STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **035205**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **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 0641 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**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 Minimum Data Set (MDS) assessments for three residents (#166, #22 and #28) were accurate. The deficient practice could affect continuity of care and result in data that is not accurate for quality monitoring. Findings include: -Resident #166 was admitted to the facility on (MONTH) 1, 2019 with [DIAGNOSES REDACTED]. Review of the admission MDS assessment dated (MONTH) 11, 2019 revealed the resident had no falls since admission. A case management progress note dated (MONTH) 24, 2019 revealed it was reported to the case manager the resident had a fall from his wheelchair. The note included the resident was in his wheelchair and had an ice pack to his forehead. The fall incident report dated (MONTH) 24, 2019 revealed it was reported the resident had a fall from his wheelchair and that the resident was in his wheelchair with an ice pack to his forehead. A nursing note dated (MONTH) 15, 2019 revealed the resident was found lying on the floor in his room with his wheelchair behind him with a laceration observed to the top of his head. The fall incident report dated (MONTH) 15, 2019 revealed the resident had an unwitnessed fall in his room and had a laceration to the top of his head. However, the discharge MDS assessment dated (MONTH) 15, 2019, revealed the resident only had one fall since the admission MDS assessment, and included the fall was with major injury. During an interview conducted with the MDS Coordinator (staff #77) on (MONTH) 19, 2019 at 12:39 p.m., she stated that she reviews the clinical record for events that have occurred and the nursing notes for any falls that may have occurred. She stated that she will code any fall that occurred after the last MDS assessment accordingly. After reviewing the clinical record, she stated that two falls should have been coded on the discharge MDS assessment. The RAI manual instructs to review all available sources for any fall since the last assessment. The manual also instructs to review nursing home incident reports, fall logs and the medical record and code the number of falls. -Resident #22 was admitted to the facility on (MONTH) 4, (YEAR), with [DIAGNOSES REDACTED]. Review of the care plan initiated (MONTH) 22, (YEAR) revealed the resident was incontinent of bladder and bowel. Review of the physician's orders [REDACTED]. Review of the progress notes for (MONTH) 2019 revealed the resident did not have an indwelling urinary catheter. However, the quarterly MDS assessment dated (MONTH) 16, 2019, revealed the resident had an indwelling catheter. An interview was conducted on (MONTH) 17, 2019 at 1:40 p.m., with the MDS Coordinator (staff #77). She stated she used the RAI manual as a reference to code the MDS assessment. She said she reviews the nurse aide documentation, monthly summaries, prior assessments and nursing notes to code the section for indwelling catheters. In a follow up interview with staff #77 on (MONTH) 17, 2019 at 2:34 p.m., she stated the MDS assessment should not have been coded for had an indwelling catheter. She said the resident did not have an indwelling catheter and that she made a mistake.An interview was conducted with the Director of Nursing (DON/staff #55) on (MONTH) 18, 2019 at 11:30 a.m. He stated his expectation is that the MDS assessment should be completed accurately and on time. The RAI manual instructs to examine the resident to note the presence of any urinary appliances. Review the medical record, including bladder record for documentation of current or past use of urinary appliances and code the assessment accordingly.-Resident #28 was admitted on [DATE] with [DIAGNOSES REDACTED]. The annual MDS assessment dated [DATE] revealed the resident had his natural teeth. Review of the Monthly Nursing Summary dated 9/2/19 revealed in the resident had his own teeth. However, review of the Nursing Progress Note dated 9/15/19 revealed the resident had no teeth. An interview was conducted with the DON (staff #55) on 9/18/19 at 9:24 AM. The DON stated Resident #28 has had dentures since he was admitted (July 11, (YEAR)). After reviewing the Monthly Nursing Summary dated 9/2/19, the DON stated the oral assessment was an error. The DON stated resident #28 has dentures but does not wear them. An interview was conducted with the MDS Coordinator (staff #77) on 9/18/19 at 10:28 AM. The MDS Coordinator stated she coded the resident had his own natural teeth on the annual MDS assessment dated [DATE]. After examining resident #28's mouth, staff #77 stated resident #28 does not have any teeth and acknowledged the annual MDS assessment dated [DATE] was incorrect.The RAI manual dated (MONTH) (YEAR) instructs Conduct exam of the resident's lips and oral cavity, Check L0200B, no natural teeth if resident is edentulous. The RAI manual also included that it is required the assessment accurately reflects the resident's status and that the importance of accurately completing and submitting the MDS assessment cannot be over emphasized.
F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy, the facility failed to ensure that a care plan for dental was developed for one resident (#28) and a care plan for hospice was developed for one resident (#63). The deficient practice could result in care issues not being addressed in resident's plan of care. Findings include: -Resident #28 was admitted on [DATE] with [DIAGNOSES REDACTED]. The quarterly Minimum Data Set assessment ((MDS) dated [DATE], revealed resident #28 had his own teeth. The annual MDS assessment dated [DATE] revealed the resident had short and long term memory problems and had moderate impaired cognition. Also, dental status was documented as having his own natural teeth. A review of the Nursing Summary dated 9/2/19, revealed the resident was confused, had memory problems, was unaware, and had his own teeth. However, review of the nursing progress note dated 9/15/19 revealed the resident had missing teeth. Review of the resident's care plan revealed that no care plans had been developed to address the issue of missing teeth. During an interview with a Certified Nursing Assistant (CNA/staff #28) on 9/18/19 at 12:30 PM, staff #28 stated the resident has no teeth. During an interview with staff #77on 9/18/19 at 2:05 PM, she confirmed there were no care plans with interventions for dental for resident #28 and there should be. A review of the facility policy for Using the Care Plan dated 4/2018 revealed a statement that the care plan shall be used

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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 0656

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Few

(continued... from page 1)
in developing the residents care routines and will be available to staff personnel who have responsibility for providing care or services to the resident. The policy included the Supervising Nurse uses the care plan to complete the CNAs daily/weekly assignment and flow sheets. CNAs are responsible for reporting to the Nursing Supervisor any change in the resident's condition and care plan goals and objectives that have not been met or expected outcomes that have not been achieved, and Changes in the resident's condition must be reported to the MDS Coordinator so that a review of the resident's assessment and care plan can be made.
-Resident #63 was readmitted to the facility on (MONTH) 13, 2019, with [DIAGNOSES REDACTED].
Review of the clinical record revealed a physician order dated (MONTH) 15, 2019 for hospice to evaluate and treat.
A progress note dated (MONTH) 23, 2019 revealed the resident was admitted to hospice services.
However, review of the clinical record revealed no evidence a care plan was developed regarding the resident receiving hospice services.
An interview was conducted with a Registered Nurse (RN/staff #10) on (MONTH) 19, 2019 at 8:51 AM. The RN stated the face sheet will identify if a resident is receiving hospice services. She stated that she does not check the care plan to see if a resident is receiving hospice services. The RN stated that they have open communication with hospice.
An interview was conducted with the Director of Nursing (DON/staff #55) on (MONTH) 19, 2019 at 9:33 AM. The DON stated the care plan is not reviewed to identify if a resident is receiving hospice services. He stated that the staff work together with hospice and keep the lines of communication open.
The facility's policy titled Using the Care Plan dated (MONTH) (YEAR), revealed the care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident. The Nurse Supervisor uses the care plan to complete the Certified Nursing Assistants daily/weekly assignment sheets and/or flow sheets.
The facility's policy titled Care plan, Comprehensive Person-Centered revised (MONTH) (YEAR), revealed a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The policy included the comprehensive person-centered care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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 interviews, and policy review, the facility failed to ensure the care plan was revised to include new interventions following a fall for one resident (#166). The deficient practice could result in care plans not being revised with new interventions following a fall.
