STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035068	A. Building B. Wing	01/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pueblo Springs Rehabilitation Center	5545 East Lee Street Tucson, AZ 85712

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42319 Based on clinical record review, staff interviews, facility documents and facility policy, the facility failed to ensure that a physician was informed of changes in condition for one resident (#4). The deficient practice could result in other residents' physicians and responsible parties not being notified and conditions worsening. Findings include: Resident #4 was admitted on [DATE] with diagnoses of end stage renal disease and dependence on renal dialysis. A 5 day scheduled Minimum Data Set (MDS) dated [DATE] included that this resident had dependence on renal dialysis. A care plan dated July 18, 2022 included needs hemodialysis related to renal failure with interventions including monitor AV shunt for bruit and thrill and to document (+) present (-) not present. This document included to notify physician if not present. A Physician's order dated June 28, 2022 included to monitor AV site for bruit and thrill and to document + for present and - for not present every shift, dialysis center to maintain shunt. A Treatment Administration Record (TAR) for November and December, 2022 included that the order for monitoring the AV site in November showed 27 incidents and in December showed 18 incidences that bruit and thrill was not present. Review of the clinical record revealed that the physician was not informed that the resident's AV site did not have bruit or thrill. Progress note dated December 28, 2022 included that the resident was sent to the hospital for low blood pressure and a clogged fistula, and that this resident returned from the hospital. These notes include that the resident stated that nothing was done with her dialysis access and that they may end up having to place a new one. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035068	A. Building B. Wing	01/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pueblo Springs Rehabilitation Center	5545 East Lee Street Tucson, AZ 85712

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	However, review of the clinical record revealed that the physician was not informed that the resident was transported to the hospital or of the results of the hospital visit upon the resident's return. A nursing note dated December 30, 2022 included that this resident was sent to the hospital for low blood pressure and a clogged fistula. An interview was conducted on January 13, 2023 at 3:43 PM with a Licensed Practical Nurse/Assistant Director of Nursing (LPN/staff #115) who said that dialysis sent the resident to the hospital and that she did not know if dialysis informed the physician. She reviewed the chart and said that the only note that she sees was that the resident was sent to the hospital for that shunt. She said that the provider should have been notified if there was a negative because a negative means that staff is not getting a bruit and that the provider should know if the resident is in the hospital. An interview was conducted on January 13, 2023 at 4:26 PM with the acting Director of Nursing (staff #136) who said residents on dialysis should get pre and post vital signs, monitor the sight for inspection, and that they should fill out the dialysis sheets. She said that a negative sign would mean no bruit or thrill and at that point they would want to notify the doctor. She said that it did not meet her expectations that hospital stay and records were not communicated to the physician. She said that if the resident was sent to the hospital from the dialysis, it is the responsibility of the facility to notify the physician that the resident has been sent to the hospital. A policy titled Change in condition reporting revealed that it was the policy of the facility that all changes in resident condition will be communicated to the physician.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035068	A. Building B. Wing	01/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pueblo Springs Rehabilitation Center	5545 East Lee Street Tucson, AZ 85712

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42319 Based on clinical record review, staff interviews, facility documents and policy, the facility failed to ensure that 2 residents (#32 and #78) are not abused by staff. The deficient practice could result in staff abuse of residents. Findings include: -Resident #32 was admitted to the facility on [DATE] with diagnoses of hemiplegia and hemiparesis, major depressive disorder and anxiety disorder. An Annual Minimum Data Set (MDS) dated [DATE] included that this resident had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident was cognitively intact. This document included that the resident required limited 2 person assistance for transfers and that the resident required extensive 2 person assistance for bed mobility. A care plan initiated June 6, 2021 included that the resident had an self care performance deficit related to dysphagia and left sided weakness with interventions of requiring staff participation with transfers and turning in bed. A review of the clinical record did not find any documentation regarding abuse between this resident and a staff member. A report was received by the State Agency (SA) on December 6, 2022 from the facility which included A CNA overheard another CNA yelling and cussing at a patient after the patient was yelling and cursing at her. The CNA was an outside agency CNA who is suspended from our facility as we investigate. The CNA was sent home after the incident occurred and was immediately separated from the patient. An interview was conducted on January 12, 2023 at 3:08 PM with a Certified Nursing Assistant (CNA/staff #100) who said that she had to kick staff #36 out of the room because the resident told her repeated to not to get that shoulder and then the resident and staff #36 started screaming at each other. She said that staff #36 told the resident to shut the f up. She said that she told her to get out of the room and she finished doing the transfer herself. She said that was the first time she saw staff #36 act like that and that before that she would have said #36 was a good CNA. An attempt was made to interview staff #36 on January 13, 2023 at 11:01 AM. A message was left on the voicemail. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035068	A. Building B. Wing	01/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pueblo Springs Rehabilitation Center	5545 East Lee Street Tucson, AZ 85712

