STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035087	A. Building B. Wing	12/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Mountain Medical and Rehabilitation Center	9155 North Third Street Phoenix, AZ 85020

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 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47910 Based on clinical record reviews, facility documentation, resident and staff interviews, and policy review, the facility failed to ensure one resident (#2) had the right to receive and deny visitors. The deficient practice could result in further violations of the resident's rights. Findings include: Resident #2 was admitted on [DATE] with diagnosis including acute and chronic respiratory failure with hypoxia critical illness myopathy, toxic encephalopathy, and dysphagia. A review of the Minimum Data Set (MDS) dated [DATE] revealed Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. Further review of the MDS revealed no indicators for mood or behaviors and dependent for upper and lower mobility. A review of the care plan revealed a focus area indicating that the resident has a potential risk for alteration in thought process/cognitive loss related to multiple complex medical conditions and has ineffective coping skills as exhibited by episodes of agitation, and verbally aggressive and abusive towards staff. Interventions included encouraging communication with family and caregivers' residents' capabilities and needs. Further review of the care plan revealed resident expressed alleged staff to resident incident on November 19, 2024. Intervention included a psych consult follow-up as ordered on November 20, 2024. A review of the progress notes revealed a psych follow-up entry dated November 20, 2024. On a mental capacity note, patient was AAOX4 during my interview today and able to name some of his medical problems as well as medications that he is currently taking. Patient demonstrated good concentration and short-term memory recall with an improvement in his MMSE score compared to the previous one done approximately 3 months ago. I believe patient now has the mental capacity to make his own medical decisions. A review of the PRN Skin Evaluation dated November 20, 2024 states no new skin alteration noted. no redness, swelling or open areas noted to right lower extremity. (continued on next page)

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

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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 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	An interview was conducted on December 2, 2024 at 9:55 A.M. with resident #2. The resident stated that when his dinner arrived the hamburger patty was crisp, almost burnt, so he sent it back with the CAN/Staff 15. He stated a girl from dietary came into my room with the original tray and asked me what was wrong with the meal? I told her it was too hard, almost burnt and hard for me to eat and asked for a softer patty. He stated this is when the girl from dietary got upset and started yelling and said you're going to eat this, I told her I was not and that I didn't like her attitude with me. Resident #2 stated the girl from dietary was standing at the end of his bed and this is when she grabbed his left ankle and twisted it. Resident #2 stated I told her to stop and grabbed my water bottle and threw it at her, she told me how dare you and threw two water bottles at me and tipped over my urinal. I was soaked with urine and water. Resident #2 stated he reported her immediately and they took him for a shower. Resident #2 stated they told him they sent her home and not seen her since. A telephonic interview was conducted on December 2, 2024 at 1:32 P.M. with a Certified Nursing Assistant (CNA#staff 7). Staff #7 stated that she had resigned from the facility two weeks prior for another position, but was previously employed as a caregiver/sitter and also worked in dietary on tray line and as a dishwasher. She stated she recalled the incident and had never met the resident prior to the alleged incident. Staff #7 stated that she was in the kitchen when Staff #15 CNA entered the kitchen with a complaint about resident #2 dinner meal, stating the resident had complained that the hamburger patty was burnt. She stated the cook told CNA #15 they did not have any ready, that they were frozen and would take sometime to prepare another. Staff #7 stated she was not working in dietary at the time not was she assigned to the resident. Staff #7 stated she was not asked by CNA #15 nor dietary to inform the resident regarding his meal, that she was on break. Staff #7 stated she went to resident #2 room and introduced herself as working in the kitchen. She stated she informed the resident that since he thought that the hamburger was burnt it would take about an hour and if he would like something else. Staff #7 stated resident #2 told her to get the fuck out of my room. She stated when he cursed at me I realized I was dealing with the wrong spirit. Staff #7 stated the resident asked he a second time to leave his