Findings include:
Resident #166 was admitted to the facility on (MONTH) 1, 2019, with [DIAGNOSES REDACTED].
Review of the clinical record revealed a care plan initiated (MONTH) 2, 2019 that the resident was a fall risk. The goal was that the resident will maintain current level of mobility with minimal risk of injury. Interventions included assisting the resident in assuming a standing position slowly, keeping the bed in low position with the brakes locked, instructing/encouraging safety measures to prevent falls and injury, and performing frequent monitoring and observation to determine safety and prevent falls.
A case management progress note dated (MONTH) 24, 2019 revealed that it was reported the resident had a fall from his wheelchair. The note included the resident was in his wheelchair having his vital signs taken with an ice pack to his forehead.
Review of the Event Report form regarding the fall dated (MONTH) 24, 2019 revealed the resident had a fall from his wheelchair. The report contained no other information about the fall such as the location of the fall, what injury was sustained, whether it was witnessed, contributing factors, etc. The report section for interventions - immediate measures taken and outcome of interventions revealed no documentation. The report included the care plan was updated, pain is resolved, and injury is resolved/healing without complications.
However, review of the care plan revealed the care plan was not revised to reflect the resident had a fall on (MONTH) 24, 2019 and did not include additional interventions or measures were implemented to possibly prevent further falls.
During an interview conducted with a Licensed Practical Nurse (LPN/staff #48) on (MONTH) 17, 2019 at 12:46 p.m., the LPN stated that if a resident has a fall, the care plan is updated to include new interventions to prevent the resident from falling again. She stated the resident's safety is a priority. The LPN stated that she will interview staff regarding the circumstances of the fall and new interventions to implement to prevent the resident from falling again and document it in the clinical record.
An interview was conducted on (MONTH) 19, 2019 at 9:54 a.m. with the Registered Nurse/case manager (RN/staff # 83) who wrote the note regarding the fall on (MONTH) 24, 2019. Staff #83 stated that when a resident has had a fall, she will conduct an investigation which includes information such as the location of the fall, what the resident was doing prior to the fall, what the factors were that precipitated the fall, etc. She stated she will document her findings in the Fall Observation Form and that based on the findings, new interventions/measures will be implemented to prevent another fall.
During an interview conducted with the Director of Nursing (DON/staff #55) on (MONTH) 19, 2019 at 12:45 p.m., he stated that when a resident falls, the nurse will conduct an investigation of the fall, conduct a root cause analysis of the fall incident, analyze the interventions and revised or update the fall interventions on the care plan as needed. The DON also stated that the fall interventions on the care plan were not revised for resident #166.
The facility's policy titled Care Plan, Comprehensive Person-Centered revised (MONTH) (YEAR), revealed assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.
The facility's policy titled Using the Care Plan dated (MONTH) (YEAR) revealed nurses and the Minimum Data Set Coordinator are responsible for updating the care plan.

F 0677

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide care and assistance to perform activities of daily living for any resident who is unable.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on clinical record review, facility documentation, resident and staff interviews, and policy review, the facility failed to ensure one sampled resident (#36) received an adequate number of showers. The deficient practice could result in hygiene needs not being met.
Findings include:
Resident #36 was admitted to the facility on (MONTH) 18, (YEAR), with [DIAGNOSES REDACTED].
Review of the care plan dated (MONTH) 1, 2019, revealed the resident had a self-care deficit related to bathing. The goal was that the resident will bathe with the assistance of staff. Interventions included assisting the resident with scheduled shower/bath.
The quarterly Minimum Data Set assessment (MDS) dated (MONTH) 30, 2019, revealed a Brief Interview for Mental Status score of 15, which indicated the resident had intact cognition. The assessment also included the resident required the assistance of one person for bathing and extensive assistance of one person for personal hygiene.
