| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 035125 | A. Building<br>B. Wing | 08/26/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Ridgecrest Post Acute | 16640 North 38th Street<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47910<br><br>Based on documentation, staff interviews, and the facility policy and procedures, the facility failed to ensure that residents are free from abuse from other residents. The deficient practice could result in residents being physically and emotionally injured.<br><br>Findings include:<br><br>Resident #8 was admitted to the facility on [DATE] with diagnoses that included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, mild cognitive impairment of uncertain or unknown etiology.<br><br>The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 13 indicating the resident was cognitively intact.<br><br>A provider progress note dated August 13, 2024 revealed resident #8 and resident #26 who reside on Sunset Secured Behavioral Unit had a verbal altercation in the dayroom. The note stated that staff were present and able to immediately separate the two residents. The note stated Resident #8 currently was on one-on-one staff supervision and ongoing investigation was in progress to collect more details. The note stated DHS (Department of Health Services), APS (Adult Protective Services), Ombudsman, Police, Provider, Case manager and responsible parties were notified.<br><br>The care plan dated June 24, 2024 revealed that the resident has potential for impaired thought processes r/t diagnosis of dementia.<br><br>-Resident #26 was admitted to the facility on [DATE] with diagnoses that included major depressive disorder, recurrent, unspecified, post-traumatic stress disorder, unspecified, dementia in other diseases classified elsewhere, unspecified severity, with agitation, generalized anxiety disorder<br><br>The care plan dated May 8, 2024 revealed that the resident is/has the is/has potential to demonstrate verbally abusive behaviors related to major depressive disorder, pos traumatic stress disorder, dementia with agitation, anxiety disorder as exhibited by thinking people are outside his window and trying to kill him, paranoid delusions, visual hallucinations.<br><br>(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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Review of the behavioral health care plan dated June 10, 2024 revealed a risk assessment for identified behavioral triggers. The identified triggers were being around people, noise, and when unable to express himself properly and/or loses his thought when speaking.<br><br>The quarterly minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 10 indicating the resident had moderate cognitive impairment. Further review of the MDS revealed resident presented with delusional behaviors.<br><br>A progress note dated August 13, 2024 revealed a Change in Condition/s (CIC) reported on this CIC Evaluation are/were: Behavioral symptoms (e.g. agitation, psychosis) and a verbal altercation between resident # 8 and #26. Staff present and able to immediately separate the two residents. [NAME] currently on one-on-one staff supervision. ON going investigation in progress to collect more details. DHS, APS, Ombudsman, Police, Provider, Case manager, responsible parties notified.<br><br>Review of the Clinical Census revealed resident #26 was moved to a different secured unit August 16, 2024.<br><br>Review of an interview statement dated August 13, 2024 by a certified nursing assistant (CNA/staff #241), revealed that she observed resident #26 swinging his fists in the air with (CNA/staff #209) and (LPN/registry staff #17) in between resident #26 and #8. She stated she never observed any physical contact between the two residents.<br><br>Review of an interview statement dated August 13, 2024 revealed that a licensed practical nurse (LPN/registry staff #17) revealed that upon leaving another residents room she saw residents #26 and #8 about to get physical with (CNA/staff #209) trying to separate them by physically holding their chests apart as resident #8 was trying to defend himself and put his hand towards resident #26's face, to keep him away. The statement revealed the two were able to be immediately separated with no injuries.<br><br>An interview was conducted on August 26, 2024 at 12:20 p.m. with resident #8 who stated he was sitting in the front area about approximately 15 ft from resident #26. He stated resident #26 stared at him for a full hour. Resident #8 stated he approached resident #26 and asked if he had an issue with him with no response. Resident #8 stated he changed places in the room, but he continued to stare at him. Resident #8 stated he approached resident #26 again and told him it really bothers him. He stated resident #26 used profanity and shoved him in the chest and hit him on the right side of his chin with a closed fist. Resident #8 stated he landed a closed fist twice on the chest and once in the face of resident #26. then it was broken up by staff. Resident #8 stated he walked away. He stated he saw him once following the incident, but nothing was said and that they moved him somewhere else. He said he had no bruises.<br><br>An interview was conducted on August 26, 2024 at 12:28 p.m. with (CNA/staff #174) who stated resident #26 was moved to an all-male high acuity unit with a lower census. She stated she was informed resident #26 was moved due to an altercation with resident #8 and that resident#8 was placed on 1:1 supervision 24/7 for a period of 3-4 days until resident #26 was discharged from the unit. Staff #174 stated they are trained to de-escalate and make sure the residents are kept apart if there was an issue and to inform the supervisor.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | An attempt was made to interview resident #26 August 26, 2024 at 12:38 p.m., but was observed to be confused and unable to express his thoughts.<br><br>An interview was conducted on August 26, 2024 at 12:40 p.m. with (LPN/staff #130) who stated resident #26 was moved to the unit one week prior due to an altercation with another resident. She stated resident #26, is extremely confused, can be physical and verbally aggressive and is easily agitated. She stated there have been no further incidents with resident #26 since his move to the unit. Staff #130 stated that she has received training on abuse and physical abuse includes striking, grabbing, and pulling.<br><br>Review of the facility investigative report revealed it was unsubstantiated by the facility due to no willful intent and no actual physical contact between the two residents. It was noted resident #26 was being monitored for change of condition due to delusional behaviors.<br><br>An interview was conducted on August 26, 2024 at 12:57 p.m. with the Director of Nursing (DON/staff #229), who stated that resident #26 and #8 were on the unit sitting on opposite sides of the room and resident #8 went up to resident #26 thinking he had spoken to him when the altercation happened. She stated the CNA was able to come between them and separated them and no one was hit. She stated abuse occurs when harm is inflicted on a resident and can be physical, mental, misappropriation, isolation, restrained, and sexual and it is the facility's responsibility to report within two hours, including providers. She stated that a 5-day investigation was completed and the allegation of abuse was unsubstantiated.<br><br>The facility policy titled, Abuse, Neglect, Exploitation, and Misappropriation Prevention 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. |