

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  07/23/2025
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)
F 0580  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.  (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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review, staff interviews, facility documentation and policy review, the facility failed to complete notifications involving abuse for two residents (# 15 and #23). The deficient practice resulted in allegations of abuse not being reported, not investigated and residents not protected from further abuse. The resident #15 was admitted on [DATE] for a planned respite stay while a patient with Arizona Care Hospice, and discharged to his home on 7/8/2025 with diagnoses that included: atherosclerotic heart disease and vascular dementia. A review of the admission Minimum Data Set (MDS) dated [DATE] revealed completion of only section A. A review of the hospice admission packet revealed that the resident was admitted to the facility from Arizona Care Hospice for a respite stay while home health services were established. Additional diagnoses in the admission packet included: aortic aneurysm, weakness, falls and weight loss. The resident had elected a Do Not Resuscitate (DNR) status. The level 1 Preadmission Screening and Resident Review (PASRR) revealed that the resident had a terminal illness and secondary diagnosis of dementia, but no identified serious mental illness, intellectual disability or substance abuse. A review of hospice summary notes included in the care plan revealed that the patient was referred to hospice care for significant cognitive decline, progressive functional dependence, and poor prognosis. The care plan revealed that the patient was alert and oriented to self and place, but not time or situation. The resident had intermittent periods of restlessness and agitation especially in the late afternoon and evening. The resident woke frequently during the night and wandered, and experienced frequent falls and episodes of lightheadedness where he needed assistance getting into bed. The note revealed that the last fall resulted in a skin tear to the left wrist and that the resident refused to use assistive devices for ambulation. A review of a fall risk assessment completed on July 3, 2025/3/2025 at 07:06 A.M. revealed a score of 15 indicating the resident was a moderate risk for falls. A review of resident progress notes dated July 3, 2025 through July 8, 2025 revealed that the resident exhibited exit seeking, wandering, verbal behaviors and inappropriate toileting behaviors requiring orders for additional benzodiazepine and antipsychotic medications that were ordered on July 5, 2025. Staff reported that the resident continued these behaviors and was becoming more difficult to redirect, but there was no evidence that the resident eloped from the facility. The allegation that the resident wandered into another resident's room and entered her bed was confirmed by staff interviews, however, there was some discrepancy noted as to who held responsibility to initiate notifications of the resident's change in condition. An interview with Licensed Practical Nurse, (LPN), (Staff #81), was conducted on 7/23/2025 at 11:54 AM. The LPN stated that the facility provides training on caring for residents with dementia and related behaviors. Staff #81 stated that knowing the residents and their baseline behaviors is one of the best ways to minimize wandering or other disruptions on the unit. The LPN further stated, Knowing the patients is 90% of the job. The LPN stated that if he encountered a resident trying to leave the secured unit or who was demonstrating other disruptive behaviors, he would remove them from the situation, try to redirect them using conversation, a snack, or a walk, and if the behaviors persisted, he would check the orders to see if medications were available to administer to decrease the behaviors. Staff #81 stated that he recalled a respite patient who was on the unit who exhibited a number of behaviors including exit seeking, and while the resident set off door alarms, he did not exit the building. An interview with Certified Nursing Assistant, (CNA), Staff #3) was conducted on 7/23/2025 at 12:22PM. The CNA confirmed that some residents are exit seeking, but staff is able to get to them in time to redirect them back to their room or another activity. The CNA stated that no resident has been able to get out of the unit during her shift. An interview with Certified Nursing Assistant, (CNA), (Staff #53) was conducted on 7/23/2025 at 12:30 PM. The CNA stated that staff become aware of resident behaviors through a review of the Kardex and through staff report. Staff #53 stated that staff receive extensive training from the Behavioral Health Team about dementia and that. The unit is staffed sufficiently to manage resident care. The CNA reported that she recalled a recent resident who was on the unit for respite care who walked into another resident's room and required redirection by staff. The CNA stated that if a resident was wandering or disruptive, she would notify the nurse. An interview with the Director of Nursing, (DON), (Staff #52), was conducted on 7/23/25 at 1:26 PM. The DON stated that an incident whenever there was an unusual occurrence such as a fall, an actual elopement, or a new skin condition, or serious resident to staff behaviors. Upon recalling the specific incident, the DON stated that residents can wander into other resident's rooms as the facility cannot shut the doors in order to ensure monitoring by staff. The DON stated</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review, staff interviews, facility documentation and policy review, the facility failed to develop and implement policies and procedures for the documentation and reporting of alleged violations involving abuse for one resident (#23). The deficient practice resulted in allegations of abuse not being reported, not investigated and residents not protected from further abuse. Findings include: The resident was admitted on [DATE] for a planned respite stay while a patient with Arizona Care Hospice, and discharged to his home on 7/8/2025 with diagnoses that included: atherosclerotic heart disease and vascular dementia. A review of the admission Minimum Data Set (MDS) dated [DATE] revealed completion of only section A. A review of the hospice admission packet revealed that the resident was admitted to the facility from Arizona Care Hospice for a respite stay while home health services were established. Additional diagnoses in the admission packet included: aortic aneurysm, weakness, falls and weight loss. The resident had elected a Do Not Resuscitate (DNR) status. The level 1 Preadmission Screening and Resident Review (PASRR) revealed that the resident had a terminal illness and secondary diagnosis of dementia, but no identified serious mental illness, intellectual disability or substance abuse. A review of hospice summary notes included in the care plan revealed that the patient was referred to hospice care for significant cognitive decline, progressive functional dependence, and poor prognosis. The care plan revealed that the patient was alert and oriented to self and place, but not time or situation. The resident had intermittent periods of restlessness and agitation especially in the late afternoon and evening. The resident woke frequently during the night and wandered, and experienced frequent falls and episodes of lightheadedness where he needed assistance getting into bed. The note revealed that the last fall resulted in a skin tear to the left wrist and that the resident refused to use assistive devices for ambulation. A review of a fall risk assessment completed on July 3, 2025/3/2025 at 07:06 A.M. revealed a score of 15 indicating the resident was a moderate risk for falls. The admission care plan dated 7/1/2025 revealed that the resident was incontinent of bowel and bladder and had a history of falls. The care plan further revealed that the resident had lost approximately 40 pounds in the past year, 5 pounds in the past week and was cachexic. A review of resident progress notes dated July 3, 2025 through July 8, 2025 revealed that the resident exhibited exit seeking, wandering, verbal behaviors and inappropriate toileting behaviors requiring orders for additional benzodiazepine and antipsychotic medications that were ordered on July 5, 2025. Staff reported that the resident continued these behaviors and was becoming more difficult to redirect, however, there was no evidence that the resident eloped from the facility. The allegation that the resident wandered into another resident's room and entered her bed was confirmed by staff interviews, however, the electronic health record revealed no documentation of the incident. Further, there was a discrepancy noted as to who held responsibility to document the resident's behaviors and change in condition. An interview with Licensed Practical Nurse, (LPN), (Staff #81), was conducted on 7/23/2025 at 11:54 AM. The LPN stated that the facility provides training on caring for residents with dementia and related behaviors. Staff #81 stated that knowing the residents and their baseline behaviors is one of the best ways to minimize wandering or other disruptions on the unit. The LPN further stated, Knowing the patients is 90% of the job. The LPN stated that if he encountered a resident trying to leave the secured unit or who was demonstrating other disruptive behaviors, he would remove them from the situation, try to redirect them using conversation, a snack, or a walk, and if the behaviors persisted, he would check the orders to see if medications were available to administer to decrease the behaviors. Staff #81 stated that he recalled a respite patient who was on the unit who exhibited a number of behaviors including exit seeking, and while the resident set off door alarms, he did not exit the building. The LPN stated that documentation of resident care is the responsibility of the nurse providing the care. An interview with Certified Nursing Assistant, (CNA), (Staff #53) was conducted on 7/23/2025 at 12:30 PM. The CNA stated that staff become aware of resident behaviors through a review of the Kardex and through staff report. Staff #53 stated that staff receive extensive training from the Behavioral Health Team about dementia and that. The unit is staffed sufficiently to manage resident care. The CNA reported that she recalled a recent resident who was on the unit for respite care who walked into another resident's room and required redirection by staff. The CNA stated that if a resident was wandering or disruptive, she would notify the nurse. An interview with the Director of Nursing, (DON), (Staff #52), was conducted on 7/23/25 at 1:26 PM. 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