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	05/19/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, facility investigation, and policies and procedures, the facility failed to update and revise the care plan after a fall for one of the three sampled residents (#1). The deficient practice could result in further falls and injuries to residents.Findings Include:Resident #1 was initially admitted on [DATE] and re-admitted on [DATE], with a diagnosis that included type 2 diabetes mellitus with hyperglycemia, anemia in chronic kidney disease, chronic kidney disease stage 3, age-related osteoporosis without current pathological fracture, alcoholic cirrhosis of the liver, hypertension, major depressive disorder, gastro-esophageal reflux disease, wedge compression fracture of T11-T12 vertebra, and hepatic.An admission Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident was cognitively intact. The MDS further documented that the resident did not have any falls.An admission fall risk tool assessment dated [DATE], revealed a score of 2, indicating the resident is at low risk for falls. The fall assessment also revealed that the resident did not have any history of falls within the last six months, and the resident was taking medication such as Antihypertensives and psychotropic medications. A care plan initiated on September 17, 2025, through September 31, 2025, documented a focus area for Resident #1, being a Moderate risk for falls related to psychoactive drugs. Interventions included anticipating and meeting needs whenever possible, calling the light within easy reach, and encouraging its use when assistance is needed; having a prompt response to all requests for assistance; and educating and providing safety reminders on what to do if a fall occurs. An admission fall risk tool assessment dated [DATE], revealed a score of 2, indicating the resident is at low risk. The fall assessment also revealed that the resident did not have any history of falls within the last six months, and the resident was taking medication such as Antihypertensives. Gait analysis revealed that the patient exhibits loss of balance while standing and uses an assistive device. A Five-day Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 09, indicating the resident had moderate cognitive impairment. The MDS further documented that the resident did not have any falls within two to six months.A nurse's note dated December 3, 2025, at 2:52 PM revealed that therapy alerted the nurse that Resident #1 was on the floor. Resident #1 was kneeling and leaning against the bed, the Resident #1 stated that she was trying to ambulate to the bathroom and slipped, and stated that she did not fall. The resident #1 was assessed, and no injuries were noted. Then the Resident #1 was assisted to bed with a two-person assist, and vitals were taken and were within normal limits. Resident #1 was educated to use the call light when needing assistance, and all of the personal items were within reach, safety precautions in place, the bed was placed in the lowest position, and the call light was within reach. Resident #1's family was notified along with the Medical Doctor (MD) and the Director of Nursing (DON). A facility internal incident report dated December 03, 2025, had an incident description documenting that the nurse was alerted by therapy that Resident #1 was on the floor. When she entered the room, Resident #1 was kneeling, leaning against the bed. Resident #1 stated that she was trying to ambulate to go to the bathroom, and then she slipped and stated that she did not fall. Immediate action included that the (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Resident #1 was assessed for injuries, but none were noted, assisted back to bed with the help of two staff members, vital signs were within normal limits, and education was provided to the resident to use call lights when needing assistance. The document further revealed that all the personal items were within reach, safety precautions were in place, such as the bed in the lowest position and the call light within reach. MD, family, and DON were made aware of the incident. The resident was not sent to the hospital when the incident occurred. The resident was oriented to person, place, and time. Pre-disposing physical factors included gait imbalance, and predisposing situation factors included ambulating without assistance, the resident attempting to toilet self/ or go to the toilet, or the resident attempting to get out of bed. A fall risk tool assessment was completed on December 03, 2025, which revealed a fall score of seven, indicating the Resident #1 was at moderate risk for falls. The reason for the assessment request revealed the resident had a recent fall. Resident #1 has a history of falls 1-2 times. The resident is using antihypertensive medication, has occasional incontinence, and has no gait analysis. A care plan initiated on December 04, 2025, had a documented focus area for Resident #1 being at risk for falls related to deconditioning, and unawareness of safety needs. Interventions included anticipating and meeting Resident #1's needs whenever possible, ensuring the call light is within easy reach, and encouraging the Resident #1 to use it for assistance as needed, prompting response to all requests for assistance as able, and following facility fall protocol at all times. Neurological Assessments (Neuro Checks) dated December 04, 2025, were completed, and no concerns were found for eyes, verbal response, motor response, extremity movements, and eye signs. A nursing progress note dated December 05, 2025, at 5:58 PM revealed that Resident #1 was observed to be lying on the floor in a supine position near the side of the bed. Resident #1 stated that she was getting up to leave. Resident #1 was assessed for injuries, but no injuries were found. Then Resident #1 was assisted back to bed with the help of two staff members. Resident #1's vitals were within normal limits. Resident #1 was able to move all extremities, with a full range of motion, and denied any pain. Resident #1 was educated to use the call light when needing assistance. Safety precautions were in place, such as the bed in the lowest position, call light, and personal items within reach. MD, family, and DON notified. Neuro checks were implemented. A facility internal incident report dated December 05, 2025, had an incident description documenting immediate action taken, the same as the nurse's note dated December 05, 2025, at 5:58 PM. Resident #1 was not taken to the hospital. The resident's mental status at the time of the incident was that of Resident #1, who was oriented to person, and no injuries were observed post-incident. Pre-disposing physiological factors included the resident being confused. The predisposing situation factors included Resident #1 ambulating without assistance and attempting to get out of bed. A fall risk tool assessment was completed on December 05, 2025, which revealed a fall score of nine, indicating the Resident #1 was at moderate risk for falls. The reason for the assessment request revealed the resident had a recent fall. Resident #1 has a history of falls 1-2 times. The resident is using antihypertensive medication and has occasional incontinence. Gait analysis included Resident #1, who required hands-on assistance to move from place to place and a decrease in muscle coordination. A care plan initiated on December 04, 2025, had a documented focus area for Resident #1 being at risk for falls related to deconditioning, and unawareness of safety needs revealed no evidence of update, revision, or interventions implemented after the fall occurred on December 05, 2025, for Resident #1.Neurological Assessments (Neuro Checks) dated December 05, 2025, were completed, and no concerns were found for eyes, verbal response, motor response, extremity movements, and eye signs.A nurse's note dated December 06, 2025, at 02:16 AM indicated that Resident #1 was observed lying supine on the floor. Resident #1 had slurred and broken speech when she was asked what happened; her pupils were not reacting at first, then the right side became sluggish. The vital signs indicated a blood pressure of 95/54, a heart rate of 48, a temperature of 97.3, and an oxygen saturation of 82%. There was a possible head injury; the Nurse Practitioner was made aware, and orders were made for Resident #1 to be sent out to the hospital. The on-call staff was called. Another nurse's note dated December 06, (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	2025, 05:29 AM revealed Resident #1 was lying supine on the floor next to her bed, with a possible head impact. When Resident #1 was asked what happened, Resident #1's speech was slurred and broken. The resident had a full range of motion to all extremities without stating pain. Resident #1 pupils were fixed, and later her right pupil became sluggish, and the left pupil was reactive upon transport. Resident #1 was not able to state that she had a head impact. Initial Fall vitals 95/54, Heart rate 45, Temperature 97.0, SaO2 (Arterial Oxygen Saturation) at 80%. At 02:00 AM, the second nurse was called as a witness and for help. At 02:05 AM, performed range of motion test, and Resident #1 stated no pain while moving, no signs of bruising or abrasion. The resident was helped back into her wheelchair and was taken to the nursing station for continuous observation while communicating with the provider at 02:10 AM. The provider gave orders to be sent out. At 2:15 a.m., transport was contacted and gave the facility the estimated arrival time of 2:50 a.m. Resident #1's vitals were stable while waiting for the vehicle to warm up. The resident left the building at 03:10 AM, and a report was given to the medical center. A facility internal incident report dated December 06, 2025, had an incident description documenting immediate action taken, the same as the nurse's note dated December 06, 2025, at 5:02 AM. Resident #1's mental status was only oriented to person, and no injuries were observed post-incident. Predisposing situational factors were that Resident #1 was ambulating without assistance. A care plan initiated on December 04, 2025, had a documented focus area for Resident #1 being at risk for falls related to deconditioning, and unawareness of safety needs revealed no evidence of update, revision, or interventions implemented after the fall occurred on December 06, 2025, for Resident #1, since the resident went to the hospital, and did not return. A call attempt was made on March 19, 2026, at 1:49 PM to a Licensed Practical Nurse (Staff #2) who made an incident report for Resident #1 for December 03, 2025, and December 05, 2025, but was unsuccessful. An interview was conducted on May 19, 2026, at 1:56 PM with a Certified Nursing Assistant (CNA/staff #3), who stated that the facility's process for an unwitnessed fall is to first get a charge nurse and not to move the resident until the nurse has assessed them for any injuries. She stated that then they would do vitals for the resident who fell. Then the CNA stated that, depending on the situation, sometimes residents are sent to the hospital. She stated that residents who are at risk for fall preventive measures taken, such as call lights being within reach of the resident, being toileted frequently, and the bed being in a low position. She stated that whenever a resident falls, new interventions are placed for the resident. She stated that if new interventions are not in place, the resident has a risk of falling again. Further, she stated that she had not worked with Resident #1. An interview was conducted on May 19, 2026, at 2:20 PM with a Registered Nurse (RN/ Staff #4), who stated that the facility's process for unwitnessed fall is to assess the resident for any injuries, find out how the fall occurred, discuss it in the fall huddle, fill out a form for the incident, do risk management on the computer, notify family, physician, case manager, and notify any appropriate parties. She also stated that we do post-adverse event and neuro checks. RN also stated that multiple preventive measures are taken for residents who are at risk for falls, such as the resident having a fall bracelet, a falling leaf outside of the door, education resident on asking for assistance when it is needed. Further, she stated that when a resident has fallen, new interventions are placed for the resident; if no new interventions are placed, then the resident will continue to fall. RN further stated that she has not worked with Resident #1. An interview was conducted on May 19, 2026, at 2:36 PM with a Director of Nursing (DON/Staff #5), who stated that the expectation of staff members when a resident falls is that nurse staff will first assess the resident head to toe, question the resident, assess the resident's vitals, incident report, complete progress note, notify family, doctor, and manager on duty. She stated that then the care plan is updated and new interventions are placed for the resident after a fall by the MDS (Minimum Data Set) Coordinator, and a meeting is conducted with the manager the day after the fall, where they discuss the fall. She stated that no new interventions were placed for the resident #1 after December 05, 2026. Then she stated that the MDS coordinator stated that all the interventions were placed on December 04, 2026, after the resident had fallen on (continued on next page)

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