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	01/30/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51124 Based on documentation, staff interviews, and the facility policy and procedures, the facility failed to ensure one resident (#5) was provided with adequate supervision to prevent a fall. The deficient practice could result in residents being harmed physically and psychologically. Findings include: Resident #5 was admitted to the facility on [DATE], with diagnoses that included spinal stenosis, chronic kidney disease, polyneuropathy, and history of falling. An admission Minimum Data Set (MDS) assessment dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. Section J revealed the resident had a fall within the last month and within the last 2-6 months. A care plan dated January 13, 2025, revealed the resident is at risk for falls. A goal indicated that the resident will not sustain serious injury requiring hospitalization through the review date. Interventions included to assist with activities of daily living (ADLs) as needed and to have call light within reach. A Skilled Note dated January 13, 2025, revealed that the resident is alert and oriented, and is pleasant and compliant with care. A Skilled Note dated January 15, 2025, revealed that the resident expressed to the nurse that he wanted to talk to the doctor because he feels he is starting to hallucinate and is wondering if he is taking a medication that might be making him feel this way. The resident stated that he can look at the mattress and thinks he sees holes in the mattress. This nurse will notify the provider. The resident is alert and oriented x 3, and able to make needs known. A Health Status Note dated January 16, 2025, revealed that the resident was agitated and with unorganized thinking. The provider was notified. The resident's wife was contacted and agreed to a medication change. The resident stated he wants to leave against medical advice (AMA), and the resident's wife was not in agreement. (continued on next page)

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

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	035117	A. Building B. Wing	01/30/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Behavior Note dated January 19, 2025, at 5:41 AM, indicated that the resident was anxious and restless, climbing out of bed, and taking off his nasal cannula. The resident was difficult to redirect. The note indicated that the resident is resting in bed, and the nurse will continue to monitor for behaviors. There was no evidence that a fall occurred at this time. Review of the clinical record revealed no evidence of any progress notes documenting any falls or an incident where the resident was found on the ground and subsequently sent to the hospital. There was evidence that on January 19, 2025, that two separate fall assessments and a neurocheck assessment documents were created, however the documents were incomplete and unsigned, with no description of a fall event. Review of the clinical record revealed no evidence of a note describing the resident's vital signs related to a fall incident on January 19, 2025. The documented vital signs on the vitals log on January 19, 2025, were at 8:18 AM: -Pulse: 95 beats per minute -Respiratory Rate: 28 breaths per minute -Oxygen: 98.0% with no dose indicated, administered via Nasal Cannula And at 8:58 AM: -Temperature (Forehead): 99.0 degrees A witness statement signed January 19, 2025, by a Registered Nurse (RN / Staff #3), revealed that the nurse was contacted by a Certified Nursing Assistant (CNA / Staff #17) regarding the resident being found on the floor. The nurse observed the resident laying on the floor on right side, but face down next to the bed, which was in the lowest position. The resident's oxygen cannula was off and the resident's breathing was not good. The nurse assessed the resident for injury, replaced the oxygen cannula, and assisted the resident back to bed with the hoyer lift. The resident was not cooperative with a blood pressure reading, and the resident's eyes slightly opened, but not answering questions appropriately. The nurse noted that the resident's upper extremities were twitching. The nurse checked with the CNA regarding the resident's mental status and twitching and the CNA stated that this is new for the resident. The nurse called the provider to notify that the resident was being sent to the emergency room . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An undated witness statement by the CNA (Staff #17), revealed that on January 19, 2025, during shift change / report, the CNA noticed that the resident was restless. The CNA then repositioned the resident in the bed to make him more comfortable. The CNA took the resident's vital signs and all vitals were normal except the resident's temperature was a little high at 99.2 degrees. The witness statement revealed that I continued to check him every few minutes. At approximately 7:45 AM, while serving breakfast trays, the CNA observed the resident on the floor, on his stomach, and his breathing was labored. The CNA immediately notified the nurse who stayed with the resident while the CNA got two additional staff members: a nurse (Staff #23) and a CNA (Staff #40). The four staff members assisted the resident back into bed with the hoyer lift. The statement revealed that the resident's vitals were taken again, his temperature was a little higher, and all other vitals were normal. Additionally, the resident was twitching and restless. The nurse called 911 and resident was transferred out to the hospital. A facility Reportable Event Record dated January 22, 2025, revealed a narrative of an event that occurred on January 19, 2025, starting at 5:53 AM, when the nurse documented that the resident was anxious, restless, taking oxygen cannula off, and climbing out of bed. The report indicated that the resident was difficult to redirect and the resident's heartrate was 132. The report indicated increased observation was provided to the resident, without specifying any further details. The report revealed that on January 19, 2025, with no time indicated, the resident was found on the floor next to their bed by the window. The bed was in the lowest position. There was urine on the floor, and the resident was breathing rapidly. The nurse assessed the resident with no obvious injury seen. The resident denied pain, was confused and reaching out, and refused to open eyes and answer question. Additionally, the resident's heartrate was 180, and the resident had twitching and tremors. Emergency services were called. The report revealed that prior to this event, the resident was ambulatory with a walker and with staff providing contact guard assistance. After the incident, staff members who were interviewed reported that the resident got out of bed unattended and had a fall on January 19, 2025. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A telephonic interview conducted on January 30, 2025, at approximately 11:00 AM, with a CNA (Staff#17) revealed that she worked with Resident #5 since his admission to the facility and was familiar with the resident. Staff #17 stated that the resident was very pleasant and was mostly independent, but needed a little assistance for a few things. She stated that she noticed that approximately 2 days before he left the facility and was readmitted to the hospital, that the resident started having quite a bit of confusion. She stated that the resident was sitting up in the chair in his room and crying, and that the resident was stating that he was seeing his dead brother was on the bed. The CNA believed that the resident was hallucinating. She stated that on the morning of January 19, 2025, that it was very apparent that his behavior was changed. She stated that she came to the facility at 6:00 AM, and started report with the other CNA at the resident's room. She stated that she noticed the resident was in bed but was agitated, and kept pulling at his hospital gown and blankets. She stated that she lowered the resident's bed all the way down. The resident kept pulling at his gowns and blankets, and the CNA asked the resident if he was hot, to which the resident did not respond. She stated that she checked on the resident approximately 5-10 minutes later, and the resident appeared agitated and still taking his sheets off. She stated she assessed his vital signs at this time and that the resident's temperature was a little high at 99.2 degrees, and that she reported it to the nurse. She stated that throughout the morning, that she was doing frequent checks on the resident, approximately every 5-15 minutes, and that the resident continued to be agitated and taking his sheets off. She stated that at approximately 7:40 AM, she was serving breakfast trays and found the resident face down on the floor beside the bed, with labored breathing. The CNA stated she went and got the nurse (Staff #3), and then 2 other staff members: a nurse (Staff #23) and a CNA (Staff #40) who helped to assist the resident with the hoyer lift back to bed. She stated that she believed the resident was confused and that he did not realize that the staff were there to help him. She stated that she took the resident's vitals again, and that she believed the resident's heart rate was in the 90's, that his blood pressure was good, and that his temperature was over 100 degrees at this point. She stated that the resident was twitching in his shoulder area. She stated that the resident was not opening his eyes, but would respond to questions in an altered manner, that he was answering questions with grunting and growling noises that were coming from his