

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035134	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2024
NAME OF PROVIDER OR SUPPLIER Rim Country Health & Retirement Community		STREET ADDRESS, CITY, STATE, ZIP CODE 807 West Longhorn Road 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49199</p> <p>Based on record review, interviews, facility documentation and policy, and the State Agency (SA) complaint tracking system, the facility failed to ensure one resident (#10) was free from abuse from a staff member. The deficient practice could lead to further abuse of residents.</p> <p>Findings include:</p> <p>Resident #10 was admitted to the facility on [DATE] with a diagnoses of congestive heart failure, edema, paroxysmal atrial fibrillation and chronic respiratory failure with hypercapnia.</p> <p>An MDS (Minimum Data Set) assessment dated [DATE] revealed a BIMS (Brief Interview for Mental Status) score of 14 indicating that resident #10 was cognitively intact.</p> <p>Review of the intake information submitted by the facility to the SA complaint tracking system on June 14, 2024 revealed that the ADON was advised by a RN (registered nurse/staff #3) of an incident with resident #10. The information included that after resident (#10) said he was not going to take the cup of medication until he saw his doctor the resident handed the cup back to the RN and as the RN turned to exit the room the resident grabbed the cup of medication and made a fist and a motion towards the RN. The information noted that the RN (staff #3) reacted by grabbing the resident's right wrist causing a skin tear.</p> <p>An interview was conducted June 18, 2024 at 1:40 p.m. with resident #10. The resident stated he used to take ten pills a day, including vitamins, prophylactic medication, an antibiotic and a heart medication. He said he did not like taking all ten pills at once and after speaking with his physician some of those pills were no longer necessary. Regarding the incident, resident #10 stated that an RN (staff #3) handed him a cup of pills but he told the RN that he was only going to take the heart medication and any other medications he absolutely needed. The resident explained that the RN took the cup from him and said that she was tired of going through this with him every day and that the RN said she was just going to say that he had refused his medications. Resident #10 said that he grabbed the cup back from the nurse and put it in his other hand to put on the table. The resident said that the RN then reached over him and grabbed his arm and then his wrist trying to grab the cup back. Resident #10 stated that the RN was very inappropriate and that his skin tore in those places (referring to where he was grabbed). The resident said that the RN came back in his room later to address his arm but he told her to get out of his room and to not come back. He said he has not seen the RN since. The resident stated that he may not be able to get out of his bed but he knew what happened.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on June 18, 2024 at 2:10 p.m., with the ADON (Assistant Director of Nursing/staff #7). The ADON stated that on the morning of June 14, 2024 at approximately 07:30 a.m. she received notification of the incident from staff #3. The ADON stated she then sent the RN (staff #3) home and got the Social Worker involved and began the investigation.</p> <p>An interview was conducted on June 18, 2024 at 2:21 PM with a CNA (Certified Nurse Assistant/staff #12). The CNA stated as she was getting residents ready for breakfast, resident #10 had his call light on. The CNA added that when she entered resident #10's room he told her that he was attacked. The CNA said she made sure the resident was alright. Then the CNA said she asked who attacked him and the resident named staff #3 and showed two skin tears, one was on the right upper arm, the other was midway, and another on the left hand. The CNA stated that the skin tears looked like it just happened because they were open and bleeding. The CNA said that she went to staff #3 because she was the nurse she reports to and told her that the resident was saying he was attached and he had skin tears. The CNA said that the nurse (staff #3) said that she had a hard time giving him his medicine and she did try to take the medications from him. The CNA also said she did not think she should report what the resident was claiming but the CNA did tell the nurse (staff #3) about the skin tears. The CNA stated that the nurse (staff #3) said to her, oh my gosh, I'm going to check on him and try to clean up the tears. Further, the CNA said it was hard because the resident had stated that the nurse attacked him but yet the nurse was who she was supposed to report to.</p> <p>The facilities policy on Resident Abuse and Neglect, dated February 9, 2024, states Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. The policy also defines physical abuse as hitting, slapping, pinching, kicking, etc.</p>		