STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035141	A. Building B. Wing	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Health Care Center	1300 South Street Globe, AZ 85501

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** Based on observations, clinical record review, staff interview, facility documentation and policy review, the facility failed to protect the rights of two residents (#7 and #9) to be free from physical abuse by another resident (#5). The deficient practice could result in further resident abuse. Findings include: Regarding residents #5 and #7: -Resident #5 was admitted on [DATE] with diagnoses of unspecified dementia, unspecified severity, with agitation, psychotic disorder with delusions due to known physiological condition, hallucinations, unspecified, generalized anxiety disorder. The care plan with revision date of January 17, 2025 included that resident had impaired cognitive function and at risk for change in mood or behaviors due to medical condition, recent BIMS (Brief Interview for Mental Status) score of 3 and dementia, and the use of antipsychotic medication; Seroquel related to diagnosis of psychotropic disorder with delusions and hallucinations, refusal of care, yelling at staff. Interventions included to administer meds as ordered; staff attempt to keep separate from other flagged residents; residents Quetiapine was increased after review of behaviors by MD who feels the gradual reduction rate was a fail with returned behaviors. On April 13, 2025 resident's roommate was moved to another room to separate at this time. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed a BIMS score of 3 indicating severe cognitive impairment. Further review of the MDS revealed a mood score of 05 indicating mild mood severity. There were no indicators for behaviors. Review of a progress event note dated April 1, 2025 at 6:42 am revealed resident#7 was seated in the TV area watching TV when resident #5 wheeled herself into the same area. Resident #5 started a verbal altercation with resident #5, totally unprovoked. The nurse heard the verbal altercation and stood to separate the two of them when resident #5 struck resident #7 on the back of the head. This incident was witnessed by staff. The note further states resident #7 was teary eyed, but okay Resident #5 though resident #7 had run over her in her wheelchair, but states this was not possible. Review of progress health status note dated March 31, 2025 revealed resident #5 behaviors were reviewed by the provider, who diagnosed resident #5 as having a failed Gradual Dose Reduction (GDR) with returned behaviors. (continued on next page)

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	-Resident #7 was admitted on [DATE] with diagnoses of unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, major depressive disorder, single episode, unspecified, depression, unspecified. The care plan dated April 3, 2025 included that resident #7 had impaired cognitive ability or impaired thought processes related to dementia, and at risk for change in mood or behaviors due to medical condition. Interventions included to cue, reorient and supervise as needed, supervision and assistance with all decision making, customary routines, and attempt to keep separate from other flagged residents, as flag on wheelchair is for visual effect. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed a BIMS score of 3 indicating severe cognitive impairment. Further review of the MDS revealed no indicators for mood and other behavioral symptoms not directed towards others and indicators for wandering. The alert charting dated March 31, 2025 revealed that resident #7 involved in a physical and verbal altercation and was struck in the back of the head by resident #5. No injuries or residual effects noted. Incident was unprovoked and witnessed by the nurse. No complaints of pain/discomfort. Resting comfortably/quietly in bed with eyes closed. Resp even and unlabored. No distress noted. Call light within reach. Able to make her needs known. The nursing event note dated March 31, 2025 revealed nurse a verbal altercation between resident #5 and resident #7 initiated by resident #5. Resident #7 was sitting in the tv area watching tv. Resident #5 then wheeled herself into the same area. (LPN/Staff #18) stood up to separate the two of them when resident #5 struck resident #7 on the back of her head, this was totally unprovoked and witnessed by (CNA/Staff #28). The two of them were separated immediately. It states resident #5 falsely accused resident #7 of running over her in the wheelchair and that this was not possible. It further states resident #7 was teary eyed but stated she was okay. Both residents were separated immediately. Review of the facility investigation with discover date of March 31, 2025 included that both resident #5 and #7 were interviewed. The facility concluded the altercation between these two residents was an isolated event with resident #7 being startled and no injuries, with preventative measures put in place. Regarding residents #5 and #9: -Resident #9 was admitted to the facility January 1, 2025 with diagnosis of unspecified dementia, unspecified severity, with other behavioral disturbance, depression, unspecified, other abnormalities of gait and mobility. The Care Plan revealed resident #9 at risk for mood or behavior due to medical condition resident, has impaired cognitive ability /impaired thought processes related to dementia and has a communication problem related to BIMS 03/15 and dementia. Interventions included; Be conscious of resident position when in groups, activities, dining room to promote proper communication with others, face and speak clearly when communicating with resident, April 13, 2025 moved temporally to separate 2 residents. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed a BIMS score of 3 indicating severe cognitive impairment. Further review of the MDS revealed no indicators for mood, display of verbal behavioral symptoms directed towards other and other behavioral symptoms not directed towards others. Review of the Event Note dated April 13, 2025 revealed (Staff/RN #32) was at the nurses station charting and heard a scream coming from resident #9 room the RN on shift went in to this resident's room as she was in the kitchen putting snacks away and then came out and informed RN #32 that resident #9 was saying that her roommate slapped her in the face as she was coming out of the bathroom (Staff/RN #32) went into the resident's room and asked what happened and resident #9 was holding the left side of her face (the cheek area) and the roommate (resident #5) states resident #9 hit her first across her chest by her heart so she hit her back. Resident #9 stated her roommate hit her first and denied hitting the roommate. Review of a Health Status Note dated April 14, 2025 revealed a status post note regarding a physical altercation with another resident, resident #9 was slapped on the left cheek area. Left cheek area with a red pinpoint mark & pinkish colored. Very teary eyed & upset. Emotional support offered. Unfamiliar to new environment, was ambulated into another room, redirected. Resting in bed respirations even and unlabored. No distress noted. Will continue to monitor. Review of the ongoing facility investigation facility report with discovery date of April 13, 2025 included resident and staff interviews were initiated. The initial report states at 9:25 p.m. resident #5 was coming out of the bathroom and resident #9 was sitting on the side of her bed with feet dangling when resident #5 slapped resident #9 across the face, with slight redness. Resident #5 stated resident #9 hit her first near her heart so she hit her back. Resident #9 denied hitting resident #5. Resident #9 was moved to another room. Leaving resident #5 by herself. An interview was conducted April 15, 2025 at 12:02 p.m. with (Staff/LPN #32). Staff #32 stated he has been with the facility since 2019 and is familiar with residents #5, #7 and #9. Staff #32 stated resident #5 had been fixated and upset about her the pending sale of her home. Staff #32 stated resident #5 is generally a pleasant lady, can be confrontational with staff and other residents- gets agitated with other residents who are verbal or loud. will tell them to shut up or if another resident should accidentally bump into her. Staff #2 stated he was told there was prior altercation with resident #7. Staff #32 stated resident #5 had been extremely upset after receiving mail informing her that her home was going to be sold and had been extremely agitated and frustrated. Staff #32 stated it might have been a cause for her lashing out. Staff #32 stated her medication has not been changed, but her order for Seroquel was reduced from 50mg to 25 mg prior to the first incident. After the first incident with resident #7 the doctor bumped it back up to 50mg, but resident #5 continued to be fixated about her home. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff #32 stated resident #9 had been out with her daughter, leaving at 3:30 for dinner and came back at approximately 7:00 p.m. Staff #32 stated I gave her meds and resident #9 was lying in her bed, Resident #5 was also lying on her bed. Staff #32 stated he was sitting at the nurse's station charting and heard resident #9 yelling saying why did you do that to me? Staff #32 stated resident #9 was sitting on the side of her bed holding her face. Staff #32 stated resident told another registered nurse (Staff/RN #13) in Spanish that resident #5 had hit her on her face. Resident #9 was observed holding the left side of her face- resident #5 was observed sitting in her wheelchair near her bed. RN #13 asked resident #5 what happened. Resident #9 stated resident #5 came out of the bathroom and hit her. Resident #5 stated resident #9 had hit her first in the chest, and she had hit her back and now she wasn't happy because I got the best of her. Resident #9 denied hitting her. Resident #9 was observed with some redness on the left side of her face. Staff #32 stated a skin assessment was done immediately on resident #5 with no redness noted as well as the day following. Staff #32 stated the doctor made a change with resident #5 medications by increasing her Seroquel and a lab work. Staff #32 stated resident #9 has never hit anyone, is easily offended and will cry. Staff #32 stated both residents were immediately separated with resident #9 moved to another room that same day. An attempt was made on April 15, 2025 at 12:21 p.m. to interview witness, licensed practical nurse (Staff/LPN #18). Message was left for a return phone call. An attempt was made on April 15, 2025 at 12:24 p.m. to interview witness certified nursing assistant (Staff/CNA #28). Message was left for a return phone call. An attempt to interview was conducted April 15, 2025 at 3:22 p.m. with resident #7. Resident stated I don't remember, but I'm fine. The resident is cognitively impaired. An interview was conducted April 15, 2025 at 3:43 p.m. with resident #9, also present was the resident's daughter. Resident #9 was observed with a reddened area located on the left side of her upper cheek. Part of the cheek area were yellowish and green in color. Resident #9 stated not remembering what happened, but feels like she was kicked by a horse. Resident stated feeling safe. The daughter stated she was told by staff #32 that her mother's roommate had slapped her on the face. An attempt to interview was conducted April 15, 2025 at 3:54 p.m. with resident #5. Resident was seated in her wheelchair in her room. Resident stated I don't know what you're talking about. The resident is cognitively impaired. An interview was conducted April 15, 2025 at 4:04 p.m. with abuse coordinator (Staff/#71). Staff # 71 stated their responsibilities are reporting to the state and initiating the investigation and to the appropriate authorities. Staff #71 stated the facility must report all allegations to the state within two hours and submit a final report within five days. Staff #71 stated the facility substantiated the report regarding residents #5 and #7 and the report regarding residents #5 and #9 was still ongoing, but will probably substantiate. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted April 15, 2025 at 4:26 p.m. with Director of Nursing (DON/Staff #92) who stated her expectations for reporting alleged abuse is that staff are to let their supervisors know and staff have been educated during in-services that the executive director is the abuse coordinator or they are to reach out to her. DON #92 stated resident #7 was assessed for injuries, there were none. Resident # 9 was assessed and noted redness on her left check. The DON stated resident #5 had no reported injuries for each incident. The DON stated there were no prior incidents or concerns between residents #5 and #7 or residents #5 and #9. Review of the facility policy titled Abuse - Prevention Issued October 4, 2022 and reviewed June 17, 2024 states It is the policy of this facility to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation. Definition Abuse - is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are residents from abuse. necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology.