STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035117	A. Building B. Wing	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Payson Care Center	107 East Lone Pine Drive Payson, AZ 85541

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** 51124 Based on observations, record review, interviews, and review of facility documentation and policy, the facility failed to ensure residents were not abused by other residents, for 4 of 5 sampled residents (#1, #2, #3, and #4) and one resident (#5) was not abused by a staff member for 1 of 5 sampled residents. The deficient practice could lead to physical harm, mental anguish, and psychosocial harm to a resident. -Regarding Resident #1 and Resident #2: Resident #1 was admitted to the facility on [DATE], with diagnoses that included dementia, anemia, type 2 diabetes mellitus, and dysphagia. The quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed that Resident #1 had a Brief Interview for Mental Status (BIMS) assessment score that was unable to be assessed due to the resident being rarely or never understood. A Behavior Note dated September 12, 2024, revealed a behavior summary for the last 6 months that Resident #1: removed decor from walls in the hallway, urinated in the hall, removed items from nurse carts, entered peers rooms and interfered with care, turned off peer's oxygen, and removed fire extinguishers from fire case. Additionally, These behaviors have been numerous and consistent. A Health Status Note dated November 18, 2024, revealed that Resident #1 hit another resident with a rolled up newspaper while passing her in the hallway. She is using inappropriate language while interacting with another resident. An Event Note dated January 6, 2025, revealed that Resident #1 was having a verbal dispute with another resident. During the verbal dispute this resident was hit with a book on her left arm causing a skin tear. Dressing applied at this time. There was no evidence that a room change occurred to separate the residents or that additional staff were placed to monitor the safety of the residents. There was no evidence that a skin assessment was completed for Resident #1 after the incident on the date of January 6, 2025. A physician order dated January 8, 2025, indicated treatment for a skin tear to the right forearm to cleanse with wound wash, cover with xeroform and dry dressing. (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
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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A care plan dated February 17, 2023, revealed a focus that the resident exhibits behavioral issues with foul language and abrasive with little concern for the feelings of others. There was no evidence that the care plan was updated after the incidents on November 18, 2024, and January 6, 2025. Resident #2 was admitted to the facility on [DATE], with diagnoses that included unspecified dementia with other behavioral disturbance, atrial fibrillation, and hyperlipidemia. A quarterly MDS assessment dated [DATE], revealed that Resident #2 had a BIMS assessment score that was unable to be assessed due to the resident being rarely or never understood. Review of the progress notes revealed no notes dated January 6, 2025, regarding the incident between Resident #1 and Resident #2. Additionally, there was no evidence that the facility provided a room change to separate the residents or that additional staff were placed to monitor the safety of the residents. A Health Status Note dated January 7, 2025, revealed Resident #2 is becoming increasingly aggressive, and that he struck a female resident on day shift of January 6, 2025. A facility Reportable Event Record/Report dated January 10, 2025, revealed that on January 6, 2025, at 6:00 PM, a resident-to-resident incident occurred. Resident #1 was in the dining room on Unit 3. She instigated a verbal altercation with Resident #2. There wasn't a known reason for the verbal altercation. The residents exchanged profanities. Resident #2 had a large book in his hand and struck Resident #1 in the arm with the book. Resident #1 pulled the book out of Resident #2's hand and threw it to the ground. The Certified Nursing Assistant (CNA / Staff #47) then separated the two residents and immediately notified the Licensed Practical Nurse (LPN / Staff #22). The LPN provided care to Resident #1's injury. The residents were separated and Resident #2 was placed on 15-minute checks. The report concluded that resident to resident abuse did occur. A witness statement from a CNA (Staff #47) revealed that on January 6, 2025, at shift change, Resident #1 and Resident #2 had a verbal altercation in the TV room and Resident #2 struck Resident #1 in the arm and the side of her face with the book he was holding in his hand. An observation was conducted on January 14, 2025, at 8:05 AM, of the locked unit where Resident #1 and #2 resided. Resident #2 was observed to be ambulating up and down the hallway of the unit, no staff were within sight on the unit. Resident #2 then struck the hallway wall forcefully with his flat hand near the nurses' station. No staff responded to the noise of the strike on the wall. Resident #2 turned and walked back down the hallway away from the nurse's station. The observation continued and at 8:09 AM, still no staff were observed on the unit. At 8:11 AM, a CNA (Staff #52) exited Resident #1's room where the door had been closed, and then wheeled Resident #1 in a wheelchair to the day room on the unit. The CNA then continued to perform cleaning duties in Resident #1's room whom she was just assisting. At 8:13 AM, Resident #2 was observed to walk into Resident #1's room and started rifling through Resident #1's belongings. The CNA exited the room and left visible sight of the residents when she took soiled linens into a utility closet. At 8:18 AM, the CNA attempted to redirect Resident #2 out of Resident #1's room and was not successful, the CNA then left Resident #1's room. At 8:35 AM, Resident #2 was observed to be in Resident #1's room still. Resident #1 was observed wheeling herself in the wheelchair in the hallway, then turned and went into the unit day room. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An additional observation of the unit was conducted on January 14, 2025, at 11:03 AM. Resident #2 was observed to be wandering up and down the unit hallway. The CNA (Staff #52) was present on the unit. An interview was conducted with the CNA (Staff #52) at this time. The CNA stated that on this locked unit there is one CNA, and a nurse from another unit comes to provide care as needed. The CNA stated that it depends on the day whether there is enough staff. She stated that it is just her on the unit, and she needs to supervise Resident #1 and Resident #2, and that if she is providing care in a resident's room or providing a shower in the shower room at the end of the hallway, then she tries to leave the door open a little bit so that she can hear what is going on outside on the unit. In regard to Resident #2's behaviors, she stated that he often goes into female resident's rooms and that she tries to redirect him but he'll swing and he can be fast. An interview was conducted with a CNA (Staff #47) on January 14, 2025, at 12:08 PM. The CNA stated that he witnessed the incident between Resident #1 and Resident #2. He stated that he was sitting in the TV room with Resident #1 and another female resident. He stated Resident #2 entered the room and Resident #1 called Resident #2 a fu**ing dumb*** (using expletives). Resident #2 was carrying a book in his hand and then struck Resident #1 in the side of her face with the book, then struck her in the arm with the book. The CNA stated he then separated the residents and called the nurse over from another unit because Resident #1 had blood dripping from her. He stated that the nurse (Staff #22) came over and assessed the resident, and the CNA reported the incident to the nurse. The CNA stated that after the incident, that Resident #2 was put on 15-minute checks. An interview was conducted with the Director of Nursing (DON / Staff #60) on January 14, 2025, at 12:49 PM. The DON stated that examples of physical abuse would be roughness when providing care from a staff member to a resident, or would be pinching, slapping, or swinging an object and making contact from a resident to another resident. At this time, the clinical record of Resident #1 was reviewed together, and specifically, the Health Status Note dated November 18, 2024, where Resident #1 was documented to strike another resident with a rolled-up newspaper. The DON stated that this was the first time she was aware of this incident, and that it was not reported to her, it was not investigated, and that it was not reported to the state agency. She stated that there was no way to tell if any injuries occurred because there was no incident report or investigation, she further stated that there was not a way to tell if the residents were separated for safety. She stated that this did not meet her expectation of how a resident to resident incident would be managed. The interview continued and the incident on January 6, 2025, involving Resident #1 and Resident #2 was reviewed together. The DON stated that the nurse called her and reported the incident that Resident #2 hit Resident #1 with a book. She stated that after the incident, that the residents were placed on 15-minute checks. The DON stated that there was still a potential for the two residents to have unsupervised access to each other on the unit. She stated that herself and the Administrator (Staff #75) were responsible for ensuring the residents are protected after an allegation of abuse, and that this had not been done as of yet, as we would have to increase our staffing. The interview was temporarily paused, and continued approximately 15 minutes later. The DON stated that there is now a one-to-one staff member supervising Resident #2 to ensure her safety. -Regarding Resident #4 and Resident #3: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #4 was readmitted to the facility on [DATE], with diagnoses that included unspecified dementia, hypertension, weakness, and age-related physical debility. A quarterly MDS assessment dated [DATE], revealed that Resident #4 had a BIMS assessment score that was unable to be assessed due to the resident being rarely or never understood. A Behavior Note dated June 28, 2024, revealed that Resident #4 entered the activity room and sat on another resident that was sitting on the couch. The other resident sat up and struck Resident #4 on the left side of the face on the cheek. The residents were separated and started on 15-minute checks. Appropriate parties were notified. Resident #3 was admitted to the facility on [DATE], with diagnoses that included Alzheimer's disease, severe dementia with agitation, and obstructive and reflux uropathy. A quarterly MDS assessment dated [DATE], revealed that Resident #3 had a BIMS assessment score that was unable to be assessed due to the resident being rarely or never understood. A Behavior Note dated July 28, 2024, revealed that Resident #3 was laying on the couch in the dining room when another resident came in and sat on him. Resident #3 sat up and hit the other resident on the left side of his face on the cheek. The residents were separated and placed on 15-minute checks, and appropriate parties will be notified. A facility Reportable Event Record dated August 1, 2024, revealed that on July 28, 2024, at approximately 2:40 PM, a resident to resident incident occurred. Resident #3 was laying on the couch in the 300 hall unit. Resident #4 went to sit on the couch and did not see Resident #3, and sat on him. Resident #3 swung at Resident #4 and did hit him on the cheek. The report indicated no injuries were sustained. A witness statement was included by a CNA (Staff #9), which revealed Staff #9 heard Resident #4 yell out from the day room. Staff #9 went into the day room and saw Resident #4 sit on Resident #3's legs who was sleeping on the couch. Resident #3 then woke up and punched Resident #4 in the face. The CNA separated the residents and reported the incident to the nurse. An interview was conducted with the CNA (Staff #9) on January 14, 2025, at 10:13 AM. The CNA stated that she recalled the incident between Resident #3 and #4, that she went into the day room and saw Resident #3 laying on the loveseat sleeping with his legs propped up on the armrest. As she was exiting the dayroom, the CNA saw Resident #4 enter the dayroom and sit down on Resident #3's legs. Resident #3 woke up and yelled out and punched Resident #4 in the face. The CNA stated that it happened very quickly. She stated the residents were separated, and she reported the incident to management right away, and that the residents were placed on 15-minute checks. An interview was conducted with the DON on January 14, 2025, at 12:49 PM. The incident between Resident #3 and #4 on July 28, 2024, was reviewed together, and the DON stated that after the incident, the residents were separated, that all appropriate parties were notified, and that she considered the incident to be an instance of abuse. -Regarding Resident #5: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035117	A. Building B. Wing	01/14/2025

