STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035092	A. Building B. Wing	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bella Vita Health and Rehabilitation Center	5125 North 58th Avenue Glendale, AZ 85301

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 - Minimal harm or potential for 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** 40581 Based on documentation, staff interviews, and the facility policy and procedures, the facility failed to protect the rights of one resident (#107) to be free from abuse by a resident. The deficient practice could result in residents subjected to further abuse. Findings include: Regarding residents #107 and #15: -Resident #107 was admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease, depression and anxiety. The minimum data set (MDS) dated [DATE] included a brief interview for mental status (BIMS)score of 3 indicating the resident had a severe cognitive impairment. The care plan dated September 5, 2024 revealed the resident had the potential for a psychosocial well-being problem related to resident to resident on September 5, 2024. Interventions included to monitor for mood behavior patterns, aggressive behaviors towards other residents and/or staff, fear of other residents and/or staff and notify provider if present; and that, when conflict arises, remove residents to a calm safe environment and allow to vent/share feelings. A progress note dated September 5, 2024 revealed that resident #107 was sitting in his wheelchair in front of the nurse's station. Per the documentation, the nurse saw resident #15 came up behind resident #107's wheelchair and began yelling that he wanted him to move.; and that, the nurse and two certified nursing assistants (CNAs) went to assist as resident #15's tone became elevated. It also included that resident #15 made contact with the right side of face of resident #107 face with a closed right fist. According to the documentation, resident #107 reported that he was in his wheelchair and the other resident (#15) came up behind him, yelled at him and wanted him to move so resident #15 could get past him in the hall; and then, struck him. -Resident #15 was admitted on [DATE] with diagnoses of secondary Parkinsonism, bipolar disorder, anxiety disorder, unspecified dementia, and unspecified psychosis. (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 - Minimal harm or potential for actual harm Residents Affected - Few	The care plan dated March 21, 2024 revealed the resident had a potential to demonstrate verbal and physical behaviors related to dementia and a bipolar disorder. Interventions included to analyze key times, places, circumstances, triggers, and what de-escalates behaviors and document. Also, to assess and anticipate the resident's needs: food, thirst, toileting needs, comfort level, body positioning, pain, etc. The minimum data set (MDS) assessment dated [DATE] included a BIMS score of 10 indicating the resident had a moderate cognitive impairment. A progress note dated June 29, 2024 revealed the resident was verbally aggressive, and threatened to hit staff. Per the documentation, the resident was not easily redirected, had to be redirected several times during the shift and was demanding for his pull-ups. A progress note dated September 5, 2024 included that resident #15 was sitting at the dining room waiting for dinner; and, resident #107 was sitting in his wheelchair in front of the nurse's station. Per the documentation, the nurse saw resident #15 came up behind the wheelchair of resident #107 and began yelling at resident #107 that he wanted resident #107 him to move. The documentation also included that the nurse and two certified nursing assistants (CNAs) went to assist as resident #15's tone became elevated; and, resident #15 made contact with the right side of face of resident #107 face with a closed right fist. It also included that both residents were separated immediately; and that, resident #15 kept saying that he was sorry when asked what happened. An interview was conducted on September 10, 2024 at 9:30 a.m. with the Director of Nursing (DON/staff #1), who stated that all staff have received training on abuse, which includes physical abuse, and the willful intent to cause harm. The DON stated that her expectation was that there is always one staff to monitor the residents in the common area, while the other staff were providing care for the other residents. An interview was conducted on September 10, 2024 at 10:53 p.m. with the Assistant Director of Nursing (ADON/staff #27), who stated that staff should be within a reasonable distance to supervise and monitor the residents. If a resident was being physically aggressive, the resident should be taken to a quiet place. Regarding residents #36 and #22: -Resident #22 admitted to the facility on [DATE] with diagnoses that included dementia in other diseases classified elsewhere without behavioral disturbance, unspecified psychosis, and an anxiety disorder. The minimum data set (MDS) assessment dated [DATE] included a brief interview for mental status (BIMS) score of 11 indicating the resident was cognitively intact. The care plan dated August 23, 2024 revealed that the resident had the potential for a psychosocial well-being problem related to an altercation with another resident. Interventions included monitor /observe resident for changes in mood/behavior patterns, aggressive behaviors towards other residents and/or staff, fear of other residents and/or staff and notify the provider if present. When conflict arises, remove residents to a calm safe environment and allow to vent/share feelings. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated August 24, 2024 revealed that at approximately 9:05 p.m. on August 23, 2024 on the behavioral secured unit, the nurse was charting in the common area dayroom and observed resident #22 sitting in a chair doing crossword a puzzle. Per the documentation, at approximately 9:10 p.m., resident #22 got up and headed towards his room; and that, the nurse turned around when she heard resident #22 and resident #36 talking, and their level of tone increased. The documentation included that as the nurse approached both residents, resident #36 took his right hand in a closed position and made contact with the left side of the face of resident #22. It also included that resident #22 reported that resident #36 hit him. According to the documentation, staff separated both residents immediately. -Resident #36 was admitted on [DATE] with diagnoses of unspecified dementia with other behavioral disturbance, unspecified psychosis and anxiety disorder. The care plan dated August 21, 2024 revealed the resident was at risk for impaired