STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035134	A. Building B. Wing	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rim Country Health & Retirement Community	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)
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** 42319 Based on clinical record reviews, facility documentation, resident and staff interviews, and policy review, the facility failed to ensure that one resident (#9) were free from physical abuse resulting in injury by other residents (resident #23). The deficient practice could result in further incidents of resident to resident abuse. Findings include: -Resident #9 was admitted to the facility on [DATE], with diagnosis that include Dementia, Psychotic disturbances, anxiety, and Alzheimer's disease. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 12 which indicated the resident had mild cognitive impairment. A behavioral care plan revised April 7, 2023 revealed the resident is at risk for impaired thought processes related to vascular dementia, with a noted intervention of keeping the resident's routine consistent in order to decrease confusion when able. However, review of the care plan revealed no care plan measures addressing verbal or physical aggression showed by the resident. -Resident #23 was admitted to the facility on [DATE] with diagnoses that include Paranoid personality disorder, and other schizoaffective disorders, and a history of lobotomy. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 08 which indicated the resident had moderate cognitive impairment. A behavioral care-plan initiated May 1, 2012, revealed the resident is at risk for mood swings and behaviors related to a history of a lobotomy as evidenced by verbally abusive behaviors, with noted interventions of when the resident becomes agitated, intervene before agitation escalates, and guide the resident away from sources of distress. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035134	A. Building B. Wing	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rim Country Health & Retirement Community	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of information received from the SA complaint tracking system revealed that on October 1, 2024, a complaint was received that revealed on October 1, 2024 at 6:25 p.m. on the secured memory and behavioral unit there was a resident to resident altercation after the evening meal in the dining room between resident #9 and resident #23. It further revealed that resident #23 grabbed resident #9 by her right arm when resident #9 was attempting to pass resident #23 to leave the dining room. Resident #9 then turned around and smacked resident #23 in her face with an open left hand. It continues that staff verbally intervened while approaching the residents asking them to separate. Resident #9 then pushed resident #23 causing resident #23 to lose her balance falling backwards and hitting the back of her head on the floor. Resident #23 was later sent to the ER for diagnostics. A review of progress notes for resident #23 revealed no documentation related to the above incident. A review of progress notes for resident #9 dated October 2, 2024 at 3:01 a.m. revealed that resident #9 returned from the ER after having a CT of the head and cervical spine, and that the resident's daughter was present with the resident at the hospital. An interview was conducted with a Licensed Practical Nurse (LPN/staff #58) on October 8, 2024 at 4:25 p.m. The LPN stated that resident #23 is behavioral, pleasant most of the time but has had incidents in the past of violent actions. The LPN noted that there have been multiple instances of resident to resident interactions with resident #23. The LPN stated that the above incident was witnessed by staff #42, as they were watching the residents at the time. The LPN further stated that after the incident resident #23 had an abrasion, a contusion, and a skin tear to the right wrist. resident #9 was complained that her head was hurting. The LPN concluded that resident #9 also gets into resident to resident incidents, and her mood fluctuates a lot. An interview was conducted with a Certified Nursing Assistant (CNA/staff #74) on October 8, 2024. The CNA revealed that resident #23 has moments where she says she is in pain and can be aggressive. The CNA stated that because we have sundowners, we have to keep on top of the patients. The CNA further revealed that resident #9 will not let you get away with hitting her, that she jumped out of her wheelchair to get at each other. The CNA also stated that resident #23 has had a few incidents in the past, and concluded that when asked what could have been done to prevent this incident, the CNA stated that her answer to preventing incidents would be to have more staff. An interview with the Director of Nursing (DON/staff #80) was conducted on October 8, 2024 at 5:39 p.m. The DON stated that that her expectations are that staff notify her immediately when an incident happens, and that they have statements to her by the next morning. The DON also stated that when dealing with incidents of resident to resident they are proactive and react appropriately, and that her expectation is that care plan is updated following an incident. However, no care plan updates were noted for resident #9, or resident #23 in relation to this incident at the time of this review. A review of facility policy titled "Resident abuse and neglect revised August 2, 2024 revealed that Rim country health 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. Rim country health will not tolerate abuse by anyone, including but not limited to staff, other residents, or other individuals.