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	04/17/2025

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** 51124 Based on observation, interviews, review of the clinical record, and review of facility policy and procedure, the facility failed to ensure two residents (#20 and #22) were not physically abused in a resident to resident altercation. The deficient practice could lead to physical and psychosocial harm to residents. Findings Include: -Regarding Resident #20: Resident #20 was readmitted to the facility November 18, 2024, with diagnoses that included anxiety disorder, insomnia, flaccid hemiplegia affecting left side, dysphagia, difficulty in walking, dysarthria, and acquired absence of left leg below the knee. A quarterly minimum data set (MDS) assessment dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment. A care plan initiated November 21, 2024, revealed Resident #20 has the potential to demonstrate physical behaviors like striking out at staff or fell ow residents due to poor impulse control and dementia, with interventions to analyze key times, places, circumstances, triggers, and what de-escalates behavior and document, monitor frequently and document any behaviors in a behavior progress note, and attempt to intervene when able. A Behavior note dated February 16, 2025, revealed a nurse observed that Resident #20 quickly propelled his wheelchair into the dining area and toward another resident and aggressively struck her drink off the table with significant force while shouting. The residents were separated. A Behavior note dated March 12, 2025, revealed the Resident #20 was on an outdoor porch during a smoking session and began pushing the furniture around. Resident #20 got behind another resident and grabbed a piece of the brief on the resident in front if him and raised the piece of brief above his head. Staff intervened and Resident #20 lowered his hand back to his side. (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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Behavior note dated March 29, 2025, revealed Resident #20 was in his wheelchair and another resident was in front of him in the hallway. Resident #20 stated to the other resident to get out of the way. Staff stated to Resident #20 that the other resident was not in the way. Resident #20 turned around very angry and pushed a table which fell to the floor. Staff accompanied the resident to his room. An Incident Note dated April 9, 2025, revealed Resident #20 had an altercation with another resident. Incident was witnessed by certified nursing assistants (CNAs) who stated that the other resident was trying to get to an empty chair and Resident #20 was in the way. CNAs state that the other resident punched out at Mr. [NAME] and ended up losing his balance and falling to the floor. Resident #20 swung at the other resident and grabbed/pulled the other resident's leg. Then, the CNAs intervened and separated the two residents. -Regarding Resident #22: Resident #22 was readmitted to the facility on [DATE], with diagnoses that included altered mental status, cognitive communication deficit, atrial fibrillation, chronic kidney disease, and rhabdomyolysis. An MDS assessment had not been completed due to the resident's newly admitted status. There was no evidence that a BIMS assessment had been completed. A care plan initiated April 8, 2025, indicated for behavior management, with interventions that included encourage participation in self-calming behaviors such as breathing exercises, meditation, or guided imagery, ensure the safety of the resident and others, and establish boundaries and limits with the resident. A Behavior note dated April 8, 2025, revealed Resident #22 was wandering the halls throughout the shift, and made several attempts to get off the unit. A Behavior note dated April 9, 2025, revealed the resident was exit-seeking, resisting personal care, and very agitated with nursing staff. Staff performing frequent checks on the resident. A Behavior note dated April 9, 2025, revealed the resident continues to roam hallways, making several attempts to get off the unit. An Incident Note dated April 9, 2025, revealed Resident #22 became upset that another resident was in his way when he wanted to sit in an empty chair. Resident #22 told the other resident to move and struck out at him and fell to the floor. The other resident punched back. Resident #22 then tried to kick the other resident and had his leg grabbed and pulled. At this point the CNAs who witnessed the altercation separated the two residents and called for the nurse. (continued on next page)

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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	A witness statement from a CNA (Staff #41), dated April 9, 2025, revealed that at 5:00 PM, Resident #20 and Resident #22 had an altercation in front of the nurse's station. Resident #22 wanted to sit in an empty chair, and Resident #20 was sitting in his wheelchair between Resident #22 and the empty chair. Resident #22 demanded that Resident #20 move so he can sit in the chair. Resident #20 did not move. Resident #22 then punched at Resident #20 but did not connect, lost his balance, and fell to the floor. Resident #20 punched Resident #22 on the upper right arm. Resident #22 then kicked Resident #20 in the stomach, and Resident #20 grabbed his leg. CNAs (Staff #41 and Staff #55) intervened and separated the residents. The nurse (Staff #33) was called to assist. A witness statement from a CNA (Staff #55), dated April 9, 2025, revealed that Resident #20 and Resident #22 had an altercation in front of the nurse's station. Resident #22 wanted to sit in an empty chair and said Resident #20 was in the way. Resident #22 told Resident #20 to move and punched him back. Resident #22 kicked at Resident #20, and Resident #20 pulled Resident #22's leg. CNAs (Staff #41 and Staff #55) intervened, separated the residents, and called the nurse. An observation was conducted on April 17, 2025, at 11:06 AM, of Resident #22. The resident was observed to have bruising to the back of his left hand and scabs on the base of the middle finger of his left hand. An interview was conducted with a Licensed Practical Nurse (LPN / Staff #33) on April 17, 2025, at 10:40 AM. Staff #33 stated that he did not witness the event, and that he was not on the unit at that time. When he returned, the CNAs had separated the two residents, and Resident #22 had a couple skin tears on the left hand. Staff #33 stated he notified the physician and the resident's families, and nursing supervisor. An interview was conducted with a CNA (Staff #41) on April 17, 2025, at 10:53 AM. Staff #41 stated it was around 5:00 PM, and Staff #41 was sitting at the nurse's station desk. Staff #41 stated that in front of the nurse's station, Resident #22 stated for Resident #20 to move out of his way so he could sit in a chair. Resident #22 got upset because Resident #20 did not move, and then punched at Resident #20 and fell . Resident #22 was sitting in a wheelchair and punched Resident #22 on his shoulder. Resident #22 then kicked Resident #20 forcefully in the stomach, and Resident #20 then grabbed the foot of Resident #22. Then, Staff #41 stated that she and Staff #55 separated the two residents. On April 17, 2025, at 11:04 AM, an interview was conducted with Resident #20 who did not recall the incident. On April 17, 2025, at 11:06 AM, an interview was conducted with Resident #22 who could not recall the incident. An interview was conducted on April 17, 2025, at 11:09 AM, with a CNA (Staff #55) who stated it was around 4:00 PM when she was at the nurse's station and she observed the altercation between Residents #20 and #22. Staff #55 stated that the facility was short-staffed the day of the incident, that normally there are two CNAs on the right side of the unit, and one CNA on the left side, but that day there was only one CNA. Staff #55 stated that Resident #22 struck at Resident #22 with a fist and kicked Resident #20, and Resident #20 held the leg of Resident #22. Staff #55 stated she called the nurse on the radio, and the residents were kept separated. Staff #55 stated that the nurse put a bandage on Resident #22's knee abrasion. (continued on next page)

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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	On April 17, 2025, at 11:40 PM, an interview was conducted with the Director of Nursing (DON / Staff #90), who stated to prevent abuse in the facility, staff develop personalized care plans for residents, that staff are made aware of what is going on with residents and act proactively to remove residents from escalating situations. The DON stated that abuse is absolutely not tolerated in the facility, and that examples of abuse could be a resident physically or verbally striking out at another resident. The DON stated the facility prevents abuse by performing frequent checks on residents, and by MDS nurses creating accurate care plans. The DON stated that the impact to residents if abuse occurs could be physical or psychosocial harm. The interview continued and the DON stated her understanding of the incident was that Resident #22 demanded that Resident #20 move, and that Resident #20 did not move quickly enough. Resident #22 swung and fell on his side. Resident #20 did lean forward and punch Resident #22 in the right upper arm. Resident #22 kicked out and contacted Resident #20 in the stomach. Resident #20 held onto Resident #22's leg. The DON stated that Resident #22 sustained a skin tear on the middle finger of his left hand, and that afterward the residents were kept separated. Review of the facility policy titled Resident Abuse and Neglect, updated August 2, 2024, revealed the facility is committed to the physical, mental, social and emotional wellbeing of the resident and has thus developed a zero-tolerance policy related to resident abuse. Any incident or suspected incident of resident abuse or un-witnessed injury that cannot be explained will be reported promptly to the appropriate agencies and individuals, Director of Nursing and Administrator. The facility will not tolerate abuse by anyone including but not limited to staff, other residents, consultants, volunteers, staff of other agencies serving the resident, family members, legal guardians, friends, or other individuals. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Physical abuse is defined as hitting, slapping, pinching, kicking, etc. It is the responsibility of the facility to identify any resident whose personal history puts them at risk for abusive behavior and to develop intervention strategies to prevent occurrence, monitoring for changes that would trigger abusive behavior and reassessment of the interventions on a regular basis.