

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035152	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Yuma Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1850 West 25th Street Yuma, AZ 85364	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581</p> <p>Based on documentation, staff interviews and the facility policy and procedures, the facility failed to ensure that one resident (#12) was free from abuse from other residents (#12). This deficient practice could result in other residents being abused.</p> <p>Findings include:</p> <p>Resident #12 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, anxiety, generalized muscle weakness.</p> <p>The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 08 indicating the resident had a moderate cognitive impairment.</p> <p>Review of a nurse practitioner note dated October 4, 2024 revealed that resident #12 is an [AGE] year old female with a past medical history of Alzheimer's disease and a mixed mood disorder and the resident resides in a memory care unit in a long-term care facility.</p> <p>Review of the progress notes revealed a late entry dated October 4, 2024 at 7:25 p.m. by the Director of Nursing (DON/staff #1), which stated that she was called into the hallway, where a certified nursing assistant (CNA/staff #7) told her that she witnessed how another resident had struck resident #12 with an open hand. The resident was removed from the area as well as other residents. The resident was remove from the area, quickly assessed and offered emergency medical services, which the resident denied.</p> <p>A progress note dated October 5, 2024 revealed that a licensed practical nurse (LPN/staff #10) was called into the hall and was notified that the resident was slapped by another resident with an open hand on the left cheek, which was witnessed by the (CNA/staff #7). The resident did not lose consciousness, was startled, but reported being fine. Upon examination, the resident presented with a slight discoloration on the right cheek. The provider and the DON were notified by phone at around 7:45 p.m. as well as a relative of the resident at around 8:30 p.m. The resident was removed immediately from the proximity of the aggressor. The resident was in good spirits and denied any pain.</p> <p>-Resident #87 was admitted to the facility on [DATE] with diagnoses that included dementia, anxiety disorder, and depression.</p> <p>(continued on next page)</p>

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the care plan did revealed a plan dated April 11, 2024 for anti-anxiety, antidepressants, mood disorder medication use. Interventions included to monitor patterns of target behaviors.</p> <p>The MDS dated [DATE] included a brief interview for mental status score of 99 indicating the resident had significant cognitive impairment.</p> <p>A progress note dated October 4, 2024 at 12:38 p.m. revealed that the resident had a physical altercation with residents and staff, and that resident #87 was sent out to the emergency room .</p> <p>A behavior note dated October 4, 2024 at 5:12 p.m. revealed that resident #87 was refusing all medications, being belligerent and aggressive towards staff and residents. The provider was notified.</p> <p>A progress note dated October 4, 2024 at 8:26 p.m. revealed that around 7:25 p.m. the writer was notified that resident #87 slapped resident #12. The other resident was examined and made sure she was not harmed. Resident #87 had been aggressive all afternoon, and when the other resident got too close to her, she slapped her on the left cheek. The DON was called at 7:36 p.m. and made aware of the situation and staff was advised to call emergency medical services to send resident #87 to the emergency room (ER) due to being a threat to others. At 8:34 p.m. the ER called to ask if they could send resident #87 back to the facility, but the writer was not comfortable having the resident back due to her attacking other residents.</p> <p>An interview was conducted on October 17, 2024 at 2:07 p.m. with (CNA/staff #7), who stated that , she has received training on abuse and when a resident hits another resident that is abuse. She stated that she was charting by the TV area and resident #87 was within 3 to 4 feet of her. Resident #12 said, hey you're in my way because she was trying to get by resident #87 in the hallway. Resident #87 was already irritated and she was trying to wheel away when she swung out her left arm and hit resident #12 on the left cheek. The residents were separated. She stated that by the end of the the shift, around 9:40 p.m., she noticed a small bruise, red in color, about the size of a nickel on resident #12's cheek, and she reported the bruising to the nurse. She stated that the police and the paramedics came resident #87 was taken away at about 9:00 p.m. She stated that resident #87 is always hitting the staff and staff try to keep her away from the other residents.</p> <p>An interview was conducted on October 17, 2024 at 2:49 p.m. with the Director of Nursing (DON/staff #1), who stated that resident #12 didn't have a bruise, but did have some redness on her cheek. She stated that both residents wander and they were separated as soon as possible. She also stated that she and all there staff have received training on abuse, which occurs when anybody intentionally inflicts harm.</p> <p>The facility Abuse Prevention Program stated that the facility will not tolerate verbal, sexual, physical and mental abuse, corporal punishment, involuntary seclusion, neglect, or misappropriation of resident property by employees, family members, visitors, or other residents.</p>		