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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>035152 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                 | (X3) DATE SURVEY COMPLETED<br><br>12/10/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Yuma Nursing Center |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1850 West 25th Street<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |
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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>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48932</p> <p>Based on clinical record review, interviews, review of facility documentation and policy review, the facility failed to ensure resident #4 was free from abuse from resident #5. The deficient practice could result in residents experiencing emotional, physical, and mental trauma from the abuse.</p> <p>Findings include:</p> <p>Related to resident #4-</p> <p>Resident #4 was admitted to the facility on [DATE] with diagnoses of Parkinson's Disease, Dementia, and unsteadiness on feet.</p> <p>Review of the admission Minimum Data Set (MDS), dated [DATE], revealed resident #4 completed a Brief Interview for Mental Status (BIMS) and scored a 12 which indicated the resident was moderately cognitively impaired.</p> <p>Review of resident #4's Electronic Health Record (EHR) revealed a progress note dated December 1, 2024 at 7:45 p.m. The note indicated that a Certified Nursing Assistant (CNA) informed the nurse that resident #4 was slapped on the right forearm by male peer who stated, you need to stop crying. The progress note also noted that both residents were separated and there were no injuries.</p> <p>Related to resident #5-</p> <p>Resident #5 was admitted to the facility on [DATE] with diagnoses of acute kidney failure, history of strokes, and type 2 diabetes.</p> <p>Review of the admission MDS, dated [DATE], revealed resident #5 completed a BIMS and scored a 4 which indicated the resident was significantly cognitively impaired.</p> <p>Review of resident #5's care plan, created October 28, 2024, revealed a focus area related to behavior management. Interventions included encouraging the resident to participate in self-calming behaviors, reorient resident to person, place, time and situation, and to monitor for signs and symptoms related to infection.</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.

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| 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>Review of resident #5's EHR revealed a progress note dated December 1, 2024 at 7:45 p.m. The note indicated that it was reported that resident #5 appeared agitated and propelled wheelchair next to female peer where he slapped her on the right forearm stating you need to stop crying. The note also indicated that residents were separated and the resident was administered a PRN (as necessary) medication of Sertraline (anti-depressant) 50 milligrams (mg).</p> <p>An interview with resident #5 was attempted on December 10, 2024 at 11:58 a.m. however, resident #5 refused interview and stated he wanted to sleep.</p> <p>An interview was conducted with Licensed Practical Nurse (LPN/Staff #15) on December 10, 2024 at 1:44 p. m. Staff #15 confirmed that she worked on December 1, 2024. She explained that she was walking down the hall when a CNA reported that resident #5 had slapped resident #4 with an open hand. Staff #15 indicated that she had asked both CNAs working the floor if there had been any triggers that led to the altercation and both CNAs had reported there were none and that resident #5 was a bit more irritable lately. Staff #15 also indicated that she contacted the provider notifying them of the incident and that resident #5 had been more irritable and requested to administer Sertraline, which the provider approved.</p> <p>An interview was conducted on December 10, 2024 at 2:40 PM with a Certified Nursing Assistant (CNA/Staff #4). Staff #4 confirmed she was working on December 1, 2024 with both resident #4 and #5. Staff #4 recalled that it was a normal shift that evening and resident #4 was crying and sitting in the common area between her and another CNA (staff #18) as they both were consoling her. Resident #5 was sitting in the common area in front of the TV when he approached the direction they were sitting at. Staff #4 indicated that she thought resident #5 was approaching her to ask her something but instead he slapped resident #4. When staff #18 asked resident #5 why he slapped resident #4, he stated that she needed to stop crying. Once resident #5 was moved away from the area, staff #4 consoled resident #4 and informed the nurse of the incident.</p> <p>A telephonic interview was conducted on December 10, 2024 at 3:23 PM with a CNA (CNA/Staff #18). Staff #18 recalled the altercation between resident #4 and #5 and indicated that she was in the common area with resident #4 consoling her because she was crying. Staff also indicated that resident #4 typically cries before bed. Resident #5 then wheeled himself next to resident #4 and looked at her while she was crying. Staff #18 indicated that resident #5 all of a sudden slapped resident #4 on her Right arm and said something to the affect of she needs to stop. Staff #18 added that both CNAs then took resident #4 to her room to put her into bed because she needed a Hoyer lift which required 2 CNAs. Staff #18 also indicated that the slap sounded hard but there was no bruising on her arm.</p> <p>An interview was conducted on December 10, 2024 with two Directors of Nursing (staff #20 and #21, respectively). When asked what would be the risks to the residents who might be abused in the facility, staff #21 responded they could suffer from psychological harm, physical harm, death, emotional harm, and it could affect their relationships with family. When asked what transpired between resident #4 and #5, staff #21 explained that resident #4 likes to cry and she was informed by the CNA that resident #5 slapped resident #4 opened handed and he said to stop crying. Staff #21 continued to explain that neither of the residents remember what happened and there were no injuries noted. Staff #20 added that resident #5 did not have prior incidents and she thought that resident #5 was trying to console resident #4 but he hit her too hard.</p> <p>(continued on next page)</p> |  |  |

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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>Review of the facility policy titled, Abuse, Neglect, Exploitation, and Misappropriation Prevention Program, indicated that residents have the right to be free from abuse. The policy also indicated that the facility will protect residents from abuse . from other residents.</p> |