Review of the facility's shower schedule revealed the resident was scheduled for showers every Monday and Thursday on the p.m. shift and to document it in the electronic record.
Review of the activities of daily living (ADLs) documentation for bathing revealed the resident received one complete bed bath or shower on (MONTH) 11, 2019 for the month of (MONTH) 2019.
For (MONTH) 2019, the ADLs for bathing documentation revealed the resident received complete bed bath or shower on (MONTH) 13, 15 and 26, 2019.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) Review of the documentation for ADLs under bathing for (MONTH) 2019, revealed the resident received complete bed bath or shower on (MONTH) 12 and 16. During an interview conducted with the resident #36 on (MONTH) 16, 2019 at 8:38 a.m., the resident stated that he that for the past 4 weeks, he was not provided showers or bed baths. The resident stated that showers are mostly missed. An interview was conducted with a Certified Nursing Assistant (CNA/ staff #22) on (MONTH) 17, 2019 at 9:16 a.m. She stated all residents are scheduled to have a shower at least two times a week. The CNA stated that if a resident refuses a shower, they document the refusal in the electronic record and report the refusal to the nurse. The CNA stated if the shower is provided, it is documented in the electronic record and includes the type of assistance provided. An interview was conducted with a CNA (staff #24) on (MONTH) 17, 2019 at 9:53 a.m. She stated that if a resident is given a shower, it is documented in the electronic record under bathing and a skin sheet is filled out and given to the nurse. The CNA stated that if the resident refuses the shower, the refusal is documented in the electronic record. An interview was conducted on (MONTH) 17, 2019 at 11:15 a.m. with a Registered Nurse (RN/staff #10). The RN stated that there is communication between her and the CNAs regarding scheduled showers for the day. The RN stated that if a resident refuses a shower, the CNA will document the refusal and notify her. She stated that on shower days, the CNAs are supposed give a complete bed bath or a shower unless the resident refuses. An interview was conducted on (MONTH) 17, 2019 at 2:59 p.m. with the Director of Nursing (DON/staff #55). He stated the residents are scheduled for showers twice a week. He stated it is their policy is to give showers at least once a week to a resident. The DON stated that if a resident refuses a shower, the expectation is that the CNA will notify the nurse who will talk to the resident. He stated that if the resident still refuses, the resident will be offered the shower later in the shift. The DON stated the CNAs are supposed to document showers or refusal of showers in the electronic record. The DON stated that resident #36 has a tendency to postpone his showers. He stated the resident will tell the staff that he will take a shower in a few hours multiple times. The DON also stated that the staff will notify the staff on the next shift that the resident wants to take a shower later. He stated the next shift either forgets to provide the shower or does not provide shower and does not document about the shower. Review of the facility's policy titled Residents Showers revised (MONTH) 2019, revealed the purpose of showers is to maintain skin integrity and ensure comfort for the residents. The policy included a shower is an important aspect of caring and is part of skincare. Residents have a right to be showered if they are not able to perform that activity on their own, staff must provide those residents with assistance. Some residents may refuse to shower, it is their right. Staff must report all refusals to the nurse on duty. Showers must be recorded in the electronic record. The policy also included showers are to be scheduled twice a week per resident to ensure the resident receives at least one shower.
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

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) 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 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.

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NAME OF PROVIDER OF SUPPLIER **SUNCREST HEALTHCARE CENTER**		STREET ADDRESS, CITY, STATE, ZIP **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	(continued... from page 4) 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.
