STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035072	A. Building B. Wing	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Phoenix Mountain Post Acute	13232 North Tatum Blvd Phoenix, AZ 85032

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** 47341 Based on resident, resident representative, and staff interviews and facility documentation, the facility failed to protect the resident's (#11) right to be free from sexual abuse by a staff. The deficient practice could result in residents' increase risk of further harm and abuse. Findings include: Resident #11 admitted to the facility on [DATE] and discharged on [DATE] with diagnoses that included Wernicke's encephalopathy, anxiety, post-traumatic stress disorder, migraines, major depressive disorder, and suicidal behavior. The care plan initiated on 09/25/2023 indicated she preferred a female caregiver relation to her risk of re-traumatization related to a history of intimate partner violence. On 02/01/2024, a goal was initiated for potential for a psychosocial well-being problem related to an inappropriate relationship with a non-caregiving associate as evidenced by Anxiety, depression, and suicidal ideation. Interventions included consultations with pastoral care, social services, and psychiatric services as well as monitoring and documenting residents' feelings related to posttraumatic stress disorder (PTSD) and the termination of the same inappropriate relationship. The Admission Minimum Data Set (MDS) assessment on 10/01/2023, she scored a 13 on her Brief Interview for Mental Status (BIMS) which indicated she was cognitively intact. She did not exhibit any behaviors in the look back period. The physician order dated 11/28/2023 revealed an order for trazodone (anti-depressant) 50 mg (milligrams) for inability to fall and stay asleep related to depression. Resident #1 had orders for the following psychotropic medications: Escitalopram 10 milligrams (mg) for depression dated 10/27/2023 and increased to 20mg on 11/29/2023, trazadone 50mg for inability to fall and stay asleep related to depression dated 11/28/2023 increased to 100mg on 01/22/2024 and increased to 150mg on 02/09/2024, Lorazepam 0.5mg for anxiety dated 10/03/2023. The Quarterly MDS from 12/13/2023, her BIMS was 15 which indicated no cognitive impairment. The physician order dated 1/22/2024 revealed the order for trazodone was increased from 50 mg to 100 mg for depression. (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The psychiatric note dated 02/01/2024 revealed resident #11 was assessed for trauma regarding a potentially inappropriate relationship between the resident and non-caregiving staff member. Per the documentation, the resident had also reported this to leadership that day; and that, resident #11 told the provider that all the interactions with the staff member (#20) were entirely voluntary and consensual. The plan was for resident #11 to continue her psychiatric medications as currently prescribed and he would follow up with her in 1-2 weeks. A progress note dated 02/01/2024 by the Interdisciplinary Team (IDT) documented the discussion of concerns regarding an inappropriate relationship between the resident and a non-caregiving staff member. The skin assessment completed on 02/01/2024 documented light bruising to left upper inner thigh, but indicated the resident reported that she got it from her brief. The clinical record revealed that on 02/01/2024 the provider ordered a pregnancy test and labs for sexually transmitted diseases (STD) which included herpes (virus), hepatitis (virus), HIV (human immunodeficiency virus), and chlamydia (bacteria). The clinical record also revealed an order for change of condition related to psychosocial well-being dated 02/01/2024 with the instructions to monitor for increased anxiety/depression and potential for suicidal ideation. The facility self-report with a date of discovery of 02/01/2024 revealed that on 02/01/2024, the resident reported a relationship between her and a male staff member (staff #20) to the administrator and DON (Director of nursing). Per the report the resident reported that the relationship was consensual; and that, it had involved oral sex on two occasions. It also included that the resident denied engaging in intercourse with staff #20. The report included a summary of the two interviews conducted with resident #11 by the DON. The summary included that the resident reported exchanged phone numbers with staff #20 and they would often text message back and forth; the relationship progressed into kissing and touching a few weeks after the text messages started; the resident and staff #20 had oral sex (both her for him and him for her) on two separate occasions (once in the shower and once in the resident's room) both times during the overnight shift. The summary also included that staff #20 shared that he was having financial hardships and the resident offered him help; but the resident confirmed that she never actually gave him money. The summary included that the resident reported she was not forced to engage in this conduct and there were no threats or promises were made by staff #20 to her. Continued review of the facility self-report included a summary of a phone interview conducted with staff #20 by the DON and the administrator on 02/01/2024. Per the documentation, staff #20 admitted that he exchanged telephone numbers with the resident; and that, he and the resident talked via text message. The documentation included that staff #20 denied any physical contact including but not limited to oral sex; and denied speaking with the resident regarding any financial hardships. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Further review of the facility self-report included that the facility concluded there were no patterns or instances of any other unprofessional or inappropriate relationships; and there were no staff interviewed had witnessed or were aware of any improper conduct or relationship as between staff and resident. It also included that while the facility determined that the relationship between the resident and the staff member was inappropriate and unprofessional, it did not constitute abuse as that term is defined in the State's Adult Protective Services statute. The labs results completed on 02/02/2024 revealed negative for STD. The psychiatric consultation note dated 02/08/2024 revealed Resident #11 told the provider her mood was even heavier and her anxiety had increased since her last visit; and, her sleep had been interrupted, causing her to wake several times per night and making her want to sleep more during the day. It also included that the provider increased her trazodone to address the insomnia as well as the increased depression symptoms. The psychiatric consultation note dated 02/15/2024 included that Resident #11 reported that she continued to experience feelings of sadness and was having thoughts that she would be better off gone. Another psychiatric consultation note dated 02/22/2024 revealed the resident reported that she was transferring to a different facility soon, was optimistic about the move; and that, she had a decrease in all behavioral symptoms. Review of the personnel file for staff #20 revealed that a job description dated 8/31/2023 and that staff #20 was a certified nurse assistant (CNA). Further, the telephone number on record matched the telephone number that was on resident #11's phone and text messages. It also included that staff #20 signed a job description for laundry staff on 01/05/2024. A review of punch details for October 2023 to February 2024 revealed that Staff #20 worked as a nursing assistant from 10/01/2023 through 12/25/2023; and, from 01/01/2024 through 01/31/2024, staff #20 worked as a housekeeping aide. The report submitted by the resident's family to the State Agency complaint portal on 5/13/2024 revealed that resident #11 still had times where she breaks down crying and had told the family member multiple times about the incidents of sexual abuse by an unlicensed caregiver. The report identified the staff involved by name (staff #20); and that, the resident had now frightening nightmares on what took place and had been disgusted with herself. Further, the report included that there had been attempts made by the director of nursing, her manager, and multiple staff to cover up the incident. The report also included that resident #11 battled depression, suicide, and anxiety and had become cautious about anyone who touches her; and that, staff #20 was given the choice to quit or be terminated from the facility. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	An interview with Resident #11 was conducted on 6/11/2024 at 10:55 a.m. The resident stated that the facility was going to do everything they can to cover up and make it seem like they [referring to the facility] did right by me. Throughout the interview, Resident #11, was not sure of the exact dates each event occurred and was only able to give general timeframes. She proceeded to say that her relationship with Staff #20 started around the end of October 2023 and that staff #20 was her assigned nursing assistant. She stated that Staff #20 first began to touch her during showers and brief changes; and, she began to notice that the touch changed and that he would caress her leg and she dismissed it as her imagination. She stated it escalated to rubbing her thighs to touching and rubbing her vagina; and, it was not something she and staff #20 had discussed, and she felt too vulnerable to stop him. The resident stated that Staff #20 further escalated to rubbing her breasts, kissing her, and oral sex; and, would tell her that he loved her, cared about her and that was why he was doing this. Resident #11 said that Staff #20 had stopped working with her and was transferred to laundry because staff #20 did not pass his CNA (certified nursing assistant) test. However, resident #11 said that staff #20 would still come to her room, but would be quick because he no longer had a valid reason to be in there. She stated that she spoke with another CNA (Staff #34) who told her they would report the situation. During an interview with resident #11 conducted on 6/11/2024 at 10:55 a. m. the resident provided copy of screenshots from the resident's cellphone that showed conversation between staff #20 and resident #11. The message sent by staff #20 included that daddy [referring to staff #20] love you and wants to be deeply inside of you to which the resident responded Can you hold me tight as you nut inside me daddy. Staff #20 responded, Yes baby I [referring to staff #20] sure will really tight. Further review the screenshots revealed that had incoming call from staff #20. The resident said that the Director of Nursing (DON/Staff #6), the Executive Director (ED/ Staff #47), and Clinical Resource (staff #52) spoke to her about the incident; and that, she showed all three of them the screenshots of the texts between her and Staff #20 she had