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	11/20/2024

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** 48932 Based on clinical record review, interviews, review of facility documentation and policy review, the facility failed to ensure resident #2 was free from abuse from resident #1. The deficient practice could result in residents experiencing emotional and mental trauma from abuse. Findings include: -Regarding Resident #1: Resident #1 was admitted to the facility on [DATE] with diagnoses of acquired absence of left leg below the knee, dementia, and aphasia. Review of a discharge Minimum Data Set (MDS) assessment dated [DATE] revealed resident #1 completed a Brief Interview for Mental Status (BIMS) and scored a 10 which indicated the resident was moderately cognitively impaired. The care plan was revised on November 11, 2024 included that the resident has potential for physical behaviors towards staff and other residents due to poor impulse control. Interventions included addressing the resident's trigger of loud noises, intervening and redirecting when inappropriate behaviors are observed and notifying the provider when the resident appears to be a danger to others. There was no evidence that this focus area was in the resident's care plan prior to November 11, 2024. A nurse's note, dated November 11, 2024, revealed a late entry note. The note indicated that at 8:50 AM a Certified Nursing Assistant (CNA) called for help and the nurse was informed that resident #1 had punched another resident in the head twice behind the right ear. The note also indicated that both residents were in their wheelchair and were then separated. A review of a hospital's health and progress notes revealed resident #1 was taken to the emergency room due to his aggression towards another resident and for a possible urinary tract infection. The note also indicated resident #2 stated he was forced to leave and to put it frankly there was a bitch walking up and down the hallway that was waking me up. Regarding Resident #2: (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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(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	Resident #2 was admitted to the facility on [DATE] with diagnoses of Major Depressive Disorder, trochanteric bursitis in the right hip, anxiety disorder, and difficulty walking. Review of the quarterly MDS assessment, dated October 27, 2024, revealed a BIMS score of 03 which indicated the resident was cognitively impaired. A care plan, last revised on October 23, 3034, revealed resident #2's risk of having impaired thought processes. Interventions included keeping the resident's routine consistent and reporting any changes related to cognitive function to the provider. A nurse's note, created on November 15, 2024 but effective on November 11, 2024, indicated a full head to toe assessment was completed after the incident; there were no injuries noted and vital signs were within normal limits. An interview was conducted with resident #1 on November 20, 2024 at 9:58 AM. Resident #1 explained that he was upset that resident #2 had hit him on his back and then he had gotten upset and hit her. He was not able to identify who resident #2 was. An interview was conducted with a Registered Nurse (RN/staff #65) on November 20, 2024 at 10:24 AM. Staff #65 confirmed that she was working on the 11th and did not witness the actual abuse but had heard staff #49 yelling for help at the end of the hall. Staff #49 had then told staff #65 that resident #1 had punch resident #2 on the left side of the head two times. Staff #65 indicated that she completed a full assessment on both residents, who were both in a wheelchair, and there were no visible injuries. She also indicated that resident #1 was assigned a 1 on 1 sitter for the rest of her shift. An interview was conducted with CNA/staff #49 on November 20, 2024 at 10:53 AM. Staff #49 confirmed she was working on November 11, 2024 and had witnessed the altercation between resident #1 and resident #2. Staff #49 explained she was in the hallway and both residents were at the end of the same hallway with resident #1 facing towards staff #49 and resident #2 was facing away from staff #49. She heard resident #2 voice out stop it and so staff #49 ran down the hall while yelling out for help from other staff members. She then heard resident #1 say get the fuck away from me, as resident #2's hand was up trying to block herself from resident #1's hand while she said ow. Staff indicated she had seen resident #1 hit resident #2 on the left side of the head near her ear. Staff #49 then pulled resident #2's wheelchair away from resident #1 while the other two staff members redirected resident #1. Staff #49 indicated that it was the first time she had seen resident #1 have a physical outburst as he usually will have verbal outburst. An interview was conducted with Resident #2 on November 20, 2024 at 11:09 AM. Resident #2 was not able to recall being hit by resident #1 and indicated that she currently felt safe at the facility. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on November 20, 2024 at 12:47 PM with the Director of Nursing (DON/staff #44). Staff #44 indicated that she had received a phone call from the facility explaining that resident #1 had hit resident #2 on the left side of her head, behind the ear, twice. Staff #44 indicated that after the incident took place, she informed resident #1 that the facility had zero tolerance for violence and had him meet with a psychiatrist via telehealth. After that appointment, the provider had determined resident #1 was a danger to himself and others so he ordered resident #1 to be sent to the hospital. When asked what the risks were related to allowing residents to abuse other residents, staff #44 stated that the facility would not be able to stay open if they were not able to protect their residents. Staff #44 indicated that resident #1 was supposed to be in the facility for 2 weeks as their family planned to move him out of state to be closer to them, however that has not yet happened. Review of the facility policy titled, Resident Abuse and Neglect indicated that abuse is defined as willful infliction of injury, and physical abuse is defined as hitting, slapping .