F 0825 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide or get specialized rehabilitative services as required for a resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, resident and staff interviews, and policy review, the facility failed to ensure 3 of 3 sampled residents (#21, #36 and #51) received specialized rehabilitation services as ordered. The deficient practice could result in resident experiencing decline in activities of daily living and range of motion. Findings include: -Resident #21 was admitted to the facility on (MONTH) 4, (YEAR), with [DIAGNOSES REDACTED]. Review of a care plan revealed that resident has a problem with activities of daily living (ADL) function, with a goal to maintain an optimum level of ADL function/performance. An intervention was to follow restorative nursing; physical therapy (PT); and occupational therapy (OT) recommendations as indicated. A physician's orders [REDACTED]. Special Instructions: When approved by insurance. Review of the Physical Therapy Evaluation and Plan of treatment for [REDACTED]. Under reasons for therapy, it included the resident requires skilled PT services to increase strength, increase range of motion, minimize falls, improve dynamic balance, facilitate independence with all functional mobility and facilitate wound healing. However, there was no clinical record documentation that physical therapy was provided to the resident as ordered. A Minimum Data Set annual (MDS) assessment dated (MONTH) 16, 2019, revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS also included the resident was admitted with bilateral limitations to both upper and lower extremities. An interview was conducted with a physical therapist (staff #12) on (MONTH) 19, 2019 at 11:11 p.m. She stated that she did the PT eval for this resident and thought the resident would benefit from a skilled therapy. She said it was discussed with the case manager who was going to work on obtaining prior authorization. An interview was conducted with the case manager (staff #83) on (MONTH) 19, 2019. Staff #83 stated the order for a PT/OT eval was written on (MONTH) 19, 2019, and that she had faxed a request for authorization on (MONTH) 10 and (MONTH) 17, 2019, to the insurance, but she did not have any transmission confirmation of the fax. She stated that she did not follow up with the insurance to make sure that they received the fax both times, and find out what the status of the authorization was. She stated that she just assumed that they got it. She also stated that she should get better with her documentation on the follow up with the insurance. During an interview conducted on (MONTH) 19, 2019, at 12:21 p.m., with the Director of Nursing(DON/staff #55), he said if the doctor orders a therapy evaluation then the expectation is that it is done. He stated when an order is written for a PT evaluation, they give the order to the therapist then the case manager obtains the authorization. He said if it takes to long, then they notify the physician, and they may discontinue the order for PT or will continue waiting. -Resident #36 was admitted to the facility on (MONTH) 18, (YEAR), with [DIAGNOSES REDACTED]. A care plan revised on (MONTH) 12, 2019, revealed the resident has a problem with ADL function. The goal was to maintain an optimum level of ADL function/performance to prevent contractures and maintain independence. Interventions were to follow restorative nursing and physical (PT) and occupational therapy (OT) recommendations as indicated, and to review Restorative Nursing documentation. The quarterly MDS assessment dated (MONTH) 30, 2019 revealed a BIMS score of 15, which indicated the resident had intact cognition. The MDS also included the resident had functional limitation in range of motion on both sides of upper extremities. Review of the physician progress notes [REDACTED]. A physician's orders [REDACTED]. However, review of the clinical record revealed there was no documentation that the PT/OT evaluations were completed as ordered. During an interview with the Director of the Rehab (staff#37) on (MONTH) 17, 2019 at 1:27 p.m., staff #37 stated that when he received the order for PT/OT to eval and treat for resident #36, he talked to the resident. He stated when he talked to the resident his leg was on a pillow and the whole pillow was saturated with fluid. He said the resident's wound was so bad that he was not appropriate for therapy at that time. Staff #37 stated that he held therapy for this resident due to wounds, but he did not know if the physician knew that therapy was withheld. He further stated that once they get the approval from the insurance, they do the evaluation and since they never received the authorization from the insurance and the resident has a wound, they were waiting for the wound to heal, so they did not do a therapy evaluation or start therapy. He said the case manager (staff #83) was working on obtaining the insurance authorization. The facility was unable to provide any documentation as to why the therapy evaluations/treatment were not completed as ordered or documentation the physician was notified that therapy was held. During an interview conducted on (MONTH) 17, 2019 with staff #83 at 1:53 p.m., she stated that when there is a therapy referral, therapy gives the order to her so they get prior authorization. She said that she remembers they were working on it and that the referral was previously submitted and they were waiting on authorization. She said that she assumed the evaluations were not done because of insurance authorization. She further stated that the facility just submitted the insurance authorization request and the resident will be evaluated as soon as authorization is received, and that there was never an issue with the insurance. The facility was unable to provide any documentation that a request for prior authorization for PT/OT had been submitted at the time of the order and was unable to provide documentation of any follow up that was done. During an interview conducted on (MONTH) 19, 2019 at 12:21 p.m. with the Director of Nursing(DON/staff #55), he stated that if the doctor orders a therapy evaluation then the expectation is that they are supposed to make sure it is done. He stated that when an order is written for a therapy evaluation they give the order to the therapist, then the case manager obtains the authorization. He said if it takes to long, then they notify the physician and may discontinue the order or will continue waiting for authorization. -Resident #51 was admitted on (MONTH) 6, (YEAR) with [DIAGNOSES REDACTED]. A written care plan initiated on (MONTH) 19, (YEAR) for potential skin break down had interventions that included to encourage repositioning in the bed and wheelchair, encourage increased mobility and ambulation as able, monitor for potential pressure injuries related to medical devices (including orthopedic braces), and to observe during routine care frequently for proper fit of footwear and clothing to prevent skin injury related to pressure and binding. A physical therapy evaluation dated (MONTH) 31, (YEAR) included that the resident would like to use his prosthetic limb (leg) and work on ambulation, and use his leg for getting in and out of bed. The evaluation included that the resident wanted to be more independent, and that he demonstrated good rehab potential, was able to follow multi-step directions, make his needs known and he was motivated. The evaluation included that the resident's gait was unable to be tested , because he was unable to stand and wear his prosthetic with a comment that read Will work on having prosthetic adjusted for proper fit. Review of physical therapy treatment records for (MONTH) and (MONTH) (YEAR) revealed the following therapy notes: -September 24: The resident's prosthetic leg did not fit. -October 10: The resident's prosthetic right leg was significantly longer than the left leg, and when the resident bent the prosthetic leg it pushed into his skin. The resident did not know where he had obtained the prosthetic leg, and it may have

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

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F 0825 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 5) been someone else's prosthetic leg. -October 12: Staff had contacted the resident's health plan and were unable to determine where the resident had obtained the prosthetic right leg, and the leg appeared to have been intended for a taller person. -October 23: Waiting for equipment, including a stump shrinker from the resident's medical equipment provider. -October 25: The facility had attempted to obtain a stump shrinker and a prosthetic leg for the resident, and that the medical equipment provider had failed to show up. -October 29: The resident was discontinued from therapy and referred to restorative nursing. Further review of the clinical record revealed there was no additional documentation that the facility had made any attempts to follow up regarding the prosthetic right leg from (MONTH) 30, (YEAR) through (MONTH) 25, 2019. A physician's orders [REDACTED]. A MDS (Minimum Data Set) assessment dated (MONTH) 19, 2019 included a BIMS (Brief Interview for Mental Status) score of 15, which indicated the resident was cognitively intact. The MDS included the resident used a wheelchair for mobility, and the use of a limb prosthesis was not documented on the assessment. Continued review of clinical record revealed no documentation that resident #51 was provided a physical therapy evaluation as ordered from (MONTH) 26, 2019 through (MONTH) 19, 2019. An interview was conducted on (MONTH) 19, 2019 at 11:30 a.m. with a Physical Therapist(staff #37). The therapist stated the resident did have a therapy evaluation ordered on (MONTH) 26, 2019, but the resident never received the evaluation. The therapist stated they may still be waiting for the insurance company to authorize the treatment. The therapist stated that this resident had a prosthetic leg which didn't fit, and had been evaluated by a medical supply vendor for another leg, but the insurance would not authorize payment for a new prosthetic leg, until the resident had enough strength in his legs to be able to stand up. The therapist stated even though the physician's orders [REDACTED]. The therapist stated that therapy services cannot be provided until authorization for payment is received. He said that he did not know if authorization for payment had ever been received. An interview was conducted on (MONTH) 19, 2019 at 11:45 a.m. with a Case Manager (staff #83). Staff #83 stated that she had applied for prior authorization for physical therapy treatment for [REDACTED]. Staff #83 stated that she dropped the ball. An interview was conducted on (MONTH) 19, 2019 at 12:21 p.m., with the Director of Nursing (staff #55). Staff #55 said that when an order is written for a physical therapy evaluation, the order is given to the therapist and then the case manager obtains the authorization. Staff #55 stated that if it takes too long to obtain the authorization, then they notify the physician and obtain orders to discontinue the order for therapy, or continue waiting for authorization. He stated that he did not know if there had been any additional follow up attempts to obtain authorization. During an interview conducted on (MONTH) 19, 2019 at 12:28 p.m. with resident #51, he stated that he does want to be able to stand up, and that he has been waiting for therapy for a long time. The resident stated that his prosthetic leg doesn't fit and that he cannot get a new prosthetic leg, until he can stand up. The resident stated that because he has not received therapy to strengthen his legs, he obtained dumbbells and does his own therapy in his room for his leg, which he designed himself and without staff assistance or supervision. Review of a policy titled, Requests for Therapy Services revealed that therapy services must be ordered by the resident's attending physician. A physician's orders [REDACTED].
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 personnel record review, staff interviews, and policy review, the facility failed to ensure that one staff member (#35) had current evidence of freedom from infectious [MEDICAL CONDITION] (TB). The deficient practice could result in increased risk of residents being exposed to infectious TB. Findings include: Review of the personnel record for staff #35 (Certified Nursing Assistant) revealed a hire date of (MONTH) 6, 2019, for full time employment. A form titled Annual Questionnaire/Reactive Skin Test which was from another facility revealed that staff #35 had a reactive TB skin test in (YEAR), had not experienced any symptoms of TB for more than three weeks at a time since the last skin test and had not been exposed to a known case of TB since the last TB test. The form was signed by a registered nurse on (MONTH) 3, (YEAR), however the form was not signed by a medical practitioner. Further review of the personnel record revealed a form titled Communicable Disease Prevention Program Annual TB Assessment revealed the last TB chest x-ray for staff #35 was in (YEAR). The form also incuded that staff #35 had not been exposed to a known case of TB or experienced any symptoms of TB since his last TB screening. This form was signed by staff #35 on (MONTH) 5, 2019, however, it was not signed by a medical practitioner. In addition, the personnel record had no evidence of the results of the chest x-ray done in (YEAR), nor any other x-ray results after that date. An interview was conducted with the Administrator (staff #53) on (MONTH) 17, 2019 at 11:11 a.m. He stated his expectation is that all staff are tested for TB, prior to starting employment. He stated that acceptable TB testing upon hire would include a skin test or a chest x-ray that was negative for TB. He said staff members must be tested annually for TB, and staff who provide a negative chest x-ray upon hire could submit a negative TB symptoms questionnaire every 11 months. He stated that normally he interviewed each staff member before they were hired, and then immediately would request the new hire complete TB testing. He said that he did not personally interview staff #35, so he did not have a chance to ensure the new hire had appropriate TB testing. He said that staff #35 had already worked more than one shift for training in a direct care position. Review of the facility's TB policy revealed that new employees were required to have a TB skin test or proof of a clear chest x-ray prior to starting work. After hire, employees were required to have one TB skin test, symptoms assessment, or chest x-ray on an eleven month period. New hires would not be scheduled to work until after the testing results were received. Any employee who was required to have a chest x-ray because of a positive TB skin test could have the x-ray performed at the facility, and an annual questionnaire would be required thereafter. The annual questionnaire would be signed by a facility doctor to ensure compliance.