on her phone. She stated that she was worried about what would happen if she reported the incident because everyone else goes home at the end of the day and she has to stay in the facility with the staff whom she accused. The resident said that after the report on 2/1/2024, Staff #20 told Resident #11 that he had been given a choice to quit or be fired; and that, Staff #20 messaged her that he was not sure how he was going to pay his rent. She asked her sister for a few hundred dollars, but her sister became suspicious and declined to give her the money. When she told Staff #20 that she could not get him the funds, he became very upset and a light came on for her that it had not been a real relationship, and he had manipulated her for sex. An interview was conducted on 06/11/2024 at 1:27 p.m. with a CNA (staff #34) who stated that she provided care for Resident #11 starting around December. The CNA stated that she cannot recall the exact date, but sometime after the new year, she was caring for Resident #11 in her room when the resident reported that Staff #20 sent the resident a message and the resident pulled up and showed the CNA the Facebook messages of staff #20 to the resident. The CNA stated that the messages did not say anything sexual but she definitely saw the Facebook profile and the back and forth messages between the resident and staff #20. The CNA stated that in one of the messages, staff #20 had said good morning, Beautiful and the messages were all in that vein. The CNA said that she reported it immediately and did not question the resident further; and that, she could not find the DON at the time, so she reported it to the staffing coordinator (Staff #73). Further, the CNA stated that she and the staffing coordinator then located the DON together and she reported the incident to the DON. The CNA stated that it was the facility's policy for staff to never text, direct message, or friend a resident on social media; and that, it was unprofessional and could lead to HIPPA (Health Insurance Portability and Accountability Act) violations. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	In an interview with a CNA (staff #82) who was a former staff conducted on 06/11/2024 at 2:55 p.m., the former CNA stated that he worked at the facility until end of December 2023; and, he recalled a moment where he and Staff #20 were in the room providing care to resident #11 together. The former CNA stated that Staff #20 boasted that Resident #11 knows he (referring to Staff #20) was the resident's favorite. The former CNA also stated that it was a little bit off thing to say; and, it was his personal opinion and also a facility policy that staff cannot exchange phone numbers with residents. An interview was conducted on 06/11/2024 at 3:28 p.m. with another CNA (Staff #59) who stated she used to work at the facility through December 2023. She stated that when Staff #20 worked as an aide at the facility, staff #20 would randomly come over on the bariatric hall (where Resident #11 resided) and would be in Resident #11's room for a really long time even though he was not scheduled to be on the unit. The CNA said that staff #20 would offer to help out on the bariatric hall a lot; and, every time Resident #11 needed a shower, Staff #20 would offer to be the one to do it. She stated that Staff #20 would flirt with Resident #11 and make dirty jokes with her all the time. She stated that she noted behavioral changes in Resident #11 and that, the resident would no longer engage in those kinds of jokes and banter with any staff. She stated that Staff #20 created a difficult work environment related to dating and flirting with female staff members. In an interview with the Staffing Coordinator (Staff #73) conducted on 06/11/2024 at 4:41 p.m. the staffing coordinator stated she had worked at the facility for approximately 2 years; and initially denied recalling Staff #20 or Resident #11. She stated she had no knowledge of the incident before surveyor had indicated which incident was being investigated. She stated that she did not recall any incident regarding resident #11 having messages on her phone from the staff member (#20); and that, she did recall a CNA reporting seeing messages from staff #20 on Resident #11's phone. The staffing coordinator stated that staff and residents needed boundaries. During the interview, the staffing coordinator retracted her statement and stated that the CNA pulled her to the side and reported that the CNA saw a message from staff member (#20) to the resident. The staffing coordinator said that she does not recall if the alleged staff (#20) was still employed at the facility; and, does not recall who the CNA who reported the incident to her and that the CNA came to her only because the CNA could not find the DON. She stated that she found the DON for the CNA and she left before any conversation took place. Further, the staffing coordinator said that she never saw any messages from staff #20 to resident #11; and she does not recall when this interaction took place, but said it was a long time ago and may have been at the end of last year, or maybe just after the new year began. The staffing coordinator stated she was unsure of any policy regarding staff engaging with residents over phone or social media. She stated that staff were not supposed to engage with residents in that way; and, it was a HIPPA violation to have residents phone numbers and contact information taken out of the facility. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview with the DON conducted on 06/11/2024 at 4:50 p.m., the DON stated that Resident #11 reported having a relationship with a staff member to the ED, who then brought the DON into the conversation. The DON said that Resident #11 met with the DON, ED, and Clinical Resource (Staff #52) in the DON's office and reported that on 02/01/2024, the resident and Staff #20 had a sexual relationship. The DON said that the resident could not say definitively when the relationship began but said that it was around October 2023; and that, the resident and staff #20 texted back and forth. The DON denied that Resident #11 had showed her any text messages and said she was not aware that any text messages existed. The DON stated she interviewed Staff #20 who denied ever giving Resident #11 his number and was appalled that the resident had alleged a sexual relationship. A review of the facility self-report for the incident was conducted with the DON who stated that Staff #20 actually had admitted to exchanging phone numbers with the resident but denied having sexual contact; and that, he never talked to the resident about needing money. The DON stated that Staff #20 crossed the line by exchanging phone numbers with the resident, but there was never anything inappropriate in the texts. She said that there was no specific policy about exchanging numbers with residents, staff boundaries and professional standards; but facility's legal department said it was not okay. The DON said that the legal department taught staff that this behavior was unprofessional and was discouraged; and that, a resident was not able to have a consensual relationship with a staff member. The DON further stated that if there was a previous relationship between a staff and resident prior to admission or hire, that would need to be disclosed to the management immediately; and, the resident and the staff could not continue while both were at the facility. Further, the DON stated that the risk would be an unequal power dynamic; and, she would never want a resident to not receive care or feel they are getting less. The DON said that this was not a message that she would ever want to be sent to anyone in the facility. In an interview conducted with the ED on 06/11/2024 at 5:06 p.m. the ED stated that Resident #11 reported consensual sexual relationship with staff #20 on 02/01/2024; and, the resident alleged that she and staff #20 had oral sex on two occasions. The ED denied ever seeing any text messages or screenshots of conversations between Staff #20 and Resident #11. He said that did not talk to Staff #20 but he was there when the DON interviewed staff #20 as part of the facility's investigation. The ED said that Staff #20 denied texting with the resident and that none of the allegations were true. The ED said staff #20 never came back to the facility and quit over phone during the investigative interview. During the interview, a review of the facility self-report investigation was conducted with the ED who retracted his earlier statement and said that Staff #20 had in fact admitted to exchanging numbers with resident #11. Further the ED stated that a relationship between staff and a resident can never be consensual; and, all staff was educated on boundaries through in-services. In an interview with clinical resource staff on 6/11/2024 at 5:53 p.m. he stated that the resident reported having a relationship with staff; but the clinical resources denied seeing the messages of screenshots of messages between the resident and staff #20, but he denies ever seeing and messages or screenshots. The clinical resource staff stated that the facility reported Staff #20 to State Board of Nursing. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's employee handbook revealed while employees were encouraged to develop friendship with residents, it is important that the relationship remain professional at all times. Employees are not allowed to purchase items or borrow money from or become involved in any personal or business relationships with residents. The handbook included to see the supervisor or the Executive Director immediately if a resident asks the employee you to engage in behavior that the staff think may cross a professional boundary. Situations of actual or potential conflict of interest are to be avoided by all employees. Personal or romantic involvement with the resident which impairs an employee's ability to exercise good judgement creates and actual or potential conflict of interest and may be cause for discipline up to and including termination. Under no circumstances may the employee solicit a gift, loan, gratuity or any item of value from anyone conducting business with us nor should the employee show or imply favoritism toward a resident who provides for such a gift. Facility policy titled Resident Rights: Reporting Alleged Violations of Abuse, Neglect, Exploitation, or mistreatment last reviewed 09/2020 stated that it was their policy that each resident has the right to be free from abuse, neglect, misappropriation of resident property, exploitation, and mistreatment. Residents must not be subjected to abuse by anyone, including, but not limited to, Facility Staff, other residents, consultants or volunteers, staff of other agencies serving the resident, resident representatives, families, friends, or other individuals. The policy goes on to define exploitation as taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats, or coercion.