cognitive function/dementia or impaired thought processes related to dementia, likely advanced, and sundowning. Interventions included a therapy evaluation and treatment as per physician orders. The care plan dated August 21, 2024 revealed the resident was on psychotropic medications related to a brief psychotic disorder, auditory hallucinations/physical aggression. Interventions included to monitor/record occurrence for target behavior symptoms, specifically brief psychotic disorder auditory hallucinations, and document. The care plan dated August 23, 2024 revealed that the resident had the potential for a psychosocial well-being problem related to an altercation with another resident. Interventions included monitor /observe resident for changes in mood/behavior patterns, aggressive behaviors towards other residents and/or staff, fear of other residents and/or staff and notify the provider. When conflict arises, remove residents to a calm safe environment and allow to vent/share feelings. A progress note dated August 23, 2024 at 5:19 a.m. revealed that the resident wandered around the unit, was verbally and physically aggressive; yelled at staff, pushed and attempted to throw chairs at staff in the dayroom, while other residents were watching. Per the documentation, the resident required redirection at all times, especially from the medication cart and the nurse's station; and that, the resident struggled with interventions. A progress note dated August 24, 2024 included that on August 23, 2024 at approximately 9:05 p.m. on the behavioral secured unit, resident #36 was ambulating in the hallway and the common area, dayroom. At approximately 9:10 p.m. the nurse turned around when the residents were talking and their level of tone was increased. Per the documentation, as the nurse approached the residents, resident #22 took his right hand which was in a closed position and hit the side of the face of the resident #36. Review of the follow up psych evaluation dated August 27, 2024 revealed that the resident had worsening episodes of aggression and agitation; and that, the dose for the antipsychotic medication was increased and and a new medication was started. Per the documentation, staff reported that resident #22 hit another resident in the face four days ago, and the attack was reportedly provoked. It also included that the resident had no recollection of the incident and doesn't remember striking anyone. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The discharge minimum data set (MDS) assessment dated [DATE] included the resident was assessed by staff to have severe cognitive impairment. It also included that the resident displayed physical and verbal behaviors towards others 1-3 days during the look-back period. Review of the behavior task sheet dated August 2024 revealed that on August 22, 2024 resident #36 exhibited the following behaviors: kicking/hitting two times, grabbing one time, abusive language two times, and threatening behaviors two times. An interview conducted on September 9, 2024 at 3:57 p.m. with a certified nursing assistant (CNA/staff #7) who stated that if a CNA was going to help a resident in the resident's room, another CNA was supposed to monitor the dining area and the hall. An interview with the Therapy Program Manager (staff #5) was conducted in September 10, 2024 at 8:40 a.m. The therapy program manager reviewed clinical record of resident #36; and stated that the resident had the strength and full range of motion to injure someone. He also stated that resident #36 did not have the cognition for intent because the resident was only oriented to self and can only follow one-step directions. An interview was conducted on September 10, 2024 at 8:56 a.m. with a licensed practical nurse (LPN/staff #31) who stated that the CNAs were putting the residents to bed, so she was the only staff in the dining area and was throwing trash away because the residents had just finished their snack. The LPN stated that resident #22 came to her and told her that resident #36 hit him; and that, resident #36 did not say anything when asked about what happened. The LPN said that she did not realize that resident #36 was still in area. The LPN also stated that resident #36 has a tendency to be aggressive and would push chairs at people; and that, someone would have to keep an eye on him unless he was sleeping. Regarding resident #22, the LPN stated that resident #22 was quiet and had no problems. She also stated that it would be beneficial if she had more support staff. During an interview with the Director of Nursing (DON/staff #1) conducted on September 10, 2024 at 9:30 a.m., the DON stated that the resident to resident incident between residents #22 and #36 occurred on a secured dementia unit between the dining area and the hallway because the residents were free and were allowed to walk about. She stated that the LPN (staff #31) and two CNAs were working on the unit. She stated that the LPN reported that she was standing at the medication cart and had a view of the dining area and the hallway; and that, residents #22 and #36 crossed paths in the hallway and their tone of voices were escalating. The DON said that the LPN could not what the two residents were saying; and that, resident #36 hit resident #22. The DON said that at the time of the incident, the two CNAs were providing care for other residents in their rooms. The DON said that it was her requirement that one staff was present at all times in the common area to monitor the residents, while other staff were doing other things, such as providing care for other residents. She stated that she was not aware that resident #36 had aggressive behaviors. During the interview, a review of the clinical record for resident #36 was conducted by the DON who stated that resident #36 had a diagnosis of unspecified dementia with other behavioral disturbance related to confusion, increased wandering, pacing, and aggression; and that, on August 22 prior to the incident, resident #36 exhibited kicking, grabbing, language, threatening behaviors. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Facility assessment dated 2024 states that residents with behaviors are elvaluated on a case-by-case basis to allow facility leadership the opportunity to evaluate the facility's ability to provide care properly and safely for the individual with the identified behavior as well as maintain the safety of other residents residing in the facility. The facility policy, Abuse: Prevention of and Prohibition Against revised October 2022 states that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. Physical abuse includes, but is not limited to hitting, slapping, pinching, and kicking.