STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035110	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sun West Choice Healthcare & Rehab	14002 West Meeker Blvd Sun City West, AZ 85375

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 - Some	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** Based on clinical record reviews, facility documentation, staff interviews and policy review, the facility failed to protect the rights of three residents (#38, #24, #23, #11) to be free from abuse from other residents (#39, #22, #10). The deficient practice could result in residents being physically or emotionally harmed.Findings include: -Regarding Resident #38 and #39 Resident #38 was re-admitted to the facility March 30, 2022, with diagnoses that included Alzheimer’s Disease, Dementia in other diseases classified elsewhere, Unspecified Severity, with other Behavioral Disturbance, Hypertension, Depression, Schizoaffective Disorder, and Unspecified Mood [Affective] Disorder. A quarterly minimum data set (MDS) assessment dated [DATE], revealed Resident #38 had a Brief Interview for Mental Status (BIMS) score of 00, indicating severe cognitive impairment. A care plan dated January 26, 2023, revealed Resident #38 was an elopement risk/wanderer related to impaired safety awareness, potential for behavior problem of physical aggression towards staff and peers, and placing self on floor. A progress note dated August 10, 2022, revealed that Resident #38 sustained a bite injury from another resident to the back of the left hand. Further review of the progress notes reveal that the resident had behaviors consisting of intrusive wandering and aggression. Resident #39 was re-admitted to the facility June 20, 2022, with diagnoses that included Unspecified Dementia with Behavioral Disturbance, Vascular Dementia with Behavioral Disturbance, Anxiety Disorder Unspecified, Unspecified Severe Protein-Calorie Malnutrition, Unspecified Osteoarthritis Unspecified Site, Hypokalemia, and Irritable Bowel Syndrome Unspecified. A discharge MDS assessment dated [DATE], revealed Resident #39 had a staff assessment for mental status which revealed that the resident had a short-term memory problem and was severely impaired in regard to cognitive skills for Daily Decision Making. The BIMS score was not indicated. Further review of the MDS indicated that the resident had behavioral symptoms that included physical behavior directed toward others containing coding that indicated that the type of behavior occurred 1 to 3 days. (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
	035110	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sun West Choice Healthcare & Rehab	14002 West Meeker Blvd Sun City West, AZ 85375

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 - Some	A care plan dated August 11, 2022, revealed Resident #39 had the potential to demonstrate physical behaviors related to behavioral and psychological symptoms of dementia, was prescribed psychotropic medications use related to agitation as evidenced by striking out. A progress note dated August 10, 2022, revealed Resident #39 had an altercation with a male resident (Resident #38) that resulted in Resident #39 biting Resident #38’s left hand and causing an injury. Resident #39 could not tell the progress note writer what provoked her to bite Resident #37. The progress note further indicated that Resident #39 is known to be very territorial and does get agitated when others come into her personal space. It was further revealed in the progress note that Resident #39 was not injured during the altercation. A documented report dated August 11, 2022 described the incident as “(Resident #38) was restless and wandering the hallway, approached (Resident #39)’s room. (Resident #39) became agitated as she can be protective of her space. Residents began arguing and when staff tried to intervene, (Resident #39) bit (Resident #38) on his left hand causing broken skin. A five-day investigation conducted by the facility revealed that, on August 10, 2022, in the Behavioral Unit, (Resident #38) was observed in the hallway, restless and pacing back and forth. (Resident #38) raised his hand in front his face and (Resident #39) leaned forward and bit (Resident #38) on the left hand between the thumb and the pointer finger. As soon as staff were able to intervene, they removed (Resident #39)’s teeth from (Resident #38)’s hand. The resultant removal of (Resident #39)’s teeth resulted in a tear to (Resident #38)’s left hand. The five-day report further indicated that a C.N.A. had witnessed Resident #39’s mouth on Resident #38’s hand and assisted Resident #38 with the removal of his hand from Resident #39’s mouth and then separated the two. -Regarding Resident #24 and Resident #22 Resident #24 was admitted initially on April 5, 2022, and was re-admitted to the facility on [DATE] with diagnoses that included Alzheimer’s disease, bipolar disorder, and major depressive disorder, recurrent, severe with psychotic symptoms. A care plan focus, initiated on June 26, 2022, indicated that Resident #24 was an elopement risk/wanderer. An additional problem focus, initiated on July 11, 2022, revealed that Resident #24 had potential for a behavior problem of physical aggression towards staff and peers, verbal aggression, yelling out, and banging on doors. Review of the Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment. A nursing note on October 23, 2022 indicated that Resident #24 was involved in an altercation with another resident, in which Resident #24 was punched on the right side of the head by the other resident. An additional nursing progress note dated October 23, 2022 revealed that a nurse had observed Resident #24 walking towards the nursing station with a shocked and confused expression. The nurse assessed the resident and found that the resident had a raised, discolored area on the right side of his head, which is stated to be in the area of the reported abuse. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035110	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sun West Choice Healthcare & Rehab	14002 West Meeker Blvd Sun City West, AZ 85375

