

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035272	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2024
NAME OF PROVIDER OR SUPPLIER VI at Grayhawk, A VI and Plaza Companies Community		STREET ADDRESS, CITY, STATE, ZIP CODE 7501 East Thompson Peak Parkway Scottsdale, AZ 85255	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, facility documentation and policy review, the facility failed to ensure resident safety was provided in accordance with professional standards of practice regarding the use of a gait belt during transfer of one resident #23. The deficient practice could result in further injury of residents based on their physical needs.</p> <p>Findings Include:</p> <p>Resident #23 was admitted on [DATE] with diagnosis including displaced intertrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing, adult failure to thrive, anxiety disorder, unspecified, muscle weakness (generalized), difficulty in walking, not elsewhere classified.</p> <p>The MDS (minimum data set) assessment dated [DATE] revealed a BIMS (brief interview for mental status) score of 15, suggesting intact cognitive abilities, no indicators for mood or behaviors were identified. Further review of the MDS identified substantial to maximal assistance for toileting, partial to moderate assistance rolling left to right, sit to lying, bed to chair to bed transfers and lying to sitting on side of the bed.</p> <p>A review of the physician's orders dated April 2, 2024 included an order for use of siderails as enablers for assistance with transfers, bed mobility and aid in positioning related to diagnosis of weakness related to femur fracture.</p> <p>Review of the care plan-initiated on August 5, 2024 included that resident #23 had a right femur fracture this year that still caused her some discomfort and she has chronic pain and was at risk for fall due to debility from recent illness, new surroundings, advancing age with comorbidities, polypharmacy, poor balance, impaired gait, and weakness. Interventions included to handle gently and try to eliminate any environmental stimuli, position for comfort with physical support as necessary and staff to cares in pairs whenever possible.</p> <p>A review of the physician progress notes dated August 12, 2024 revealed that the resident #23 felt tired that day and was visited by her son. The note further stated that per the staff and son, there had been issues with the resident's care by CNA (Certified Nursing Assistant). The note stated that was being further evaluated by the team, supportive measures were being provided, escalation of opiate dosing was offered and the resident stated she will discuss further with her son.</p> <p>(continued on next page)</p>		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The social services progress note revealed resident #23's son informed social services of a claim presented to him by his mother's caregiver that the facility's nurse's aide was rough when helping his mother back to bed on 8/11/24 and his mother referred to the aide as aggressive.</p> <p>An interview was conducted on July 21, 2023 at 1:33 p.m. with resident # 23 who stated CNA (Staff #198) had assisted her to the bathroom and to bed. Resident stated while transferring her to bed Staff#198 caused her pain in both her upper legs and to her right hip. The resident stated staff #198 had placed her wheelchair by the side of her bed and had the resident place her arms around her waist lifting her and sitting her on the side of the bed. The resident stated when the staff then raised both her legs and swung her into the bed real fast and abrupt. The resident stated the move caused her pain in both her legs and hip and caused her to fall backwards on the bed. Resident #23 stated she did not know staff#198 was going to swing her legs on to the bed without warning. The resident denied being grabbed by the wrist at any time, but did state no gait belt was used with either transfer to the bathroom or while placing in bed.</p> <p>An interview was conducted with the CNA (Staff #198) on August 20, 2024 at 12:45 p.m. Staff #198 stated she has been employed with the facility for three years and stated she had received abuse training approximately one year ago. Staff #198 stated she worked the night shift on August 11, 2024 and was assigned to resident #23. She stated the resident had her call light on and went to her room to assist her to the bathroom. She stated the resident's personal caregiver was in the room with the resident and went into the bathroom while assisting the resident to the toilet. She stated the resident pulled herself up to the side rails and she assisted with pulling down her brief. Staff #198 stated when the resident was done, she changed her brief and assisted her with incontinence care.</p> <p>She said she then had the resident sit back in the wheelchair and parked it beside her bed. She stated she had the resident place her arms around her waist, because she did not have a gait belt with her. She said she stood the resident and had her sit on the side of the bed. She stated the resident was taller and heavier than her and found it difficult. She stated she lifted both of the resident's legs into the bed. She again stated she struggled because she found the residents legs to be heavy. She stated she was unable to support the resident's back when placing the resident's legs in the bed, because she is shorter than the resident. Staff # 198 stated she did not ask for help with transferring the resident because we were short staffed. She stated she then placed pillows under the resident's legs and the resident was able to position her upper body herself with no complaints of pain from the resident following the transfer.</p> <p>An interview was conducted on August 20, 2024 at 1:44 p.m. with the Director of Nursing (DON/staff #87). Staff #87 stated it is her expectation that for proper transferring, staff always use a gait belt for safety, and follow therapy recommendations. Staff #87 stated she is aware that resident #23 is care planned for safety and impulsivity due to what appears to be sundowning and has a personal caregiver from 7pm to 7am daily.</p> <p>Review of the facility policy revised October 2017 titled Gait Belts states This policy defines when gait belts are used in the care of residents in the licensed care venue. A gait belt is used to facilitate safety in transferrin or ambulating residents who have difficulty with mobility, unless its use is contraindicated.</p>		