for the resident on (MONTH) 15, 2019. Staff #85 stated she was working the morning shift on (MONTH) 15, 2019 and was assigned to the resident that day. She said when she came on shift, another CNA asked her to go to the resident's room. She said when she entered the room, she saw the resident on his knees with his head on the floor and he was bleeding from his head. She said there was a pool of blood on the floor. She said the resident was confused, could not tell if he was in pain and he could not say what happened. She stated the resident was already changed for the day, as the night shift had gotten him up early and then left the resident in the wheelchair by himself. She stated the nurses and the CNA's know that the resident cannot be left by himself, because he was confused and always wanted to get up from his chair. She said the position of the resident when she saw him was as if he had tried to get up from his chair on his own. Staff #85 continued to state that she could not remember the name of the nurse on duty (on (MONTH) 15), but that nurse instructed her and another CNA to lay the resident in bed and do 15 minute checks. She stated that every time she went to check the resident, his wound would not stopped bleeding. She said that she told the nurse the resident needed to be transferred to the hospital, but the nurse did not think so. She said later that morning, the nurse called the supervisor who instructed her to send the resident to the hospital. Staff #85 further stated the resident should not have been left alone in his wheelchair. During an interview with a licensed practical nurse (LPN/staff #48) conducted on (MONTH) 17, 2019 at 12:46 p.m., she stated residents are assessed for fall risk on every interaction made with the resident such as medication administration and after every fall. She stated that she instructs the CNA's to report any changes in the residents, when providing care. Staff #48 said if a resident is assessed to be at risk for falls, she will instruct the CNA to check on the resident more frequently. She stated after each fall, a head to toe assessment is done to check for injuries and the physician and family

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 -** Actual harm **Residents Affected -** Few	(continued... from page 1) will be notified. She stated if the fall is unwitnessed, neuro checks will be initiated immediately. She said if a resident has an unknown injury, she will conduct an investigation and ask the CNA's to figure out what might have happened. She said that she will also document in the progress notes what she saw or the details of the fall. She further stated that if the resident has fallen in the past, the care plan should be updated to ensure new interventions were put into place to prevent the resident from falling again. She stated resident's safety is a priority, so she will talk with other staff about how the fall happened, what the resident was doing and new ways to prevent the resident from falling again. She stated everything will be documented in the clinical record. In an interview with a CNA (staff #28) conducted on (MONTH) 17, 2019 at 1:49 p.m., she stated that every time a resident has a fall whether it is witnessed or not and whether or not there is an injury, she notify's the nurse who will then conduct an assessment and call the physician. She stated that after each fall, the CNA's will conduct 15 minute checks and document it in separate paper documentation. She said when a resident is identified as high risk for falls and is sitting in the wheelchair, the resident will be placed close to the nurse's station so anyone can see and intervene immediately if needed.An interview was conducted on (MONTH) 18, 2019 at 10:08 a.m. with the LPN (staff #63), who was the nurse on duty at the time of the resident's fall on (MONTH) 15, 2019. Staff #63 stated that on (MONTH) 15, she entered the resident's room to obtain a blood sugar reading from the roommate, when she saw resident #166 on the floor with blood. She conducted a head to toe assessment and found a laceration on the top of his head. She stated the resident did not complain of any pain and could not tell her what happened. She stated there were two other residents in the room, but they were both confused and could not say what happened. She stated that 2 hours after the incident, the resident's wound continued to bleed and the physician ordered for him to be transferred to the ER (emergency room). She said that she reported the incident to the DON (staff #55). An interview was conducted on (MONTH) 19, 2019 at 9:54 a.m. with the case manager (registered nurse/staff #83), who wrote the note regarding the fall on (MONTH) 24. Staff #83 stated that when she receives reports of fall incidents whether observed or unwitnessed, she will conduct a head to toe assessment and initiate neuro checks every 15 minutes. She stated that she will ensure that any injuries sustained from the fall are identified and documented. She said she will use nursing judgment to determine whether it is safe to transfer or move the resident from the floor to the bed or chair; and will call the physician. She said that she will conduct an investigation to figure out the events that led to the fall, which include information such as location of the fall, what the resident was doing prior to the fall, what were the factors that precipitated the fall and she will talk to staff who might have witnessed the fall. She said if the fall occurred in a room with other residents, she will ask the residents what happened, even if they have cognitive issues. She stated that she will document her assessments and findings on the Fall Observation Form. She said based on the findings, new interventions/measures will be put in place to prevent another fall. She said that all reports of falls even if it's a resident who has a history of making up