

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  02/12/2025
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45809</p> <p>Based on clinical record review, staff and caregiver interviews, and policy and procedures, the facility failed to ensure medications were securely stored in accordance with professional standards for one resident (#10). The deficient practice resulted in resident hospitalization .</p> <p>Findings include:</p> <p>Resident #10 was admitted on [DATE], with diagnoses of essential hypertension, adult failure to thrive, atherosclerotic heart disease, anxiety disorder, and major depressive disorder.</p> <p>The nursing note dated February 6, 2025 at 8:00 a.m. revealed that the resident was found unresponsive and unknown medications were found with resident. Per the documentation, the resident was sent to the local emergency department (ED) for further evaluation.</p> <p>Further review of the clinical record revealed no additional documentation regarding this incident.</p> <p>During an initial interview with the Director of Nursing (staff #124) conducted on February 11, 2025 at approximately 2:55 p.m., the DON stated that the resident was admitted to the facility on [DATE] at approximately 8:00 p.m.; and, was later found unresponsive with empty medication bottles with the resident on February 6, 2025 at approximately 6:10 a.m. The DON further stated that the resident's family reported giving the box of resident's medications to the nurse; and that, the resident's family had seen the registered nurse (RN/staff #19) put the bottles of medications in the medication cart. The DON also said that the other medications of the resident were destroyed.</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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on February 12, 2025 at approximately 9:45 am with a licensed practical nurse (LPN/staff #48) who stated that he arrived for his shift that day at approximately 6:00 a.m. and received a report from previous nurse (RN/staff #19) who was concerned about a small turquoise box of medications that were missing that belonged to the resident; and that, the medications were not immediately located or secured. The LPN stated he was then asked by a certified nursing assistant (CNA/staff #31) to come to the room of resident #10. He stated that he found resident #10 unresponsive, had a labored breathing and had a very low BP (blood pressure). The LPN said that the resident also had a blue box between her legs with medication bottles in it and one of the medication bottles was clonazepam (anti-anxiety) was opened and laying on top. The LPN stated he attempted to arouse the resident using a sternal rub with no response from the resident and then called the nurse manager and 911. Further, he stated that when the resident's bedding was pulled back in preparation for paramedics, there were three (3) additional empty medication bottles found on the resident's bed. He stated that one bottle was for Isosorbide (vasodilator), second bottle was for Plavix (platelet inhibitor) and he could not recall what the third bottle was for. He stated that the paramedics arrived and began treatment of the resident and he gave the empty medication bottles to the paramedics; and that, the resident was then taken to the local hospital. The LPN said that he then took the blue box to the medication room and locked it in that room. However, he does not know where the box was now or what happened to it after he locked it in the medication room; and, he did not see the box again. He stated that he was not aware of any additional keys to the medication room. The LPN stated that later in the shift that day (February 6, 2025) a hospital physician from the metro area called and asked about the events that led to the incident; and that, the hospital physician was not from the local hospital that the resident was taken to. The LPN stated that the hospital physician told him that the resident was admitted at the hospital in the metro area; and that, the resident was intubated in the hospital and was nonresponsive. Further, the LPN stated that the DON also asked him questions about the incident.</p> <p>During an interview with the CNA (staff #31) conducted on February 12, 2025 at 10:39 a.m., the CNA stated that he arrived for work around 6:00 a.m. that day; and, he taking vital signs. The CNA stated that he entered the room of resident #10 who was still and did not wake up so he attempted again to wake up the resident but the resident did not. He stated that he then called out for the LPN (staff #48). The CNA stated that the resident's BP was very low; and, there was a blue box between the resident's legs with an empty bottle on top. The CNA stated that the LPN (staff #48) took a picture of the box and then left the room to call 911. He stated that while waiting for the LPN to return he continued to try to awaken the resident with no response. The CNA also said that when the LPN returned and acknowledged that 911 was coming, he and the LPN pulled the blanket back and found three more open, empty medication bottles. He stated that when the paramedics arrived and began treating the resident he had no further involvement. The CNA further stated that no one had asked him any questions regarding this incident prior to this interview.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A phone interview with the resident representative (RR) was conducted on February 12, 2025 at approximately 11:12 a.m. The RR stated that she was the resident's primary caregiver at home; and, she was in charge of the resident's medications at home and the resident did not have access to medications at home. She also said that on the day of the resident's admission at the facility, she had a blue box containing the resident's medications that she gave to an RN (staff#19) whom she identified by name. The RR said that she saw the RN take the box and placed it in a room where they keep medications; and that, there were no medications in resident's room. She further stated that at around 4:30 a.m. or 5:00 a.m., the RN (staff #19) called her to ask if she had taken home the box of resident's medications; and that, she told the RN (staff #19) that she gave it to the RN. The RR also said that between 6:30 a.m. and 7:00 a.m., the LPN (staff #48) called her and told her of the incident. She stated that the resident had been transferred from the local hospital to a larger hospital in the metro area; and that, the resident remained intubated and unresponsive.</p> <p>In another interview with the DON (staff #124) conducted on February 12, 2025 at approximately 11:35 a.m., the DON stated that the resident representative (RR) told her that the resident may have been suicidal. The DON further stated that the RN (staff #19) called the RR prior to the end of the RN's shift in an effort to reconcile medications. The DON retracted her prior statement that all the resident's medications were destroyed; and it was an error. The DON said that all of the resident's medications were sent with resident to the hospital.</p> <p>On February 12, 2025 at approximately 11:40 a.m., the DON initiated a telephone communication with the hospital case manager involved in the admission of the resident to the facility. The DON stated that the case worker told her that the resident representative (RR) told the case worker that the resident was behavioral; and that, that after the incident on February 5, 2025 the RR informed the case worker that the resident may have been suicidal.</p> <p>Multiple attempts were made to conduct a phone interview with the RN (staff #19) on February 12, 2025 but was unsuccessful. The RN did not answer and/or return the call.</p> <p>In an interview with another RN (staff #65) working in the facility conducted on February 12, 2025 at 1:05 p.m. , the RN stated that if a family brought in medications for a resident, she would reconcile those medications and notify the physician. The RN stated that if she was unable to reconcile the medications at the time they were delivered or given to her she would lock them in the medication cart until she was able to reconcile them because she would be responsible for the medications. She further stated that even in an emergency she would secure the medications.</p> <p>During another interview with the DON (staff # 124) conducted on February 12, 2025 at approximately 1:10 p. m., the DON stated the expectation was that the nurse would secure medications in the medication cart or in the medication room until the nurse were able to complete a reconciliation. She stated that medications should never be left in a resident's room. Regarding the incident, the DON stated that according to the report from the resident's RR, the RN (staff #19) acted appropriately by securing the box of resident's medications in the medication cart/room. However, the DON was unable to say where the box of medications went after the LPN (staff #48) secured it in the medication room. She stated that the LPN (staff #48) took pictures of the box and sent the pictures to her but these pictures were immediately deleted from the LPN's and DON's phone because these were HIPAA (Health Insurance Portability and Accountability Act) violation.</p> <p>(continued on next page)</p>		

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F 0689  Level of Harm - Actual harm  Residents Affected - Few	The facility policy on Security of Medications with revision date of March 25, 2022 included that the facility will ensure the security of all medications in the facility to maintain resident and staff safety. Nursing will ensure that all medications are secured at all times. Nurses must ensure that the medication cart is securely locked at all times when not in nurses view. Only licensed staff will have access to any area that medications are stored.		