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	05/29/2025

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 clinical record review, facility documentation, and staff interviews, the facility failed to protect the rights of two residents to be free from abuse (#10 and #20). The deficient practice could result in residents being at risk for abuse. -Regarding Resident #10: Resident #10 was admitted to the facility on [DATE] with a diagnosis that included type 2 diabetes mellitus, arthritis, and dementia. Review of quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 4.0, which indicated severely impaired cognition. The assessment also revealed that the resident exhibited verbal and other behavioral symptoms directed towards others. A event progress note dated May 14, 2025 revealed a Certified Nursing Assistant (CNA)/med tech was walking by the room, staff heard a commotion, and witnessed Resident #10 and her roommate arguing over a plastic flower. The staff witnessed Resident #10 get slapped on the right side of her face by her roommate. Resident #10 then shoved her roommate's left shoulder. The note indicated that the Residents were separated and skin assessment was completed, with no injuries noted. The note also relayed that the Assistant Director of Nursing (ADON), Director of Nursing (DON), Administrator, and the provider were notified. The note also revealed that a room change was completed. A behavioral progress note, dated May 14, 2025, revealed that staff were unable to notify the resident's representative and case manager of the altercation with the resident's roommate. A care plan initiated on May 14, 2025 revealed that Resident #10 had the potential to be verbally aggressive related to dementia. Interventions initiated on May 14, 2025 included to assess and anticipate resident's needs such as food, thirst, toileting needs, comfort level, body positioning, and pain; assess resident's understanding of the situation, allow time for the resident to express self and feelings towards the situation; and give the resident as many choices as possible about care and activities. On May 29, 2025 at 11:00 am, Resident #10 was observed lying in her bed, making non-discernable response when called by her name, but end up answering the surveyor's question which resident stated that she was fine. (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	Regarding Resident #20: -Resident #20 was admitted to the facility on [DATE] with a diagnosis that included dementia, age related osteoporosis, and type 2 diabetes mellitus. An annual MDS assessment dated [DATE], revealed no recorded BIMS score. The assessment revealed that the resident had short term and long term memory problems, was rarely/never understood, and behavioral symptoms were not exhibited. A behavioral progress note, dated May 14, 2025, revealed that a Medication Technician stated that Resident #20 and her roommate were fighting over a plant, both claiming it was their plant, and staff separated both residents. The Medication Tech stated that they had hands on each other. Staff notified the social worker and the DON and Resident #20 was moved to another room. The note also indicated that the Resident's family and provider were notified of the room change. A care plan initiated on May 14, 2025, revealed that Resident #20 had a potential to be verbally aggressive related to dementia. Interventions initiated on May 14, 2025, included to assess and anticipate the resident's needs such as food, thirst. toileting needs, comfort level, body positioning, and pain; assess resident's understanding of the situation, allow time for the resident to express self and feelings towards the situation; and observe for behaviors every shift, and document observed behavior and attempted interventions. An observation was conducted on May 29, 2025 at 11:31 a.m. of Resident #20 sitting in the activity room. The resident was observed sitting in her wheelchair, smiling, propelling her wheelchair back and forth with her hands. An interview was conducted on May 29, 2025 at 11:04 a.m. with a Licensed Practical Nurse (LPN/Staff #5), who stated that she was familiar with the altercation incident. She stated that Staff #8 witnessed the incident and separated the residents (#10 and #20). The LPN further stated that the residents were fighting about a plastic flower, one resident got hit or slapped. The LPN further stated that the residents were separated and the DON and the administrator were notified. The LPN also stated that she assessed the residents to make sure that there were no physical injuries, and that she had not observed any signs of redness or bruising. The LPN stated that she interviewed the residents and both residents could not remember what had occurred. The LPN added that the resident altercation happened in the morning in the residents' room. She stated that Resident #10 had confusion, was able to wheel herself around in her wheelchair, and liked being in her own room. The LPN stated that Resident #20 was moved to another room. The LPN also stated that a physical altercation is a form of abuse, if there is a slap, push, punch, or being hit by another resident, she considered it as abuse, and she would notify the DON and administrator of the incident. The LPN stated that she received abuse training when she first started, during orientation, watched videos, and received abuse inservices. The LPN further stated that she was trained on abuse a week or so ago. (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 on May 29, 2025 at 11:17 a.m. with a Medication Technician (Staff #8), who stated that she was working on the day of the altercation between Resident #10 and Resident #20. She stated that she heard the residents arguing in room their shared room, and they were fighting over a vase of flowers. The Medication Technician stated that there was physical contact when Resident #20 swung her right hand to the left side of Resident #10's face. She further stated that Resident #10 wanted to swing back but she stepped in between, separating them. The Medication Technician stated that she took Resident #20 out of the room, and notified an LPN (Staff #5), DON and the administrator. She also stated the incident was a form of abuse because one resident hit another resident and abuse is physical contact between residents. The Medication Technician stated that abuse training, it is conducted yearly, and she had just recently competed it. An interview was conducted on May 29, 2025 at 11:46 am with the facility Administrator (Staff #3) and the DON (Staff #4) in the conference room. The DON stated that Resident #10 and Resident #20 were roommates, that there seemed to be no problem until a staff member heard a commotion in the residents' room, and when she walked walked in the residents were arguing over a fake flower. The Administrator stated that one resident (#20) slapped the other resident (#10), and Resident #10 resident responded by pushing Resident #20's shoulder. The DON stated that it is considered abuse if there is physical contact. Review of facility's policy titled, Abuse Prevention, last reviewed date of June 17, 2024 revealed it is the policy of this facility to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation. Review of facility's policy titled, Resident Rights, last revised date of September 10, 2024 revealed the resident has the right to be free from abuse.