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51124 Based on observation, interviews, review of the clinical record, and review of facility policy and procedure, the facility failed to ensure the medical record was complete and accurate for two residents (#20 and #22) regarding assessment following an incident of abuse. The deficient practice could result in care team members not being adequately informed regarding the status of residents and lead to missed or delayed care. Findings Include: -Regarding Resident #20: Resident #20 was readmitted to the facility November 18, 2024, with diagnoses that included anxiety disorder, insomnia, flaccid hemiplegia affecting left side, dysphagia, difficulty in walking, dysarthria, and acquired absence of left leg below the knee. A quarterly minimum data set (MDS) assessment dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment. An Incident Note dated April 9, 2025, revealed Resident #20 had an altercation with another resident. Incident was witnessed by certified nursing assistants (CNAs) who stated that the other resident was trying to get to an empty chair and Resident #20 was in the way. CNAs state that the other resident punched out at Mr. [NAME] and ended up losing his balance and falling to the floor. Resident #20 swung at the other resident and grabbed/pulled the other resident's leg. Then, the CNAs intervened and separated the two residents. The clinical record was reviewed and there was no evidence of documentation of a head to toe assessment, or any injuries sustained, for Resident #20 following the incident. -Regarding Resident #22: Resident #22 was readmitted to the facility on [DATE], with diagnoses that included altered mental status, cognitive communication deficit, atrial fibrillation, chronic kidney disease, and rhabdomyolysis. An MDS assessment had not been completed due to the resident's newly admitted status. An Incident Note dated April 9, 2025, revealed Resident #22 became upset that another resident was in his way when he wanted to sit in an empty chair. Resident #22 told the other resident to move and struck out at him and fell to the floor. The other resident punched back. Resident #22 then tried to kick the other resident and had his leg grabbed and pulled. At this point the CNAs who witnessed the altercation separated the two residents and called for the nurse. The clinical record was reviewed and there was no evidence of documentation of a head to toe assessment, or any injuries sustained, for Resident #22 following the incident. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A witness statement from a CNA (Staff #41), dated April 9, 2025, revealed that at 5:00 PM, Resident #20 and Resident #22 had an altercation in front of the nurse's station. Resident #22 wanted to sit in an empty chair, and Resident #20 was sitting in his wheelchair between Resident #22 and the empty chair. Resident #22 demanded that Resident #20 move so he can sit in the chair. Resident #20 did not move. Resident #22 then punched at Resident #20 but did not connect, lost his balance, and fell to the floor. Resident #20 punched Resident #22 on the upper right arm. Resident #22 then kicked Resident #20 in the stomach, and Resident #20 grabbed his leg. CNAs (Staff #41 and Staff #55) intervened and separated the residents. The nurse (Staff #33) was called to assist. A witness statement from a CNA (Staff #55), dated April 9, 2025, revealed that Resident #20 and Resident #22 had an altercation in front of the nurse's station. Resident #22 wanted to sit in an empty chair and said Resident #20 was in the way. Resident #22 told Resident #20 to move and punched him back. Resident #22 kicked at Resident #20, and Resident #20 pulled Resident #22's leg. CNAs (Staff #41 and Staff #55) intervened, separated the residents, and called the nurse. An observation was conducted on April 17, 2025, at 11:06 AM, of Resident #22. The resident was observed to have bruising to the back of his left hand and scabs on the base of the middle finger of his left hand. An interview was conducted with a Licensed Practical Nurse (LPN / Staff #33) on April 17, 2025, at 10:40 AM. Staff #33 stated that he did not witness the event, and that he was not on the unit at that time. When he returned to the unit, the CNAs had separated the two residents, and Resident #22 had a couple skin tears on the left hand. Staff #33 stated he notified the physician and the resident's families, and nursing supervisor of the incident. Staff #33 stated he assessed the residents following the incident, but could not remember if he had documented it in the clinical record. An interview was conducted on April 17, 2025, at 11:09 AM with a CNA (Staff #55) who stated it was around 4:00 PM when she was at the nurse's station and she observed the altercation between Residents #20 and #22. Staff #55 stated that Resident #22 struck at Resident #22 with a fist and kicked Resident #20, and Resident #20 held the leg of Resident #22. Staff #55 stated she called the nurse on the radio, and the residents were kept separated. Staff #55 stated that the nurse put a bandage on Resident #22's knee abrasion. On April 17, 2025, at 11:40 PM, an interview was conducted with the Director of Nursing (DON / Staff #90), who stated her understanding of the incident was that Resident #22 demanded that Resident #20 move, and that Resident #20 did not move quickly enough. Resident #22 swung and fell on his side. Resident #20 did lean forward and punch Resident #22 in the right upper arm. Resident #22 kicked out and contacted Resident #20 in the stomach. Resident #20 held onto Resident #22's leg. The DON stated that Resident #22 sustained a skin tear on the middle finger of his left hand, and that she was not aware of any other injuries. The clinical record was reviewed, and the DON stated there was no documentation in the progress notes or assessment lists or anywhere in the medical record of either resident that indicated an assessment of the residents was completed following the incident, or any injuries sustained. The DON stated that this would not meet her expectation and that it would not be adequate for the medical record. A formal request was made on April 17, 2025, to the facility for the policy on documentation in the clinical record, and the DON signed a statement that the facility had no policy. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of federal regulation S483.70(h), revealed the facility must maintain medical records, in accordance with accepted professional standards and practices, on each resident that are complete, accurately documented, readily accessible, and systematically organized.