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted on January 13, 2023 at 1:32 PM with resident #32 who said that staff #36 was trying to take a towel off his chest, and that she didn't realize she had a handful of his chest hair. The resident said that he asked her 2 times to stop and that she said to shut up, she'll take care of me. This resident said that he told her he'd kick her ass. He said that staff #100 was the one that wrote the incident up and that staff #100 was in the room at the time of the incident. He said that staff #100 told staff #36 to stop because she was hurting him and that she finally let go and stormed off. He said that the two staff were transferring him from the gurney to the bed after a shower. An interview was conducted on January 23, 2023 at 3:43 with an LPN/Assistant Director of Nursing (staff #115) who said that this resident had an incident with the agency CNA and that the facility asked her to leave right there and then. She said that the facility had two different stories because 1 CNA said that he cussed at her, 1 CNA said that she cussed at him. She said that the facility provided education to the staff. -Resident #78 was admitted to the facility on [DATE] with diagnoses of hemiplegia and hemiparesis, Major Depressive Disorder, and anxiety disorder. An Annual Minimum Data Set (MDS) dated [DATE] included that this resident had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident was cognitively intact. This document included that the resident required extensive 1 person assistance for bed mobility and required supervision and setup assistance for eating. A care plan dated October 26, 2021 included that the resident had a potential for mood problem related to admission abusive language towards staff with interventions that when the resident becomes aggressive/abusive to calmly talk with the resident and if the resident continues to leave him alone to calm down and attempt to re-approach at a later time. A 5 day report dated July 21, 2022 included that a CNA (staff #100) said, I saw (staff #49) bump into the table that had resident #78 food on it and some of it spilled on the table and him. Resident #78 started cussing at (staff #49), calling her a fucking bitch and to be more careful. resident #78 said a lot of other things. (staff #49) said back to him Don't you be cussing at me. I'll whoop your ass. Resident #78 responded by saying Don't you fucking swear at me. (staff #49) said that she doesn't put up with this bullshit and left the room. This document also included that another CNA (staff #58) said (staff #49) was assisting had resident #78 with his tray. had resident #78 asked for the tray to be repositioned. While she was doing that, I think had resident #78 bumped the table and spilled the food. (Staff #49) said she would get something to clean it up and the patient said fuck this. (Staff #49) told had resident #78 that she cannot speak to her like that. Patient continued to cuss at her. (Staff #49) got really upset and said Fuck this, I'm gonna whoop your ass if you keep talking to me like this. She then left the room yelling in the hallway and making a scene. I helped (staff #100) clean up. This document concluded that The leadership team at the facility has completed their investigation related to the above allegation. After interviewing multiple staff members and residents, Pueblo Springs has concluded that TNA (staff #49) was verbally aggressive towards resident #78. We do not condone this behavior by any means. We have reported this to the agency that (staff #49) works for and have taken steps to ensure that (staff #49) never returns to the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035068	A. Building B. Wing	01/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pueblo Springs Rehabilitation Center	5545 East Lee Street Tucson, AZ 85712

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted on January 13, 2023 at 4:26 PM with the acting Director of Nursing (staff #136) who said that her expectation was that abuse needs to be reported, thoroughly investigated, type up the 5 day and send in the report. She said that is was also her expectation that abuse not occur in the facility. She said that it did not meet her expectation that staff yell and curse at a patient. A policy titled Abuse: Prevention of and Prohibition Against revealed that it is the policy of this Facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This document included that the facility will provide oversight and monitoring to ensure that its staff, who are agents of the Facility, deliver care and services in a way that promotes and respects the rights of the residents to be from abuse, neglect, misappropriation of resident property, and exploitation. This document defined verbal abuse includes the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their representatives, or within their hearing distance, regardless of their age, ability to comprehend, or disability.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035068	A. Building B. Wing	01/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pueblo Springs Rehabilitation Center	5545 East Lee Street Tucson, AZ 85712