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #5 was readmitted to the facility on [DATE], with diagnoses that included myositis ossificans progressiva, chronic pain syndrome, dysphagia, major depressive disorder, and muscle wasting and atrophy. A quarterly MDS assessment dated [DATE], revealed that Resident #5 had a BIMS assessment score of 15, indicating intact cognition. Section G indicated the resident required extensive assistance to total assistance from caregivers for bed mobility, transfers from bed to chair, dressing, toileting, and personal hygiene. A facility Reportable Event Report dated August 14, 2023, revealed that on August 9, 2023, at approximately 6:55 PM, Resident #5 reported to a CNA (Staff #50) that she had asked another CNA (Staff #64) to assist her in changing. Resident #5 reported that Staff #64 then said no and walked out of the room. Additionally, Resident #5 reported that Staff #64 was rude, mean, and yells at her. The report continued and noted that another resident's husband delivered a letter to the facility on [DATE]. The letter indicated that Staff #64 was rough with the resident when providing care, and that Staff #64 was rude and mean. The report additionally revealed that another resident was interviewed during the investigation and stated that Staff #64 does not always meet her needs when answering the call light, and that Staff #64 told her that if she keeps yelling out then Staff #64 would shut the resident's door, and reported that Staff #64 did shut the door. Additionally, the resident stated that Staff #64 is rude and mean to her. Also, the report revealed that Staff #64 was terminated. Review of a Termination Form for Staff #64 dated August 14, 2023, revealed that the staff was terminated effective August 14, 2023, for a violation of the facility's abuse policy. An interview was conducted with Resident #5 on January 14, 2025, at 11:13 AM. The resident stated that she recalled the CNA (Staff #64), and that it's taken care of, she doesn't work here anymore. She stated that the CNA was rude to her and that she could not recall exactly what was said, but that Staff #64 did not change her or get her coffee when she had requested. Resident #5 stated that there were approximately 3 or 4 instances where the resident had turned on her call light for assistance, and Staff #64 would come into the room and turn the call light off, tell the resident to wait, and then leave without addressing the concern. Resident #5 stated that she reported to another staff member that she had not been changed all night long when she had requested to be changed. She stated that she was soaking wet, and other CNAs came in the morning and took care of her. An interview was conducted with the DON on January 14, 2025, at 12:49 PM. The DON stated that verbal abuse can be belittling someone, something that makes them feel bad about themselves, unkind words, and name-calling. She also stated that physical abuse included rough handling of a resident by a staff member. The DON stated that the facility's process in allegations of abuse is to ensure the resident's safety, to report the incident to mandated reporting sources within 24 hours, to complete an internal facility investigation, and complete a 5-day report to the state agency. (continued on next page)

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	035117	A. Building B. Wing	01/14/2025

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with the Administrator (Staff #75) on January 14, 2025, at 1:41 PM. The Administrator stated that with allegations of abuse or neglect, that it is his expectation that staff report to him immediately. He stated that the residents should be separated in resident-to-resident incidents, and staff are suspended if the alleged abuser is a staff member. He stated that an assessment is completed, and that a report should be done. Witness statements are taken from staff and residents, and then a conclusion is drawn from the investigation to ensure it does not happen again. In regard to the allegations by Resident #5, the Administrator stated that Staff #64 was suspended immediately, and that an investigation was conducted by the facility, and that three residents were found to have similar complaints against Staff #64. The Administrator stated that the facility concluded that verbal abuse did occur, and that we found evidence of her rough handling of residents, and that the facility terminated Staff #64. Review of the facility policy titled Abuse - Prevention, reviewed June 17, 2024, revealed that it is the policy of the facility to prevent and prohibit all types of resident abuse and neglect. The facility must develop and implement written policies and procedures that prohibit and prevent abuse and neglect, and to investigate any such allegations. Review of the facility policy titled Abuse - Conducting an Investigation, reviewed June 17, 2024, revealed that it is the policy of the facility that allegations of abuse are investigated promptly and thoroughly. Additionally, the facility will prevent further abuse from occurring while the investigation is in progress. The alleged victim will be examined for any sign of injury. If the alleged perpetrator is an employee, the employee will be placed on suspension pending the results of the investigation. If the accused abuser is another resident, the residents must be separated while investigating the incident. Interventions must be implemented to assure the safety of all residents. Review of the facility policy titled Abuse - Reporting and Response - Suspicion of a Crime, revised April 9, 2024, revealed that the facility will ensure reporting reasonable suspicion of crimes against a resident within prescribed timeframes to the appropriate entities. The facility's policy revealed that if there is reasonable suspicion that a crime has occurred at the facility involving a resident, it must be reported to the State Agency and local law enforcement as follows: -Serious Bodily Harm - reported immediately but not later than 2 hours after forming a suspicion. -No Serious Bodily Injury - reported as soon as practical, but not later than 24 hours. A discrepancy was noted between the facility's policy on reporting abuse and the federal guideline in the State Operations Manual Appendix PP: 483.12 (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: 483.12 (c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.

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	035117	A. Building B. Wing	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Payson Care Center	107 East Lone Pine Drive Payson, AZ 85541

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51124 Based on observations, record review, interviews, and review of facility documentation and policy, the facility failed to ensure that written policies and procedures were developed and implemented to prohibit and prevent abuse for one resident (#1). The deficient practice could lead to physical harm, mental anguish, and psychosocial harm to a resident. Resident #1 was admitted to the facility on [DATE], with diagnoses that included dementia, anemia, type 2 diabetes mellitus, and dysphagia. The quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed that Resident #1 had a Brief Interview for Mental Status (BIMS) assessment score that was unable to be assessed due to the resident being rarely or never understood. A Behavior Note dated September 12, 2024, revealed a behavior summary for the last 6 months that Resident #1: removed decor from walls in the hallway, urinated in the hall, removed items from nurse carts, entered peers rooms and interfered with care, turned off peer's oxygen, and removed fire extinguishers from fire case. Additionally, These behaviors have been numerous and consistent. A Health Status Note dated November 18, 2024, revealed that Resident #1 hit another resident with a rolled up newspaper while passing her in the hallway. She is using inappropriate language while interacting with another resident. There was no evidence that an incident report or assessment was completed for Resident #1 after the incident on the date of November 18, 2024. Additionally, there was no evidence that the facility conducted a thorough investigation of the incident, or put interventions in place to ensure the residents' safety while the investigation took place. A care plan dated February 17, 2023, revealed a focus that the resident exhibits behavioral issues with foul language and abrasive with little concern for the feelings of others. There was no evidence that the care plan was updated after the incident on November 18, 2024. An interview was conducted with the Director of Nursing (DON / Staff #60) on January 14, 2025, at 12:49 PM. The DON stated that examples of physical abuse would be roughness when providing care from a staff member to a resident, or would be pinching, slapping, or swinging an object and making contact from a resident to another resident. At this time, the clinical record of Resident #1 was reviewed together, and specifically, the Health Status Note dated November 18, 2024, where Resident #1 was documented to strike another resident with a rolled-up newspaper. The DON stated that this was the first time she was aware of this incident, and that it was not reported to her, it was not investigated, and that it was not reported to the state agency. She stated that there was no way to tell if any injuries occurred because there was no incident report or investigation, she further stated that there was not a way to tell if the residents were separated for safety. She stated that this did not meet her expectation of how a resident to resident incident would be managed. (continued on next page)