mouth. The CNA stated that the nurse (Staff #3) called an ambulance at around 8:15 AM, which arrived for the resident at approximately 8:20 AM. An interview was conducted with a CNA (Staff #55) who stated that she recalled working with Resident #5 on her shifts on January 15, 16, and 17, 2025. The CNA stated that she recalled that the resident was able to sit himself up independently and was appropriately asking for things like coffee and water, and that he was not confused or restless or hallucinating. An interview was conducted with a CNA (Staff #40) on January 30, 2025, at 12:39 PM. Stated that she recalled working with Resident #5 a few times, and that she recalled him being confused on the shift that she believed was January 18, 2025. She stated she recalled the resident appeared as if he was hallucinating, that the resident was requesting her assistance to pick something up off the floor, but there was nothing there. She stated that she did not go into the resident's room at all on January 19, despite the witness statement indicating that she assisted with the hoyer transfer, because she was assigned to a different unit and could not leave the unit. (continued on next page)

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	035117	A. Building B. Wing	01/30/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A telephonic interview was conducted on January 30, 2025, at 12:57 PM, with a Nurse Practitioner (NP / Staff #46) who stated that he recalled providing care to Resident #5. He stated that he had a provider visit with Resident #5 on Friday, January 17, 2025, and that the resident was not confused and that he was fine, I had a good talk with him. The NP stated that he was not contacted at all by facility staff to notify him that the resident had a change in behavior or confusion until the morning of January 19, 2025, at 5:40 AM, when a nurse contacted him to let him know that the resident was restless and pulling off his oxygen cannula. The NP stated that he was contacted again after the resident was found on the ground after a fall, to notify him that the resident was being transferred to the hospital. A telephonic interview was conducted on January 30, 2025, at 12:57 PM, with a Licensed Practical Nurse (LPN / Staff #29) who was the night shift nurse for Resident #5 on the night of January 18 through January 19, 2025. The LPN stated that on the morning of January 19, at around 5:30 AM, she recalled Resident #5 was combative with staff and kept taking off his oxygen. She stated that she asked other staff regarding the resident's behavior and the staff said that his behavior had changed, and that he was normal before this. The LPN stated that she did not contact the provider about the behavior change because the resident was calm after the staff put his oxygen back on. She stated that the resident had a fall during her shift in the morning: that the resident crawled out of bed and had his knees on the floor. The resident stated let me get into this chair, and that herself and other staff had assisted the resident back to bed. A telephonic interview was conducted with Resident #5's daughter and emergency contact on January 30, 2025, at 1:44 PM. The resident's daughter stated that she was informed that Resident #5 had fallen out of bed face first, and that the resident needed to be transferred to the hospital. An additional telephonic interview was conducted with Resident #5's other daughter on January 30, 2025, at 1:46 PM. She stated that she was informed that Resident #5 fell forward, and had a bruise on his knee and a scratch on his head, and that she was informed by the staff in the emergency room in the hospital that Resident #5 was confused and had an extremely low blood pressure. An interview was conducted with the Director of Nursing (DON / Staff #9) on January 30, 2025, at 2:16 PM. The DON stated that the facility's process if a resident experiences a fall is to complete a skin and pain assessment and neurochecks if indicated, to document it, and to contact the DON, the provider, and responsible parties. The DON stated that multiple things are considered a fall: if a resident slides out of bed, or lands on their knees or on the floor. The DON stated that it is her expectation for staff to recognize hazards that could lead to accidents or falls and to address the hazards. Additionally, in regard to Resident #5, the DON stated that she was aware of one fall that the resident had during his stay at the facility where he was found down in his room and sent out to the hospital, but was not aware of the other fall onto the resident's knees that was described by Staff #29. The DON stated that she was not aware that the resident had any hallucinations or any confusion prior to his fall on January 19, 2025. She stated that she recalled that the resident was complaining of pain in his leg after the fall. The clinical record was reviewed for Resident #5 together, and the DON stated that she could not find any notes regarding any falls, there were no post-fall assessment details, and that there were no neurochecks, or skin assessments, or pain assessments completed. She stated this would not meet her expectation. (continued on next page)

