

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 09/09/2024
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** 47954</p> <p>Based on clinical record reviews, facility documentation, resident and staff interviews, and policy review, the facility failed to protect the rights of one resident (#50) to be free from physical abuse by another resident (resident #99). The deficient practice could result in resident not protected from further abuse.</p> <p>Findings include:</p> <p>-Resident #50 was admitted on [DATE], with diagnoses of depression, hypertension, constipation, weakness, anxiety, and bursitis.</p> <p>A behavioral care-plan initiated February 10, 2023 revealed the resident was at risk for confusion. The goal was to maintain the resident's current level of cognitive function. Interventions included to keep the resident's routine consistent and try to provide consistent care givers as much as possible to decrease confusion.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 03 which indicated the resident had severe cognitive impairment.</p> <p>The progress note dated August 25, 2024 revealed that the nurse heard resident #99 said I just shit my pants in an upset manner from inside of her room. Per the documentation, within seconds at approximately 11:10 p.m., resident #50 opened the door and wheeled herself out of the room into the hall; and that, resident #50 was bleeding from a half dollar sized hematoma to the middle of her forehead. It also included that the nurse immediately wheeled resident #50 to the nurse's station for treatment; and that, resident #50 reported that her roommate (#99) hit her.</p> <p>-Resident #99 was admitted on [DATE] with diagnoses of chronic pain syndrome, anxiety, hypertension, diabetes mellitus type 2, and depression.</p> <p>A behavioral care plan with revision date of March 13, 2023 revealed the resident showed behaviors such as being very needy and repetitive with staff, demanding and swearing at times. The goal was that the resident's behaviors will be managed through staff monitoring. Interventions included to monitor the resident for triggers which lead to aggressive behaviors and remove the resident before the resident's behavior escalates.</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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(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>Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 12 which indicated the resident had mild cognitive impairment.</p> <p>The facility investigation included that on August 25, 2024 at 9:15 p.m. a registry licensed practical nurse (LPN) reported that resident #99 hit resident #50 while both residents were in their room. The report included that resident #50 was bleeding from a half-dollar sized contusion to the center of her forehead; and, had wheeled herself out of the room to the unit LPN that was directly across from the resident's room. Per the documentation resident #50 was assessed and had her wound taken cared of; and, resident #50 reported that her roommate (#99) hit her, did not know why she was hit and did not know if she was hit openhanded or closed fist by resident #99. The report also included that resident #99 reported that she just woke up, was knocking things over, did not really know what happened but she hit resident #50 with her hand. Per the report, resident #99 did not remember whether she made a fist or not and did not remember what happened. The report concluded that resident #99 admitted to striking out at resident #50 while angry.</p> <p>An interview was conducted with resident #99 on September 9, 2024 at 5:44 p.m. Resident #99 stated resident #50 used to be her roommate; and that, she hit resident #50.</p> <p>An interview with the Director of Nursing (DON/staff #15) was conducted on September 9, 2024 at 6:05 p.m. The DON stated that resident #99 hit resident #50; but, she did not feel that it was the intent of resident #99 to do it maliciously. The DON further stated that resident #99 was upset that she messed in her pants and took it out on resident #50.</p> <p>The facility policy on Resident Abuse and Neglect with revision date of August 22, 2024 revealed that the facility is committed to the physical, mental, social, and emotional well-being of the resident, and thus has developed a zero-tolerance policy related to resident abuse. The policy also included that the facility will not tolerate abuse by anyone, including but not limited to staff, other residents, or other individuals.</p>		