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	035117	A. Building B. Wing	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Payson Care Center	107 East Lone Pine Drive Payson, AZ 85541

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The interview continued, and the DON stated that the facility's process in allegations of abuse is to ensure the resident's safety, to report the incident to mandated reporting sources within 24 hours, to complete an internal facility investigation, and complete a 5-day report to the state agency. An interview was conducted with the Administrator (Staff #75) on January 14, 2025, at 1:41 PM. The Administrator stated that with allegations of abuse or neglect, that it is his expectation that staff report to him immediately. He stated that the residents should be separated in resident-to-resident incidents, that an assessment is completed, and that a report should be done. Witness statements are taken from staff and residents, and then a conclusion is drawn from the investigation to ensure it does not happen again. Review of the facility policy titled Abuse - Prevention, reviewed June 17, 2024, revealed that it is the policy of the facility to prevent and prohibit all types of resident abuse and neglect. The facility must develop and implement written policies and procedures that prohibit and prevent abuse and neglect, and to investigate any such allegations. Review of the facility policy titled Abuse - Conducting an Investigation, reviewed June 17, 2024, revealed that it is the policy of the facility that allegations of abuse are investigated promptly and thoroughly. Additionally, the facility will prevent further abuse from occurring while the investigation is in progress. The alleged victim will be examined for any sign of injury. If the alleged perpetrator is an employee, the employee will be placed on suspension pending the results of the investigation. If the accused abuser is another resident, the residents must be separated while investigating the incident. Interventions must be implemented to assure the safety of all residents.

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	035117	A. Building B. Wing	01/14/2025

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51124 Based on observations, record review, interviews, and review of facility documentation and policy, the facility failed to ensure that an allegation of abuse was reported immediately but not later than two hours to the State Agency and mandated entities for one resident (#1). The deficient practice could lead to physical harm, mental anguish, and psychosocial harm to a resident. Resident #1 was admitted to the facility on [DATE], with diagnoses that included dementia, anemia, type 2 diabetes mellitus, and dysphagia. The quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed that Resident #1 had a Brief Interview for Mental Status (BIMS) assessment score that was unable to be assessed due to the resident being rarely or never understood. A Behavior Note dated September 12, 2024, revealed a behavior summary for the last 6 months that Resident #1: removed decor from walls in the hallway, urinated in the hall, removed items from nurse carts, entered peers rooms and interfered with care, turned off peer's oxygen, and removed fire extinguishers from fire case. Additionally, These behaviors have been numerous and consistent. A Health Status Note dated November 18, 2024, revealed that Resident #1 hit another resident with a rolled up newspaper while passing her in the hallway. She is using inappropriate language while interacting with another resident. There was no evidence that an incident report or assessment was completed for Resident #1 after the incident on the date of November 18, 2024. There was no evidence that the allegation of abuse was reported immediately but not later than two hours to the State Agency and mandated entities. An interview was conducted with the Director of Nursing (DON / Staff #60) on January 14, 2025, at 12:49 PM. The DON stated that examples of physical abuse would be roughness when providing care from a staff member to a resident, or would be pinching, slapping, or swinging an object and making contact from a resident to another resident. At this time, the clinical record of Resident #1 was reviewed together, and specifically, the Health Status Note dated November 18, 2024, where Resident #1 was documented to strike another resident with a rolled-up newspaper. The DON stated that this was the first time she was aware of this incident, and that it was not reported to her, it was not investigated, and that it was not reported to the state agency. She stated that this did not meet her expectation of how a resident to resident incident would be managed. The interview continued, and the DON stated that the facility's process in allegations of abuse is to report the incident to mandated reporting sources within 24 hours. (continued on next page)

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	035117	A. Building B. Wing	01/14/2025

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Administrator (Staff #75) on January 14, 2025, at 1:41 PM. The Administrator stated that with allegations of abuse or neglect, that it is his expectation that staff report to him immediately. He stated that the residents should be separated in resident-to-resident incidents, that an assessment is completed, and that a report should be done. Witness statements are taken from staff and residents, and then a conclusion is drawn from the investigation to ensure it does not happen again. Review of the facility policy titled Abuse - Prevention, reviewed June 17, 2024, revealed that it is the policy of the facility to prevent and prohibit all types of resident abuse and neglect. The facility must develop and implement written policies and procedures that prohibit and prevent abuse and neglect, and to investigate any such allegations. Review of the facility policy titled Abuse - Reporting and Response - Suspicion of a Crime, revised April 9, 2024, revealed that the facility will ensure reporting reasonable suspicion of crimes against a resident within prescribed timeframes to the appropriate entities. The facility's policy revealed that if there is reasonable suspicion that a crime has occurred at the facility involving a resident, it must be reported to the State Agency and local law enforcement as follows: -Serious Bodily Harm - reported immediately but not later than 2 hours after forming a suspicion. -No Serious Bodily Injury - reported as soon as practical, but not later than 24 hours. A discrepancy was noted between the facility's policy on reporting abuse and the federal guideline in the State Operations Manual Appendix PP: 483.12 (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: 483.12 (c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035117	A. Building B. Wing	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Payson Care Center	107 East Lone Pine Drive Payson, AZ 85541

