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	12/26/2024

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** 47911 Based on documentation, interviews, and the facility policy and procedures, the facility failed to ensure that one resident (#21) did not abuse another resident (#32). The deficient practice could result in residents being physically and/or emotionally injured. Findings include: -Resident #32 was admitted on [DATE] with diagnosis that included unspecified dementia with unspecified severity and without behavioral disturbance, psychotic disturbance, mood disturbance, schizoaffective disorder, Alzheimer's disease and anxiety. A review of the annual MDS (minimum data set) dated December 6, 2024 revealed a BIMS (brief interview of mental status) score of 01, indicating severe cognitive impairment. The MDS further revealed no noted potential indicators of psychosis, but did note physical behaviors 1-3 days and wandering 4-6 days within a week. The care plan revealed that resident #32 uses psychotropic medications for behavior management, schizoaffective disorder, anxiety and dementia with behaviors. Furthermore, the care plan indicated that resident #32 was a wanderer, at risk for impaired thought processes and has the potential to be unable to avoid a physical confrontation with a fell ow resident due to dementia. -Resident #21 was admitted on [DATE] with diagnosis that included senile degeneration of the brain, Alzheimer's disease, dementia of unspecified severity with psychotic disturbance and other mixed anxiety disorder. A review of the quarterly MDS dated [DATE] revealed a BIMS score of 03, indicating severe cognitive impairment. The MDS further revealed that the resident had no noted potential indicators of psychosis and that verbal behaviors were present 1-3 days per week. A review of the physician orders revealed that the resident was prescribed lorazepam (Psychotropic medication) and quetiapine fumarate (Psychotropic medication). The care plan for resident #21 revealed that the resident uses psychotropic medications, is at risk for impaired thought processes, has the potential to demonstrate verbally abusive behaviors and has demonstrated the physical behavior of slapping another resident (noted posted incident). (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the progress notes dated December 12, 2024 at 1:52 P.M. revealed that a nurse was standing at the nurse's station when she heard yelling from the dining room. It was noted that a resident who was sitting in front of the nurse's station stated that that lady just slapped that man across the face. It was noted that the nurse ran over to separate the residents and asked the resident if she had slapped the gentleman, to which it was noted that she replied I did slap him but don't ask me why I can't remember. No injuries were noted in the progress notes. Review of the electronic health record revealed no evidence of prior physical resident to resident altercations. A review of the facility 5-day investigation revealed that on December 11, 2024 at 8:35 P.M. resident #21 was in the dining room in the secured behavioral unit with fell ow resident #32. It was noted that resident #32 was propelling his wheelchair past resident #21 and bumped into her when she struck resident #32 with a open hand to his left cheek. It was noted that the residents were separated and that no injuries were observed. It was noted that resident #24 had witnessed the incident and that staff #13 had separated the residents. The report further revealed that resident #21 did state that she hit resident #32 but could not recall why. An interview was attempted with resident #32 on December 26, 2024 at 12:32; however, the resident refused to answer any questions. An interview was conducted with the Human Resource Director staff #20 on December 26, 2024 at 12:36 P. M. as the director of nursing, administrator were not available and the facility did not have an assistant director of nursing. Staff #20 stated that the expectation is for resident to resident altercations not to happen and that effective interventions suited to the resident are expected to be carried out. She stated that staff had recently gone through behavioral health training, identifying triggers, which was extremely beneficial. Two trainings had been conducted on the 18th of November 2024 and the other on the 12th of December, 2024. She stated that the risk with resident to resident altercations is not protecting the resident from being abused, injury, getting hurt, fear and not understanding why it had happened. She stated that she was aware of the incident and that it had occurred during the evening meal when the altercation occurred but she had not been involved in the investigation. She further stated that the facilities 5-day investigation did not address the absence of staff in the pine dining room, but stated that it should have been addressed. An interview was conducted with LPN (staff #21) on December 26, 2024 at 2:02 P.M. Staff #21 stated that staff receive ongoing training for behavioral health related concerns. He stated that when an incident occurs, residents are separated and assessed for injuries right away and then the formal reporting process starts. He stated that in the dining room area there should always be staff present. He stated, that during meal times, if staff is not present the residents could also be at risk for choking or other injuries. He stated that he was not aware of any resident to resident altercations on his unit. (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 with resident #24 on December 26, 2024 at 3:15 P.M. Resident #24 stated that she observed resident #21 slap resident #24. The resident, per MDS dated [DATE], is noted to have a BIMS score of 13, indicating that she is cognitively intact. She stated that they were just talking to each other and then resident #21 slapped resident #32 for no reason. She stated that the incident had occurred in the dining room. She stated that 3 staff were present on the unit and felt that enough staff were there but that the incident had just happened so fast. She stated that she did not observe any injuries on resident #32, but that resident #21 had a history of being aggressive. A review of the policy entitled Resident Abuse and Neglect with a review date of August 2, 2024 revealed that the facility has a zero-tolerance policy related to resident abuse and that abuse will not be tolerated by anyone including other residents. The policy further defines physical abuse as hitting, slapping, pinching, kicking, etc.