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 - Some	Resident #22 was admitted to the facility on [DATE] with diagnoses that included schizophrenia and depression. Review of the MDS dated [DATE] revealed a BIMS score of 9, indicating moderate cognitive impairment. This MDS indicated that during the assessment period, the resident had exhibited verbal behavioral symptoms towards others one to three days and other behavioral symptoms not towards others one to three days. A nursing note dated October 23, 2022 at 3:00PM revealed that Resident #22 was agitated due to confusion and a wet bed. The note indicated that Resident #22 lashed out physically and hit another resident on the head. An additional nursing note dated October 23, 2022 at 3:00PM revealed that a nurse had observed Resident #24 at 2:45PM in his room, and the resident had asked for assistance to change clothes. The nurse observed at this time that Resident #24’s incontinent product was wet and indicated that staff would assist him soon. The nurse indicated that another resident (Resident #24) was observed sitting in a chair asleep in the hallway at this time, as the nurse was returning to the nursing station. The nurse sat at the nursing station to chart until other staff reported the altercation. Interview was conducted on August 29, 2025 at 9:28AM with a Certified Nursing Assistant (CNA/Staff #172) who confirmed that she had witnessed the altercation between Resident #22 and Resident #24. The CNA stated she had worked with the two residents frequently, and recalled that the two residents did not like each other and often had tension between the two. The CNA explained that Resident #24 frequently wandered into other residents’ rooms, and Resident #22 did not like this, as Resident #22 was very protective of his belongings. The CNA stated that on October 23, 2022, she witnessed Resident #24 sleeping in a chair outside of Resident #22’s room. Resident #22 then approached Resident #24 and appeared to hit him. The CNA stated that Resident #22 had suspected that Resident #24 had gone into his room and may have stolen something. The CNA explained that following the event, the two residents were separated. Interview was attempted with other witnesses, but the other staff witnesses were unable to be reached for interview. -Regarding Resident #23 and Resident #22 Resident #23 was admitted to the facility on [DATE] with diagnoses that included dementia with behavioral disturbance, anxiety disorder, depressive disorder, and Parkinson’s disease. The MDS dated [DATE] revealed a BIMS score of 8, indicating moderate cognitive impairment. A nursing note dated February 26, 2023 indicated that Resident #23 was involved in a resident-to-resident altercation. The note detailed that while attempting to leave the dining room, Resident #23’s wheelchair got tangled with another resident’s wheelchair, and staff attempted to separate the two. The note indicated that the other resident struck Resident #23 in the face, causing a lower lip laceration. The residents were then separated. Resident #22 was admitted to the facility on [DATE] with diagnoses that included schizophrenia and depression. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035110	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sun West Choice Healthcare & Rehab	14002 West Meeker Blvd Sun City West, AZ 85375