stories, will be treated as true and that the nurses are to assess, investigate and document the incident in the clinical record. Immediately following the interview, the fall incident report dated (MONTH) 24, 2019 and the resident's clinical record was reviewed with staff #83. She confirmed there was a lack of details regarding this fall and a lack of new interventions after the fall. She said that day she saw the resident sitting in his wheelchair with an ice pack on his head. She said a CNA told her that the resident had a fall earlier in the day. She further stated that she did not conduct an assessment of the resident at that time and did not know what type of injury the resident had, and did not recall if the details of the fall were investigated. During an interview with the Director of Nursing (DON/staff #55) conducted on (MONTH) 19, 2019 at 12:45 p.m., he stated when a resident has a fall the nurse should assess the resident, conduct every 15 minute checks, investigate the events of the fall and conduct root cause analysis of the fall incident, analyze the interventions and revised the fall interventions as needed. Regarding the fall on (MONTH) 24, 2019, staff #55 stated that he cannot say whether the resident was assessed after the fall, because he could not find any documentation about it. He stated the nurse should have completed the Fall Observation form to include what happened. He further stated because there was no documentation of the details of the fall and how it happened, the fall interventions were not revised. Regarding the fall on (MONTH) 15, 2019, staff #55 stated the CNA (staff #85) sat the resident in his wheelchair and instead of wheeling the resident to the nurse's station, staff #85 left the resident in their room. Review of the policy regarding Fall Risk Assessment revealed the nursing staff, in conjunction with the attending physician, consultant pharmacist, therapy staff and others, will seek to identify and document resident risk factors for falls. Assessment data shall be used to identify underlying medical conditions that may increase the risk of injury from falls and staff will seek to identify environmental factors that may contribute to falling, such as lighting and room layout. The policy regarding Managing Falls and Fall Risk included that Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize the complications from falling. It also included that if falling recurs despite the initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. Staff will monitor and document each resident's response to the interventions. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help staff reconsider possible causes that may not have previously been identified. -Resident #28 was admitted on [DATE] with [DIAGNOSES REDACTED]. The quarterly Minimum Data Set assessment ((MDS) dated [DATE], revealed resident #28 had severe impaired cognition. The annual MDS assessment dated [DATE] revealed the resident had short and long term memory problems and had moderate impaired cognition. The Smoking Risk assessment dated [DATE], revealed the resident carries cigarettes and lighter and the frequency of use was every few hours. The question regarding general awareness and orientation, which included the ability to understand and follow the facility safe smoking policy revealed the resident had no problem. The total smoking risk assessment indicated the resident was a safe smoker. A review of the Nursing Summary dated 9/2/19, revealed the resident was confused, was unaware and had memory problems. A review of the facility list of the residents who do not need supervision with smoking revealed resident #28 was on the list. An interview with the MDS Coordinator (MDS/staff #77) was conducted on 9/16/19 at 11:16 AM. At this time she reviewed the Smoking Risk assessment for resident #28 and stated that she just watches residents smoke to determine if they are safe. She also stated she could not confirm that resident #28 understood the facility safe smoking policy. An interview with the Director of Nursing (DON/staff #55) was conducted on 9/16/16 at 12:00 PM. He reviewed the Smoking Risk assessment for resident #28 dated 8/2/19 and stated the resident does have memory problems, but is safe to smoke. During an interview with resident #28 on 9/17/19 at 9:32 AM, the resident answered OK to all questions and did not know the date or his room number. Resident #28 was asked what he would do if something caught fire when he was smoking and the resident answered OK. The resident was also asked if he knew the facility's smoking safety rules and again he answered OK. During the interview, there were five packs of cigarettes and a lighter on his bedside table. During an observation on 9/17/19 at 10:00 AM, resident #28 was in the unsupervised smoking area of the facility and he was smoking without supervision. A review of the Interdisciplinary Team progress note dated 9/17/19 at 12:00 PM, revealed the committee determined resident #28 had increased forgetfulness and noted generalized weakness. The note further included that resident #28 was to be placed on a list of supervised smokers for the safety of this resident and others. The facility policy and procedure regarding Smoking Policy dated 8/2019, revealed Smoking is both a fire and health hazard. The purpose was to ensure resident safety and to comply with State, Federal, and Community regulations. An assessment will be completed and documented within 24 hours of admission to determine if the resident will require supervision while smoking. An independent smoking resident must be able to handle cigarettes, must not be dropping ashes on clothing and must be able to make sound judgement about smoking. If deemed necessary, resident with any deficits will be supervised by staff while smoking. Matches, lighters, and cigarettes will be kept at the nurse's station for supervised smokers.