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F 0657

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48932

Based on clinical record review, interviews, review of facility documentation and policy review, the facility failed to ensure resident #1's care plan was updated to accurately reflect the resident's care. The deficient practice could result in residents not getting the appropriate care they need.

Findings include:

Resident #1 was admitted to the facility on [DATE] with diagnoses of acquired absence of left leg below the knee, dementia, and aphasia.

A nurses' note, dated October 18, 2024 at 5:34 AM indicated resident #1 had raised his hand toward the nurse when the nurse refused to leave his morning medications on his table. No physical contact was made.

A nurses' note dated, October 30, 2024 at 6:30 PM, revealed resident #1 had punched a Certified Nursing Assistant (CNA), on the front of the upper thigh, who was attempting to redirect him out of another resident's room. The note indicated the punch resulted in a large bruise which was 6 centimeters round on the CNA's thigh.

A nurse's note, dated November 11, 2024, revealed a late entry note. The note indicated that at 8:50 AM resident #1 had punched another resident in the head.

The care plan was revised on November 11, 2024 included that the resident has potential for physical behaviors towards staff and other residents due to poor impulse control. Interventions included addressing the resident's trigger of loud noises, intervening and redirecting when inappropriate behaviors are observed and notifying the provider when the resident appears to be a danger to others. There was no evidence that this focus area was in the resident's care plan prior to November 11, 2024.

Review of a discharge Minimum Data Set (MDS) assessment dated [DATE] revealed resident #1 completed a Brief Interview for Mental Status (BIMS) and scored a 10 which indicated the resident was moderately cognitively impaired.

A care plan note, dated November 22, 2024 at 9:00 AM indicated the resident's care plan was updated to reflect the recent physical behavior.

An interview was conducted with resident #1 on November 20, 2024 at 9:58 AM. Resident #1 explained that he was upset that another resident had hit him on his back and then he had gotten upset and hit her.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on November 20, 2024 at 12:47 PM with the Director of Nursing (DON/staff #44). Staff #44 explained that resident #1 had hit and struck another resident on the side of the head, twice. She indicated that after the incident she spoke with the resident about the facility's zero tolerance for violence. Staff #44 had also explained that prior to the resident-to-resident altercation, resident #1 had hit one of her CNAs so hard that she couldn't walk that day. Staff #44 explained that the facility had accepted the resident knowing he had a history of physical behaviors at his previous placement because the plan was for the resident to be onsite for two weeks. After two weeks, the resident's daughter had planned to move the resident closer to her. However, the transfer did not happen as planned. Staff #44 indicated that care plans are updated by the facility's MDS coordinator (staff #37) and then she (staff #44) then signs off on them. Staff #44 indicated that she took full responsibility for the care plan not being updated after the resident-to-staff altercation took place and that I thought it was crazy we didn't have anything in the care plan about the physical behaviors prior, because the resident had a history of physical behaviors at the other facilities prior to coming here. Staff #44 indicated that the risk of not having care plans updated then abuse would not be noted as potential abuse. An interview was conducted with staff #37 on November 20, 2024 at 1:13 PM. Staff #37 confirmed that she is responsible for updating resident care plans. When asked what would be considered a change in a resident's condition, staff #37 indicated that resident falls, new skin conditions, and incidents would be some examples. Staff #37 indicated that she does update care plans after a resident to resident altercation however, she does not after a resident to staff altercation. Staff #37 indicated that she probably should have. She confirmed that she did update resident #1's care plan after his recent resident to resident altercation. When asked what would be the risk(s) to the residents if their care plan was not updated to include physical behaviors, she indicated that the risk would be that the incident could happen without anyone realizing what was going on with the resident. A review of the facility's policy titled, Change of Condition defines it as a decline or improvement in a resident's mental, psychosocial . functioning which requires a change in the resident's comprehensive plan of care. A review of the facility's policy titled, Care Plans and Care Plan Meetings indicates that care plans are updated as scheduled or as needed.