STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035125	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgecrest Post Acute	16640 North 38th Street Phoenix, AZ 85032

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49319 Based on clinical record review, staff interviews and facility documentation and policy review, the facility failed to ensure that 3 residents (#20,#15, #127) are free from abuse. The deficient practice could result in residents not protected from further abuse. Findings include: Regarding resident #20 and resident #152 -Resident #20 was admitted on [DATE] with diagnoses of Huntington's disease, schizoaffective disorder, anxiety disorder, major depressive disorder, and alcohol dependence. A review of the clinical record revealed a BIMS (Brief Interview for Mental Status) score of 0 indicating the resident had severe cognitive impairment. It also included that the resident had a history of yelling, throwing things, pacing, wandering, refusing cares, cursing and hitting staff. -Resident #152 was admitted on [DATE], with diagnoses that included Huntington's disease, bipolar disorder, PTSD (post-traumatic stress disorder), significant history of abuse and methamphetamine use. Review of the clinical record revealed the resident had a BIMS score of zero indicating the resident had severe cognitive impairment. The facility self-report submitted to the SA (State Agency) on December 6, 2022 revealed that resident #152 got up from her seat during dinner time and walked over to resident #20 and started punching resident #20 in the face with closed fists four to five times. Per the documentation, resident #152 then walked back to her chair in the day room and sat down. The facility report included a signed witness statement dated December 6, 2022 by the certified nurse assistant (CNA/staff #207) who wrote that during dinner time in the dayroom at 5:40 p.m., resident #152 got out of her seat, walked over to resident #20 who was sitting and watching television. According to the written statement, resident #152 started punching resident #20 in her face four to five times with a closed fist. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the report included a signed witness statement dated December 6, 2022 by a registered nurse (RN/staff #212) who wrote that the RN left dayroom when dinner was winding down and went to chart at the nurses' station; and that, the CNA (staff #207) reported the attack to the RN; and that, both residents were separated immediately. The statement also included that resident #152 was removed from the dayroom and the RN administered an ice pack the PRN (as needed) pain medication to resident #20. Regarding resident #153 and resident #15 -Resident #153 was admitted to the facility on [DATE] with diagnoses that included neurocognitive disorder due to alcohol related dementia, post-traumatic stress disorder, anxiety, depression, violent behavior, and alcohol abuse. The care plan dated September 6, 2022 revealed that the resident had impaired thought processes related to alcohol induced dementia and had a history of wandering and physical aggression. Review of the clinical record revealed the resident had a BIMS score of 13/15 indicating the resident was cognitively intact. -Resident #15 was admitted to the facility on [DATE], with diagnoses of schizoaffective disorder, personality disorders, anxiety disorder, severe dementia with agitation, alcohol dependence and insomnia. The care plan dated November 23, 2015 revealed that resident #15 exhibited intrusive wandering, had history of sexually inappropriate behavior, hallucinations, disruptive yelling, and exit-seeking. The clinical record revealed that resident #15 had a BIMS score of 1/15 indicating the resident had severe cognitive impairment. A review of the facility self-report that was submitted to the SA on June 2, 2023 revealed that resident #153 pushed resident #15. Per the documentation, on June 2, 2023, at 11:00 a.m. resident #153 reported that resident #15 came into his room; and that, resident # 15 started touching his stuff so he told resident #15 to get out of his room. It also included that resident #15 did not get out so he pushed resident #15 on her upper chest with his palms and resident #15 stumbled backwards and then left his room. The report included an interview the facility conducted on June 2, 2023 with a licensed practical nurse (LPN/staff #11) who reported that resident #153 reported to her that resident #15 was trying to go into his room; and that, he told resident #15 to stop but resident #15 continued to try to go into his room anyway so he pushed resident #15 who bumped the door. The report further included an interview with a registered nurse (RN/staff #165) conducted on June 2, 2023. Per the documentation, the RN stated that the RN was in the dayroom when LPN/staff # 11 came and saida resident # 15 had received physical aggression from resident # 153 and that resident # 15 went into resident # 153's room and was told by resident # 153 to get out but did not, so resident # 153 grabbed her and shoved resident # 15 towards the door. Regarding resident #127 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident # 127 was admitted to the facility on [DATE], with diagnoses that included history of falls and alcohol use, altered mental status including hallucinations, asthma, COPD (Chronic Obstructive Pulmonary Disease), type 2 diabetes and anxiety. A review of resident # 127's clinical records revealed that resident # 127 had been assessed with a BIMS score of 10/15, indicating moderately impaired cognition. A review of the facility self-report to the SA on January 19, 2023, revealed that, CNA/staff # 210 observed LPN/staff# 211 attempted to administer medication to resident #127, then she observed LPN/staff# 211 open handedly hitting the side of resident # 127's head to arouse resident # 127. CNA/staff # 210 observed LPN/staff# 211 moved resident # 127's upper extremities in a circular motion in attempt to assist resident # 127 in getting resident # 127's medicine down and CNA/staff# 210 also observed resident # 127 was coughing after medication was administered by LPN/staff# 211. A review of LPN/staff # 211's witness statement dated January 19, 2023, stated that the LPN (staff#211) could not arouse resident # 127 by holding resident's #127 shoulder so the LPN shook resident #127 and called resident # 127's name. Then the statement stated the LPN tapped resident # 127 on the head with open hand with palms while calling resident #127's name to get resident # 127's attention. After the resident # 127 responded by verbal grunt, the