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51124 Based on observations, record review, interviews, and review of facility documentation and policy, the facility failed to ensure that an allegation of abuse was thoroughly investigated, and that further potential abuse was prevented during an investigation of abuse for one resident (#1). The deficient practice could lead to physical harm, mental anguish, and psychosocial harm to a resident. Resident #1 was admitted to the facility on [DATE], with diagnoses that included dementia, anemia, type 2 diabetes mellitus, and dysphagia. The quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed that Resident #1 had a Brief Interview for Mental Status (BIMS) assessment score that was unable to be assessed due to the resident being rarely or never understood. A Behavior Note dated September 12, 2024, revealed a behavior summary for the last 6 months that Resident #1: removed decor from walls in the hallway, urinated in the hall, removed items from nurse carts, entered peers rooms and interfered with care, turned off peer's oxygen, and removed fire extinguishers from fire case. Additionally, These behaviors have been numerous and consistent. A Health Status Note dated November 18, 2024, revealed that Resident #1 hit another resident with a rolled up newspaper while passing her in the hallway. She is using inappropriate language while interacting with another resident. There was no evidence that an incident report or assessment was completed for Resident #1 after the incident on the date of November 18, 2024. Additionally, there was no evidence that the facility conducted a thorough investigation of the incident, or put interventions in place to ensure the residents' safety while the investigation took place. A care plan dated February 17, 2023, revealed a focus that the resident exhibits behavioral issues with foul language and abrasive with little concern for the feelings of others. There was no evidence that the care plan was updated after the incident on November 18, 2024. An interview was conducted with the Director of Nursing (DON / Staff #60) on January 14, 2025, at 12:49 PM. The DON stated that examples of physical abuse would be roughness when providing care from a staff member to a resident, or would be pinching, slapping, or swinging an object and making contact from a resident to another resident. At this time, the clinical record of Resident #1 was reviewed together, and specifically, the Health Status Note dated November 18, 2024, where Resident #1 was documented to strike another resident with a rolled-up newspaper. The DON stated that this was the first time she was aware of this incident, and that it was not reported to her, it was not investigated, and that it was not reported to the state agency. She stated that there was no way to tell if any injuries occurred because there was no incident report or investigation, she further stated that there was not a way to tell if the residents were separated for safety. She stated that this did not meet her expectation of how a resident to resident incident would be managed. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The interview continued, and the DON stated that the facility's process in allegations of abuse is to ensure the resident's safety, to report the incident to mandated reporting sources within 24 hours, to complete an internal facility investigation, and complete a 5-day report to the state agency. An interview was conducted with the Administrator (Staff #75) on January 14, 2025, at 1:41 PM. The Administrator stated that with allegations of abuse or neglect, that it is his expectation that staff report to him immediately. He stated that the residents should be separated in resident-to-resident incidents, that an assessment is completed, and that a report should be done. Witness statements are taken from staff and residents, and then a conclusion is drawn from the investigation to ensure it does not happen again. Review of the facility policy titled Abuse - Prevention, reviewed June 17, 2024, revealed that it is the policy of the facility to prevent and prohibit all types of resident abuse and neglect. The facility must develop and implement written policies and procedures that prohibit and prevent abuse and neglect, and to investigate any such allegations. Review of the facility policy titled Abuse - Conducting an Investigation, reviewed June 17, 2024, revealed that it is the policy of the facility that allegations of abuse are investigated promptly and thoroughly. Additionally, the facility will prevent further abuse from occurring while the investigation is in progress. The alleged victim will be examined for any sign of injury. If the alleged perpetrator is an employee, the employee will be placed on suspension pending the results of the investigation. If the accused abuser is another resident, the residents must be separated while investigating the incident. Interventions must be implemented to assure the safety of all residents.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51124 Based on observations, record review, interviews, and review of facility documentation and policy, the facility failed to ensure that the medical record was complete and accurately documented for one resident (#1). The deficient practice could lead to an insufficient record of a resident's status resulting in a decreased quality of care provided. Resident #1 was admitted to the facility on [DATE], with diagnoses that included dementia, anemia, type 2 diabetes mellitus, and dysphagia. The quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed that Resident #1 had a Brief Interview for Mental Status (BIMS) assessment score that was unable to be assessed due to the resident being rarely or never understood. A Behavior Note dated September 12, 2024, revealed a behavior summary for the last 6 months that Resident #1: removed decor from walls in the hallway, urinated in the hall, removed items from nurse carts, entered peers rooms and interfered with care, turned off peer's oxygen, and removed fire extinguishers from fire case. Additionally, These behaviors have been numerous and consistent. A Health Status Note dated November 18, 2024, revealed that Resident #1 hit another resident with a rolled up newspaper while passing her in the hallway. She is using inappropriate language while interacting with another resident. There was no evidence that an incident report or assessment was completed for Resident #1 after the incident on the date of November 18, 2024. Additionally, there was no evidence that the facility conducted a thorough investigation of the incident, or put interventions in place to ensure the residents' safety while the investigation took place. A care plan dated February 17, 2023, revealed a focus that the resident exhibits behavioral issues with foul language and abrasive with little concern for the feelings of others. There was no evidence that the care plan was updated after the incident on November 18, 2024. An interview was conducted with the Director of Nursing (DON / Staff #60) on January 14, 2025, at 12:49 PM. The clinical record of Resident #1 was reviewed together, and specifically, the Health Status Note dated November 18, 2024, where Resident #1 was documented to strike another resident with a rolled-up newspaper. The DON stated that this was the first time she was aware of this incident. She stated that there was no way to tell if any injuries occurred because there was no incident report, assessment, or investigation, she further stated that there was not a way to tell if the residents were separated for safety. She stated that this did not meet her expectation of how a resident to resident incident would be managed or documented. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled Nursing Documentation, reviewed September 5, 2024, revealed that the facility will ensure nursing documentation is consistent with professional standards of practice, the state nurse practice act, and any state laws governing the scope of nursing practice. Additionally, the medical record shall reflect a resident's progress and maintenance of their clinical, functional, mental and psychosocial status. The medical record must contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress, including his/her response to treatment and/or services, and changes in his/her condition, and objectives and interventions. Review of the facility policy titled Incident and Reportable Event Management, revised August 15, 2023, revealed that event management includes, but is not limited to, the following types of events: alleged abuse, skin related injuries, and verbal and physical aggression. The licensed nurse should create an event note: and include the following details: the assessment details of the resident, presence or absence of injury and treatment rendered, notification to family or responsible party, notification to physician and any orders received.