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 - Minimal harm or potential for 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** 42319 Based on clinical record review, staff interviews, and review of facility policy and procedure, the facility failed to assess and monitor and provide supervision to one resident (#17) to prevent elopement. The deficient practice could result in resident elopement, placing residents at risk for harm in the community. Findings include: Resident #17 was admitted on [DATE] with diagnoses of multiple fractures, dysphagia, schizophrenia, and bipolar disorder. An Admission Minimum Data Set (MDS) dated [DATE] included that this resident had a Brief Interview for Mental Status (BIMS) score of 7, which indicated the resident was severely cognitively impaired. This document included that the resident required extensive 2 person assistance for transfers and that the resident required supervision 1 person assistance for locomotion off unit. This document also included that this resident required care for surgical wounds and pressure wounds. Review of the care plan did not include elopement or the resident's improved mobility. A Psychiatry Progress note dated November 16, 2022 included that the resident was in a hit and run while a pedestrian and that the resident required restraints while in the hospital due to severe agitation as a result of his injuries. This note included that the resident has intermittent agitation and that he is able to transfer with assistance from bed to chair and back again. A progress note dated December 5, 2022 included that this resident said that he needs to leave, there is a staff member who is saying his gang name. This note included that the resident was repeating over and over that he had to leave and he did not want to do what his dad used to do but would not clarify what that was. This note included the staff member called the resident's mother who said that over the past few days that she had noticed a change in the resident's behavior and that she wondered if the resident was having some kind of mental change. The note revealed staff allowed the resident and his mother to speak and the staff and mother encouraged the resident to stay. This note included that behavioral health was contacted and a one time as needed medication was ordered and that an officer would be there soon to speak with the resident. However, no plan was implemented for future elopement. A progress note dated December 5, 2022 included (This resident) came into this writer's office and asked to speak to his mother on speaker with me. We called her and again both of us explained the importance of him staying at the facility, (this resident) asked his mother what she wanted him to do. She told him she would prefer he stay and continue to get the care he needs. (This resident) agreed to stay, and this writer took him back to his room. (This resident) said he was really tired and would be going to bed to get some sleep. (Behavioral health staff) told (This resident) they would come follow up with him tomorrow. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035068	A. Building B. Wing	01/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pueblo Springs Rehabilitation Center	5545 East Lee Street Tucson, AZ 85712

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 - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated December 10, 2022 included that this resident has left facility, whereabouts are unknown and that the staff had informed the resident's mother that resident is missing, and that it was his second attempt today to leave the facility. A Quality Improvement Plan/Action Plan dated December 12, 2022 included that the resident left from the facility through the window in their room and that facility leadership was unaware that he had exited through the window prior to the second time. This document included the facility will continue to provide education related to the elopement process and reportable events for new team members. An interview was conducted on January 12, 2023 at 10:59 AM with a Licensed Practical Nurse (LPN/staff #132) who said that she was there on the day he eloped. She said that but that he was fine in the morning, he was not assigned to her but she said hi in the morning, and he was acting normally. She said that his roommate came and told me and she alerted his nurse, staff #49. She said that was the first time he eloped. She said that the nurse had gotten an order and the resident was gone again. An interview was conducted on January 12, 2023 at 11:31 AM with a Registered Nurse (RN/staff #49) who was assigned the resident at the time of his elopement. This RN said that if a resident elopes that staff should tell the administrator right away, call police, and call the next of kin. She said that she did not know how the resident had gotten out of the building and that he had done it before. She said to keep residents from eloping, the doors to the building are locked and that there was usually a person at the front of the building. She said that people were saying the resident got out through the window. She said that she did not know who the resident's nurse was at the time of the elopement and then said that she did what she was supposed to do for an elopement which was call the administrator, call the police and call the family. She said that she did not remember what happened that day or if she had put any interventions in place to stop the resident from eloping other than the facility having locked doors. An interview was conducted on January 13, 2023 at 11:15 AM with a Certified Nursing Assistant (CNA/staff #84) who said that staff had told him that the resident walked out of the door once and then climbed out a window once. This CNA stated that he was told that the resident was asking for his mother. An interview was conducted on January 13, 2023 at 3:43 with an LPN/Assistant Director of Nursing (staff #115) who said that the resident was at the facility a little over a month and that initially he was not able to get out the wheelchair. She said that the staff were doing treatments on his legs. She said that he would always tell his mom he wanted to leave but she said she could not take care of him. She said that she saw him waiting by the front desk. She said that the management actually did not even know about the first attempt until the nursing staff notified me after he eloped and that they did an in-service and education. She said that the staff member was fairly new and did not know and was provided education on how to proceed when something like that happens. She said that the staff said they had closed the doors and locked the patio door because they go out there to smoke and she thinks that's why he used the window. She said the CNAs did say they were checking on him but the nursing shift was about to change over and that's when he left out of the window. This LPN said that he was found at St Mary's and that he did not have any harm. An interview was conducted on January 13, 2023 at 4:26 PM with the acting Director of Nursing (staff #136) who said that the resident had eloped and that he was at the bus stop, they were calling the provider and he left. She said that they had already done an inservice on this incident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035068	A. Building B. Wing	01/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pueblo Springs Rehabilitation Center	5545 East Lee Street Tucson, AZ 85712