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 - Some	Review of the MDS dated [DATE] revealed a BIMS score of 9, indicating moderate cognitive impairment. This MDS indicated that during the assessment period, the resident had exhibited verbal behavioral symptoms towards others one to three days and other behavioral symptoms not towards others one to three days. A nursing note dated February 26, 2023 indicated that Resident #22 was involved in a resident-to-resident altercation when leaving the dining room. The note indicated that the two residents’ wheelchairs were tangled up, and Resident #22 struck another resident in the face, causing injury to the lower lip. Staff separated the two residents. A review of the facility investigation dated February 26, 2023 revealed that a staff member and multiple residents reported witnessing Resident #22 hit Resident #23. -Regarding Resident #11 and Resident #10: Resident #11 was admitted to the facility on [DATE] with diagnoses that included intracranial injury and psychotic disorder with hallucinations. Review of the Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 5, indicating severe cognitive impairment. The MDS also revealed that the resident did not have any hallucinations, delusions, or physical or verbal behaviors towards others during the assessment period. A review of the MDS dated [DATE] revealed no short-term memory impairments and that the resident was independent with decision making regarding tasks of daily life. This MDS indicated that during the assessment period, the resident had exhibited physical and verbal behavioral symptoms towards others one to three days and other behavioral symptoms not towards others four to six days. The nursing progress note dated August 12, 2023 revealed that two Certified Nursing Assistants (CNAs) had called the nurse to the dining room, stating that an altercation had occurred between Resident #11 and Resident #10. The note indicated that the two residents were talking at the dining table and got into an argument. Resident #10 attempted to elbow Resident #11, and Resident #11 then hit Resident #10. Staff then attempted to escort Resident #11 away when Resident #10 stood and hit Resident #11 in the back before falling to the ground. The note indicated that the two residents were assessed and no injuries were found. Resident #11 continued to be aggressive with staff and was sent out to the hospital for evaluation. Resident #10 was admitted to the facility on [DATE] with diagnoses that included hemiplegia/hemiparesis following cerebral infarction affecting non-dominant left side and hypertension. Review of the MDS dated [DATE] revealed a BIMS score of 14, indicating intact cognition. The care plan focus, initiated June 26, 2023, indicated that Resident #10 had a behavior problem, related to resisting care, declining or throwing medications, and being aggressive with staff at times. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035110	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sun West Choice Healthcare & Rehab	14002 West Meeker Blvd Sun City West, AZ 85375

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 - Some	The nursing progress note dated August 12, 2023 revealed that the nurse was called to the dining room, stating that an altercation had occurred between Resident #11 and Resident #10. The note indicated that the two residents were talking at the dining table and both became verbally aggressive. Resident #10 attempted to elbow Resident #11, and Resident #11 then hit Resident #10. Staff then attempted to escort Resident #11 away when Resident #10 stood and hit Resident #11 in the back before falling to the ground. Interview was attempted with the staff members working the day of the incident who may have witnessed the altercation, but none of the staff could be reached for interview. Interview was conducted on August 28, 2025 at 8:41AM with a Certified Nursing Assistant (CNA/Staff #95), who stated that she would consider a resident hitting another resident to be abuse, and she would report this immediately to the administrator after separating the residents. The CNA reported that she often worked on the behavioral unit, so she had received training on how to de-escalate conflict. She reported that if a resident were to begin to scream at another resident or staff, she would try to give the resident space. She stated that this often helps. Interview was conducted on August 28, 2025 at 8:46AM with a Registered Nurse (RN/Staff #92), who stated that she often works with residents with behaviors, and they can get agitated easily. She stated that the difference between behaviors and abuse can sometimes be difficult to determine, but she stated that physical contact would be considered abuse. The RN explained that if a physical altercation occurred, the two residents should be separated and assessed for injury. Then, the manager, doctor, family, and administrator should be notified. Interview was conducted on August 29, 2025 at 10:35AM with the Director of Nursing (DON/Staff #151), who stated that abuse is anything willful, intentional, and deliberate. The DON stated that any physical altercations between residents are reported as abuse allegations. She also stated that the residents in the facility are mostly confused and do not know what they are doing. During this interview, the DON explained that she was not working at the facility when the altercation with Resident #22 and Resident #4 occurred, nor when the altercation with Resident #22 and Resident #23 occurred. She did explain that she remembered that Resident #22 was cognitively impaired and had behaviors, which she felt could be managed at the facility. Additionally, the DON stated that while she was present in her role when the altercation between Resident #10 and Resident #11 occurred, she could not recall details about the incident. Review of the facility policy titled, “Abuse: Prevention of and Prohibition Against”, revealed that residents have the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.