room. Staff #7 stated I didn't leave his room when he told me to leave, I tried to reason with him, I thought I could make him understand that his burger really wasn't burnt and he could eat it or it would take an hour for another one, but it got worse. Staff #7 stated resident #2 attempted to kick her while she was standing at the end of his bed so I grabbed his leg. Staff #7 then stated I didn't actually grab his leg, I swung my hand to move his leg to avoid him from kicking me. It was a reflex for me. Staff #7 stated she may have lightly touched it when asked if she had made contact with resident #7's leg at any time. Staff #7 stated resident #2 pitched his water at me and that was my time to leave the room. A telephonic interview was conducted on December 2, 2024 at 2:50 P.M. with a CNA (CNA/staff #15. Staff #15 stated she was assigned to the resident. Staff #15 stated the resident had concerns that his burger was burnt, so she took the tray back to the kitchen and was told me it would take some time because they would need to make it from scratch and to come back to for the burger. Staff #15 stated they were preparing dinner trays at the time. Staff #15 stated she returned to the kitchen approximately 20-30 minutes for the resident's meal and took the tray to the resident's room. Staff #7 stated there was no conversation between her and staff #7 about going to the resident's room and explaining why his try was going to be late. Staff # 7 stated If anyone was to go back and talk to the patient it would have been me. (continued on next page)

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F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	An interview was conducted on December 2, 2024 at 3:18 P.M. with the Director of Nursing (DON/staff #24). Staff #24 stated that the expectation when a resident asks staff to leave their room when requested as the resident would get upset and are free from abuse. Staff #118 further stated CNA #7 walked into a situation she did not know how to handle and should have walked away. A follow-up interview was conducted on December 2, 2024 at 3:50 P.M by a clinical resource and RN (RN/Staff #50 and a Licensed Practical Nurse (LPN/Staff #10). Staff #50 stated she was at the interview with CNA #7 and had stated multiple times that she blocked the resident from kicking her. A review of the facility policy titled Residents Rights states As a resident of this nursing facility, you have the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. You have the right to exercise your rights without interference, coercion, discrimination, or reprisal from the facility as a resident of the facility and as a citizen or resident of the United States. Self-Determination. You have the right to self-determination through support of your choice, including the right to: receive visitors of your choosing at the time of your choosing, subject to your right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** 47910 Based on clinical record reviews, facility documentation, resident and staff interviews, and policy review, the facility failed to ensure that one resident (#2) was free from physical abuse. The deficient practice could result in further incidents of staff to resident abuse. Findings include: Resident #2 was admitted on [DATE] with diagnosis including acute and chronic respiratory failure with hypoxia critical illness myopathy, other toxic encephalopathy, and dysphagia. A review of the Minimum Data Set (MDS) dated [DATE] revealed Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. Further review of the MDS revealed no indicators for mood or behaviors and dependent for upper and lower mobility. A review of the care plan revealed a focus area indicating that the resident has a potential risk for alteration in thought process/cognitive loss related to multiple complex medical conditions and has ineffective coping skills as exhibited by episodes of agitation, and verbally aggressive and abusive towards staff. Interventions included encouraging communication with family and caregivers' residents' capabilities and needs. Further review of the Care Plan revealed resident expressed alleged staff to resident incident on November 19, 2024. Intervention included a psych consult follow up as ordered on November 20, 2024. A review of the progress notes revealed a psych follow-up entry dated November 20, 2024. On a mental capacity note, patient was AAOX4 during my interview today and able to name some of his medical problems as well as medications that he is currently taking. Patient demonstrated good concentration and short-term memory recall with an improvement in his MMSE score compared to the previous one done approximately 3 months ago. I believe patient now has the mental capacity to make his own medical decisions. A review of the PRN Skin Evaluation dated November 20, 2024 states no new skin alteration noted. no redness, swelling or open areas noted to right lower extremity. An interview was conducted on December 2, 2024 at 9:55 A.M. with resident #2. The resident stated that when his dinner arrived the