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	035117	A. Building B. Wing	01/30/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Change in Resident's Condition or Status, revised September 5, 2024, revealed that the facility will notify the resident, the primary care provider, and the resident's representative of changes in the resident's condition or status. The facility must immediately inform the resident and consult with the resident's physician when there is a significant change in the resident's physical, mental, or psychosocial status. Review of the facility policy titled Incident and Reportable Event Management, reviewed September 25, 2024, revealed that the facility to the best of its ability strives to provide an environment that is free from accident hazards, and provides supervision and assistive devices to each resident to prevent avoidable accidents. An avoidable accident means that an accident occurred because the facility failed to identify environmental hazards, assess individual resident risks of an incident, analyze the hazards and risks and eliminate them, implement interventions, including adequate supervision, and to monitor the effectiveness of the interventions. A fall refers to unintentionally coming to rest on the ground, floor, or other lower level. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred. In cases of incidents, including falls, the licensed nurse should evaluate the resident, create an event note with assessment details of the resident, presence or absence of injury, what occurred, notification of family or responsible party, and notification of physician. The nurse should create a risk report and notify the supervisor on duty and/or DON.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51124 Based on observation, record review, interviews, and facility policy review, the facility failed to ensure respiratory services were provided according to professional standards for one resident (#5). The deficient practice could result in residents receiving unmonitored doses of supplemental oxygen, and the provider not being aware of the resident's status. Findings include: Resident #5 was admitted to the facility on [DATE], with diagnoses that included spinal stenosis, chronic kidney disease, polyneuropathy, and history of falling. An admission Minimum Data Set (MDS) assessment dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. Review of the care plan revealed no evidence of a care plan for oxygen use. A physician order dated January 6, 2025, indicated for Oxygen continuously per nasal cannula. Document, with no further instructions or information. Review of the O2 Sats Summary log revealed that from January 6, 2025, through January 19, 2025, that Resident #5 was documented to have Oxygen via Nasal Cannula, except for two dates on January 12 and January 15, where the resident was documented to be on Room Air. Only one date on the entire log, January 14, revealed the specific dose the resident was on: 3 liters. All other log entries revealed no specific dose of oxygen. In an interview with a Registered Nurse (RN / Staff #36) conducted on January 30, 2025, at 12:46 PM, the RN stated that it is the facility's process to monitor oxygen use by obtaining a physician order for the oxygen, and that the order would have a dose on it. The RN additionally stated that every resident who is on oxygen should have an order for it. An interview was conducted with the Director of Nursing (DON / Staff # 9) on January 30, 2025 at 2:16 PM. The DON stated that the facility's process for administering oxygen is to obtain an order from the provider, and the staff apply the oxygen dose according to the order. The DON stated that there should be a dose indicated on an oxygen order. The DON stated that if a resident was receiving an unmonitored oxygen dose, that it could affect a resident's cognition, and could lead to the provider not being aware of what dose the resident is on. The oxygen order was reviewed for Resident #5, as well as the O2 Sats Summary log, and the DON stated that there were no parameters for the dose on the oxygen order, that the dose was not consistently charted on the vitals log, and that it would not meet her expectation for providing respiratory care. Review of the facility policy titled Oxygen Administration (Safety, Storage, Maintenance), revised October 11, 2024, revealed that an oxygen order should be written for specific liter flow required by the resident.

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	035117	A. Building B. Wing	01/30/2025

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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 documentation, staff interviews, and the facility policy and procedures, the facility failed to ensure that the medical record was complete and accurate for one resident (#5). The deficient practice could lead to interdisciplinary team members not being aware of the resident's status and could lead to a gap in care. Findings include: Resident #5 was admitted to the facility on [DATE], with diagnoses that included spinal stenosis, chronic kidney disease, polyneuropathy, and history of falling. An admission Minimum Data Set (MDS) assessment dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. A Behavior Note dated January 19, 2025, at 5:41 AM, indicated that the resident was anxious and restless, climbing out of bed, and taking off his nasal cannula. The resident was difficult to redirect. The note indicated that the resident is resting in bed, and the nurse will continue to monitor for behaviors. There was no evidence that a fall occurred at this time. Review of the clinical record revealed no evidence of any progress notes documenting any falls or an incident where the resident was found on the ground and subsequently sent to the hospital. There was evidence that on January 19, 2025, that two separate fall assessments and a neurocheck assessment documents were created, however the documents were incomplete and unsigned, with no description of a fall event. Review of the clinical record revealed no evidence of a note describing the resident's vital signs related to a fall incident on January 19, 2025. The documented vital signs on the vitals log on January 19, 2025, were at 8:18 AM: -Pulse: 95 beats per minute -Respiratory Rate: 28 breaths per minute -Oxygen: 98.0% with no dose indicated, administered via Nasal Cannula And at 8:58 AM: -Temperature (Forehead): 99.0 degrees (continued on next page)

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	035117	A. Building B. Wing	01/30/2025

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A witness statement signed January 19, 2025, by a Registered Nurse (RN / Staff #3), revealed that the nurse was contacted by a Certified Nursing Assistant (CNA / Staff #17) regarding the resident being found on the floor. The nurse observed the resident laying on the floor on right side, but face down next to the bed, which was in the lowest position. The resident's oxygen cannula was off and the resident's breathing was not good. The nurse assessed the resident for injury, replaced the oxygen cannula, and assisted the resident back to bed with the hoyer lift. The resident was not cooperative with a blood pressure reading, and the resident's eyes slightly opened, but not answering questions appropriately. The nurse noted that the resident's upper extremities were twitching. The nurse checked with the CNA regarding the resident's mental status and twitching and the CNA stated that this is new for the resident. The nurse called the provider to notify that the resident was being sent to the emergency room . An undated witness statement by the CNA (Staff #17), revealed that on January 19, 2025, during shift change / report, the CNA noticed that the resident was restless. The CNA then repositioned the resident in the bed to make him more comfortable. The CNA took the resident's vital signs and all vitals were normal except the resident's temperature was a little high at 99.2 degrees. The witness statement revealed that I continued to check him every few minutes. At approximately 7:45 AM, while serving breakfast trays, the CNA observed the resident on the floor, on his stomach, and his breathing was labored. The CNA immediately notified the nurse who stayed with the resident while the CNA got two additional staff members: a nurse (Staff #23) and a CNA (Staff #40). The four staff members assisted the resident back into bed with the hoyer lift. The statement revealed that the resident's vitals were taken again, his temperature was a little higher, and all other vitals were normal. Additionally, the resident was twitching and restless. The nurse called 911 and resident was transferred out to the hospital. A facility Reportable Event Record dated January 22, 2025, revealed a narrative of an event that occurred on January 19, 2025, starting at 5:53 AM, when the nurse documented that the resident was anxious, restless, taking oxygen cannula off, and climbing out of bed. The report indicated that the resident was difficult to redirect and the resident's heartrate was 132. The report revealed that on January 19, 2025, with no time indicated, the resident was found on the floor next to their bed by the window. The bed was in the lowest position. There was urine on the floor, and the resident was breathing rapidly. The nurse assessed the resident with no obvious injury seen. The resident denied pain, was confused and reaching out, and refused to open eyes and answer question. Additionally, the resident's heartrate was 180, and the resident had twitching and tremors. Emergency services were called. After the incident, staff members who were interviewed reported that the resident got out of bed unattended and had a fall on January 19, 2025. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A telephonic interview conducted on January 30, 2025, at approximately 11:00 AM, with a CNA (Staff#17) who stated that on the morning of January 19, 2025, that she came to the facility at 6:00 AM, and started report with the other CNA at the resident's room. She stated that she noticed the resident was in bed but was agitated, and kept pulling at his hospital gown and blankets. She stated that she lowered the resident's bed all the way down. The resident kept pulling at his gowns and blankets, and the CNA asked the resident if he was hot, to which the resident did not respond. She stated that she checked on the resident approximately 5-10 minutes later, and the resident appeared agitated and still taking his sheets off. She stated she assessed his vital signs at this time and that the resident's temperature was a little high at 99.2 degrees, and that she reported it to the nurse. She stated that throughout the morning, that she was doing frequent checks on the resident, approximately every 5-15 minutes, and that the resident continued to be agitated and taking his sheets off. She stated that at approximately 7:40 AM, she was serving breakfast trays and found the resident face down on the floor beside the bed, with labored breathing. The CNA stated she went and got the nurse (Staff #3), and then 2 other staff members: a nurse (Staff #23) and a CNA (Staff #40) who helped to assist the resident with the hoyer lift back to bed. She stated that she believed the resident was confused and that he did not realize that the staff were there to help him. She stated that she took the resident's vitals again, and that she believed the resident's heart rate was in the 90's, that his blood pressure was good, and that his temperature was over 100 degrees at this point. She stated that the resident was twitching in his shoulder area. She stated that the resident was not opening his eyes, but would respond to questions in an altered manner, that he was answering questions with grunting and growling noises that were coming from his mouth. The CNA stated that the nurse (Staff #3) called an ambulance at around 8:15 AM, which arrived for the resident at approximately 8:20 AM. A telephonic interview was conducted on January 30, 2025, at 12:57 PM, with a Licensed Practical Nurse (LPN / Staff #29) who was the night shift nurse for Resident #5 on the night of January 18 through January 19, 2025. The LPN stated that the resident had a fall during her shift in the morning: that the resident crawled out of bed and had his knees on the floor. The resident stated let me get into this chair, and that herself and other staff had assisted the resident back to bed. An interview was conducted with the Director of Nursing (DON / Staff #9) on January 30, 2025, at 2:16 PM. The DON stated that the facility's process if a resident experiences a fall is to complete a skin and pain assessment and neurochecks if indicated, to document it, and to contact the DON, the provider, and responsible parties. The DON stated that multiple things are considered a fall: if a resident slides out of bed, or lands on their knees or on the floor. Additionally, in regard to Resident #5, the DON stated that she was aware of one fall that the resident had during his stay at the facility where he was found down in his room and sent out to the hospital, but was not aware of the other fall onto the resident's knees that was described by Staff #29. The clinical record was reviewed for Resident #5 together, and the DON stated that she could not find any notes regarding any falls, there were no post-fall assessment details, and that there were no neurochecks, or skin assessments, or pain assessments completed. She stated this would not meet her expectation. Review of the facility policy titled Change in Resident's Condition or Status, revised September 5, 2024, revealed that the facility will notify the resident, the primary care provider, and the resident's representative of changes in the resident's condition or status. The facility must immediately inform the resident and consult with the resident's physician when there is a significant change in the resident's physical, mental, or psychosocial status. (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	01/30/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Incident and Reportable Event Management, reviewed September 25, 2024, revealed that a fall refers to unintentionally coming to rest on the ground, floor, or other lower level. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred. In cases of incidents, including falls, the licensed nurse should evaluate the resident, create an event note with assessment details of the resident, presence or absence of injury, what occurred, notification of family or responsible party, and notification of physician. The nurse should create a risk report and notify the supervisor on duty and/or DON. Review of the facility policy titled Nursing Documentation, revised 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. The medical record shall reflect a resident's progress toward objectives and goals. Staff must document a resident's medical and non-medical status when any positive or negative condition change occurs. The medical record must also reflect the resident's condition and the care and services provided across all disciplines to ensure information is available to facilitate communication among the interdisciplinary team. The medical record must contain an accurate representation of the actual experience of the resident and include enough information to provide a picture of the resident's response to treatment/services, the resident's condition, and/or interventions.