LPN asked resident # 127 if he was okay, to which the resident # 127 responded with a yes. So, The LPN continued to pour lesser amounts of fluid, waiting for swallow reflux. The statement further stated the CNA/staff # 210 who was in the resident's room the whole time asked the LPN, aren't you being kind of rough? and the LPN answered stating that was the only way the LPN knew to make sure resident # 127 did not choke. The LPN stated of being rough. A review of CNA/staff# 210's witness statement dated, January 19, 2023, stated that the CNA questioned the LPN/staff # 211 if the resident was going to be medicated because the resident was not even waking up. The LPN/staff # 211 had replied saying yes because the doctor had told the LPN to medicate the resident. The CNA stated staying in resident #127's room, The CNA then stated with an open hand, using the whole inside of LPN/staff # 211 hand, LPN/staff # 211 started hitting resident # 127's right side of the head to try to wake up resident # 127 and then LPN/staff #211 palmed the top of resident # 127's head and started shaking resident #127's head in a circular motion so resident # 127's medicine could go down. The statement revelaed that the CNA told LPN/staff # 211, Hey what are you doing? You are hurting him and hitting him very hard. LPN/staff # 211 stated, Yes, I know. I know that is abuse. If you want to report me, go ahead. So then, LPN/staff # 211 gave resident # 127 juice to have the medicine go down and resident # 127 started coughing a little. I stayed in resident # 127's room until LPN/staff # 211 exited resident # 127's room together. Resident # 20 Resident # 20 was admitted to the facility on [DATE], with diagnoses that included Huntington's disease, schizoaffective disorder, anxiety disorder, major depressive disorder, and alcohol dependence. A review of resident # 20's clinical records revealed that resident # 20 had been assessed with a BIMS score of zero, indicating severe memory impairment. Resident # 20 had a history of yelling, throwing things, pacing, wandering, refusing cares, cursing and hitting staff. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility self-report submitted to the SA on December 28, 2022, revealed that night shift CNA/staff # 22 stated that she was scheduled to work on December 27, 2022 from 10:00pm to 6:00am. CNA/staff# 22 stated that when she walked in the doors, CNA/staff #22 saw registry CNA/staff# 212 and RN/staff# 213 in front of resident # 20's room. CNA/staff#22 saw staff # 212 holding resident #20's door shut with a resident gown tied from resident # 20's room doorknob to the hallway side rail. A review of a signed witness statement by registry CNA/staff # 216 on December 29, 2022, stated that, while coming on shift, I saw the evening shift had a night gown tied to resident # 20's room door. CNA/staff # 22 was by resident #20's room door, untying the gown from it. A review of a signed witness statement by night shift LPN/staff# 29 on December 27, 2022, stated that, I received report from CNA/staff # 22 and CNA/staff # 216 that they witnessed possible abuse towards resident #20. LPN/staff # 29 confirmed the statement by CNA/staff # 22 regarding CNA/staff 212 holding resident # 20's room door shut with a gown tied from the room doorknob to the hallway side rail. LPN/staff # 29 reported this allegation to the DON/staff # 149 (Director of Nursing). An interview regarding current practice on abuse with LPN/staff # 59 on June 12, 2024, at 12:45pm was conducted. LPN/staff # 59 stated that all staff receive training on abuse and neglect during new employee orientation and those are ongoing during meetings and individualized training. An interview regarding current practice on abuse with ADON/staff # 7, on June 12, 2024, at 10:40am, was conducted. ADON/staff # 7 stated that abuse and neglect procedures are taught during new employee orientation, then discussed at every staff meeting. Additional training is provided to staff, individually, based on need. A review of the facility's policy on abuse, dated April 2021, and it states, residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms.

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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** 49319 Based on clinical record review, staff interviews and facility documentation and policy review, the facility failed to identify residents who are at risk of unsafe wandering. The deficient practice could result in physical injury. Findings include: Resident #154 was admitted on [DATE] with diagnoses of aphasia, stroke, muscle weakness, abnormalities of gait and mobility, altered mental status and repeated falls. A review of the hospital history and physical note dated March 11, 2023 revealed that resident was alert and oriented to person and place only. The baseline care plan dated March 16, 2023 revealed that the resident was confused. The wandering risk assessment dated [DATE] revealed the resident was found to be disoriented and can be disturbed by environmental noise levels. The wandering risk assessment dated [DATE] included the resident was found to be forgetful/short attention span and known wanderer or had a history of wandering. A progress note dated March 21, 2023 revealed the resident was outside with the police due to wandering through a residential neighborhood south of the facility. Per the documentation, the resident was previously seen in his room at 5:55pm by a certified nurse assistant (CNA/staff # 208). The documentation also included that the resident was agitated, had a small skin tear to the posterior left hand, was resistive to returning to the facility; and, was placed on a one-on-one monitoring. A review of the facility self-report submitted to the SA (state Agency) on March 21, 2023, revealed that at approximately 6:40 p.m. on March 21, 2023, resident #154 was seen by a neighbor walking down the street just south of the facility; and, was returned to the facility by the police. Per the documentation, the resident exited the facility through his room window which had been opened and the screen was pushed out. An interview with the assistant Director of Nursing (ADON/staff #7) was conducted on June 12, 2024. The ADON stated that stations one and two were not locked or secured; and that, the level of independence of each resident in the unit was determined by risks and cognition levels of each resident. A review of the facility's policy on Wandering and Elopement dated March 2019 included that the facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents; and, if identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety.