

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 12/30/2025
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 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. (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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews, and policy review, the facility failed to ensure that one resident (#34) was free from abuse by another resident (#50). The deficient practice could result in residents being physically and emotionally harmed. Findings Include:-Regarding Resident #50 Resident #50 was readmitted to the facility on [DATE], with diagnoses that included suicidal ideations, displaced fracture of the right lower leg, effusion of the right ankle, chronic pain syndrome, anxiety disorder, muscle weakness, hypertension, seizures, type 1 diabetes, major depressive disorder, insomnia, and spastic hemiplegia affecting the left nondominant side.A Quarterly Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderately impaired cognition. A care plan initiated on December 10, 2025, revealed a focus on the resident getting easily agitated when other residents' behaviors disrupted her normal routine related to impulse control, with an intervention to guide her away when she and intervene before her agitation escalates and engage calmly in conversation.A progress note dated December 10, 2025, at 10:15 a.m. revealed that a report was submitted on 12/10/2025 to Adult Protective Services (APS) for an altercation on 12/9/2025, and that the ombudsman and police department had been notified.A progress note dated December 10, 2025, at 12:47 p.m. revealed that at approximately 4:45 p.m., the nurse was notified of an altercation in the dining room. The note further revealed that upon observation, the victim was shouting expletives in the dining area, and the perpetrator was seated at a nearby dining table at the time of the incident. The progress note revealed that the perpetrator stood and placed both hands on the victim's shoulder while yelling at the victim, and the victim attempted to move away from the perpetrator. The note further revealed that during the victim's movement, the perpetrator's arm moved upward and made contact with the victim's nose before the victim positioned themselves further away from the perpetrator. -Regarding Resident #34 Resident #34 was admitted to the facility on [DATE], with diagnoses that included cutaneous abscess of the neck, severe sepsis, generalized anxiety disorder, hypothyroidism, insomnia, major depressive disorder, dementia, and urinary tract infection. A Quarterly Minimum Data Set (MDS) dated [DATE], revealed that a Brief Interview for Mental Status (BIMS) could not be conducted because the resident was rarely or never understood. The MDS also revealed that the resident exhibited physical, verbal, and other behavioral symptoms for 1-3 days, and she had hallucinations and delusions. A care plan focus initiated on December 10, 2025, revealed that the resident would reminisce about her parents, and her behaviors might escalate and disrupt other residents, with interventions to monitor episodes to determine the underlying cause and document behaviors. A progress note dated December 9, 2025, at 4:18 p.m. revealed that the resident was yelling and tossing furniture in the hallway in the afternoon while repeatedly saying, I want my mom. The note further revealed that staff stayed with the resident, redirected her, and kept her under close watch for safety.A progress note dated December 10, 2025, at 10:12 a.m. revealed that a report was submitted on 12/10/2025 to Adult Protective Services (APS) for an altercation on 12/9/2025, and that the ombudsman and police department had been notified.A progress note dated December 10, 2025, at 12:52 p.m. revealed that at approximately 4:45 p.m., the nurse was notified of an altercation in the dining room. The note further revealed that upon observation, the victim was shouting expletives in the dining area, and the perpetrator was seated at a nearby dining table at the time of the incident. The progress note revealed that the perpetrator stood and placed both hands on the victim's shoulder while yelling at the victim, and the victim attempted to move away from the perpetrator. The note further revealed that during the victim's movement, the perpetrator's arm moved upward and made contact with the victim's nose before the victim positioned themselves further away from the perpetrator.A telephonic interview was attempted on December 30, 2025, at 11:34 a.m. with Resident #34's responsible party, and there was no response.An interview was conducted on December 30, 2025, at 11:44 a.m. with Resident #50, who stated that she could not remember if she had been involved in any altercations recently due to her memory loss, but she could recall knowing who Resident #34 was.A telephonic interview was conducted on December 30, 2025, at 12:21 p.m. with the facility psychiatrist (Psychiatrist/Staff#29), who stated that he could recall an altercation being reported to him regarding residents #34 and #50. The psychiatrist further stated that he met with the residents on December 15, 2025, but he did not speak with them about the incident so as not to agitate them. The psychiatrist stated that neither of the residents brought the altercation up in their session, but that Resident #50 would be the one who could recall the</p>		