hamburger patty was crisp, almost burnt, so he sent it back with the CNA/Staff 15. He stated a girl from dietary came into my room with the original tray and asked me what was wrong with the meal? I told her it was too hard, almost burnt and hard for me to eat and asked for a softer patty. He stated this is when the girl from dietary got upset and started yelling and said you're going to eat this, I told her I was not and that I didn't like her attitude with me. Resident #2 stated the girl from dietary was standing at the end of his bed and this is when she grabbed his left ankle and twisted it. Resident #2 stated I told her to stop and grabbed my water bottle and threw it at her, she told me how dare you and threw two water bottles at me and tipped over my urinal. I was soaked with urine and water. Resident #2 stated he reported her immediately and they took him for a shower. Resident #2 stated they told him they sent her home and not seen her since. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A telephonic interview was conducted on December 2, 2024 at 1:32 p.m. with a Certified Nursing Assistant (CNA/staff #7). Staff #7 stated that she had resigned from the facility two weeks prior for another position, but was previously employed as a caregiver/sitter and also worked in dietary on tray line and as a dishwasher. She stated she recalled the incident and had never met the resident prior to the alleged incident. Staff #7 stated that she was in the kitchen when Staff #15 CNA entered the kitchen with a complaint about resident #2 dinner meal, stating the resident had complained that the hamburger patty was burnt. She stated the cook told CNA #15 they did not have any ready, that they were frozen and would take sometime to prepare another. Staff #7 stated she was not working in dietary at the time not was she assigned to the resident. Staff #7 stated she was not asked by CNA #15 nor dietary to inform the resident regarding his meal, that she was on break. Staff #7 stated she went to resident #2 room and introduced herself as working in the kitchen. She stated she informed the resident that since he thought that the hamburger was burnt it would take about an hour and if he would like something else. Staff #7 stated resident #2 told her to get the fuck out of my room. She stated when he cursed at me I realized I dealing with the wrong spirit. Staff #7 stated the resident asked he a second time to leave his room. Staff #7 stated I didn't leave his room when he told me to leave-I tried to reason with him, I thought I could make him understand that his burger really wasn't burnt and he could eat it or it would take an hour for another one, but it got worse. Staff # 7 stated resident #2 attempted to kick her while she was standing at the end of his bed so I grabbed his leg. Staff #7 then stated I didn't actually grab his leg, I swung my hand to move his leg to avoid him from kicking me. It was a reflex for me. Staff #7 stated she may Have lightly touched it when asked if she had made contact with resident #7's leg at any time. Staff #7 stated resident #2 pitched his water at me -that was my time to leave the room. A telephonic interview was conducted on December 2, 2024 at 2:50 p.m. with a certified nursing assistant (CNA/staff #15). Staff #15 stated she was assigned to the resident. Staff #15 stated the resident had concerns that his burger was burnt, so she took the tray back to the kitchen and was told me it would take some time because they would need to make it from scratch and to come back to for the burger. Staff #15 stated they were preparing dinner trays at the time. Staff #15 stated she returned to the kitchen approximately 20-30 minutes for the resident's meal and took the tray to the resident's room. Staff #7 stated there was no conversation between her and staff #7 about going to the resident's room and explaining why his try was going to be late. Staff # 7 stated If anyone was to go back and talk to the patient it would have been me. An interview was conducted on December 2, 2024 at 3:18 p.m. with the director of nursing (DON/Staff #24). The DON stated that the expectation when a resident asks staff to leave their room when requested as the resident would get upset and are free from abuse. Staff #118 further stated CNA #7 walked into a situation she did not know how to handle and should have walked away. A follow-up interview was conducted on December 2, 2024 at 3:50 p.m. with a Clinical resource/Registered Nurse (RN/Staff #50) and a Licensed Practical Nurse (LPN/Staff #10). Staff #50 stated she was at the interview with CNA #7 and had stated multiple times that she blocked the resident from kicking her. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A review of the facility policy titled Reporting Alleged Violations of Abuse, Neglect, Exploitation or Mistreatment revised October of 2023 revealed It is the policy of this Facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, exploitation and mistreatment. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. 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.