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 - Minimal harm or potential for actual harm Residents Affected - Few	A policy titled Elopement revealed that is the policy of this facility to ensure that the facility provides a safe and secure atmosphere for all residents in the facility and that residents identified to be high risk for elopement will have an appropriate plan of care developed to address the risk.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035068	A. Building B. Wing	01/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pueblo Springs Rehabilitation Center	5545 East Lee Street Tucson, AZ 85712

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42319 Based on clinical record review, staff interviews, facility documents and facility policy, the facility failed to monitor one resident's (#33) dialysis access point. The deficient practice could result in complications and infections from unmonitored access points. Findings include: Resident #33 was admitted on [DATE] with diagnoses of end stage renal disease, dependence on renal dialysis and metabolic encephalopathy. An Admission Minimum Data Set (MDS) dated [DATE] included that this resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. This document included that the resident was dependence on renal dialysis. A physician's order dated November 26, 2022 included to monitor AV site for bruit and thrill and to document + for present and - for not present every shift, dialysis center to maintain shunt. A Medication Administration Record for November, 2022 through January, 2023 included the order to monitor AV site for bruit and thrill and to document + for present and - for not present every shift. However, charting November 26 through January 9 did not include a + or - to indicate whether the bruit and thrill were present, however the record was marked with an X. A review of the progress notes indicate that the resident was checked for bruit and thrill November, 2022 on the 20, 26, 27, and December, 2022 on 21, 22, 23, 28. However, the progress notes did not include that assessment on any other days. A review of the dialysis communication sheets included that the resident was assessed for bruit and thrill on December, 2022 on 5, 9. 12, 16, 19, 21. However, the progress notes did not include that assessment on any other days. An interview was conducted on January 12, 2023 at 10:59 AM with a Licensed Practical Nurse (LPN/staff #132) who said that when a resident returns from dialysis she would assess vital signs, weight, and their shunt site. She said that she usually charted when the residents leave for dialysis. She said that she a note with pre-dialysis vital signs but said that they are sometimes charted in progress notes too. She said that residents have a dialysis communication sheet that is sent along with sack lunch and that dialysis is supposed to fill it in and that it included if site is working. An interview was conducted on January 13, 2023 at 2:36 PM with an LPN (staff #132) who said that she did not know what an X is. She said that usually there is a box and you type in a yes or no, or a y or n or - or positive, or something like that but that she had never seen an x. An interview was conducted on January 13, 2023 at 3:43 PM with a Licensed Practical Nurse/Assistant Director of Nursing (LPN/staff #115) who said that an X does not have a formal meaning. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035068	A. Building B. Wing	01/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pueblo Springs Rehabilitation Center	5545 East Lee Street Tucson, AZ 85712

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on January 13, 2023 at 4:26 PM with the acting Director of Nursing (staff #136) who said residents on dialysis should get pre and post vital signs, monitor the sight for inspection, and that they should fill out the dialysis sheets. She said that a negative sign would mean no bruit or thrill and at that point they would want to notify the doctor. She said that for this resident, the nurse went in and deleted the documentation on the 26 of November, there was not monitoring unless on the sheets. I know the nurse when she took it off of the MAR TAR and she charted on the progress note but the other nurses did not. A policy titled Dialysis (Renal), Pre and Post Care revealed that it was the policy of the facility to assess and maintain patency of renal dialysis access; and assess resident daily for function related to renal dialysis. This document included that the dialysis access should be assessed upon return to the facility for patency and any unusual redness or swelling, care given, and condition of renal dialysis access and that all assessments are documented in the clinical records.