

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  035169	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/21/2024
NAME OF PROVIDER OR SUPPLIER  Desert Highlands Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1081 Kathleen Ave Kingman, AZ 86401	

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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581</b></p> <p>Based on documentation, staff interviews, and the facility policy and procedures, the facility failed to ensure that resident (#7) was not exposed to inappropriate sexual behaviors by resident (#10). The deficient practice could result in residents being sexually abused.</p> <p>Findings include:</p> <p>Resident #7 was admitted to the facility on [DATE] with diagnoses that included multiple sclerosis, dementia, and generalized muscle weakness.</p> <p>The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 9 indicating the resident had a mild cognitive impairment.</p> <p>An incident note dated November 17, 2024 revealed that a certified nursing assistant (CNA) reported at 2:15 p.m. that resident #10 was in resident #7's room and exposed himself to resident #7.</p> <p>Review of a progress note dated November 17, 2024 revealed that the central nurse reported on November 17, 2024 at 2:15 p.m. that the nurse's aid observed resident #10 in resident #7's room displaying inappropriate behavior. Resident #10 redirected immediately to stay on the East Hall until further notice . The incident was reported to the Administrator.</p> <p>A social services progress note dated November 20, 2024 revealed that the facility made a police report.</p> <p>-Resident #10 was admitted to the facility on [DATE] with diagnoses that included type II diabetes, acute kidney failure, and alcohol abuse.</p> <p>The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 14 indicating the resident was cognitively intact.</p> <p>A progress note dated November 19, 2024 revealed that resident #10 was discharged home with a family member.</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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<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 5-day investigation dated November 20, 2024 revealed that on November 17, 2024, between 2:30 p.m. and 3:30 p.m. a licensed nursing aid (LNA/staff #12) informed the Director of Nursing (DON/staff #60) that resident #10 had exposed his private parts to resident #7 in the hallway. A licensed nurse practitioner (LPN/staff #8) stated that they didn't witness the incident and reiterated to with resident #10 that he was not permitted into the hallway. Staff #12 immediately redirected resident #10 back to his room and reported the incident to the Administrator (staff #1). On Monday, November 18, 2024, the Administrator (staff #1) initiated a formal investigation. The Administrator interviewed resident #7, who stated that she did not recall the incident. During the interview with resident #10, he denied intentionally exposing himself, but acknowledged scratching his genital area. On Tuesday, November 19, 2024 resident #10 was discharged from the facility. Given that resident #10 had a similar history of behavior in other facilities, he was discharged promptly.</p> <p>An interview was conducted with (LNA/staff #12) on November 20, 2024 at 12:22 p.m., who stated that she has received training on abuse, which includes sexual abuse and emotional abuse. She stated that resident #10 visits resident #7 in her room. Staff #12 stated that the door was open and resident #10 was in his wheelchair facing away from the door towards the resident, who was in bed, when she entered the room looking for wipes. She stated that resident #7 looked a little red as if she was blushing and the two residents were talking, but she couldn't hear what they were saying. Staff #12 glanced over and saw resident's #10's penis was out and in his hand. Staff #12 reached up on the dresser to get the wipes and when she turned around, resident #10 had put his penis back in his pants. Staff #12 told resident #10 to leave the room. She asked resident #7 if she knew what resident #10 was doing and the resident was babbling and then said, well, I told him to put it away. Staff #12 stated that she believes that (LPN/staff #8) told resident #10 not to leave his hallway, not to go past the nurse's station and imagined that he was in his room. She stated that resident #10 has visited another female resident (#4), but doesn't think that she would remember anything because she has severe dementia.</p> <p>An interview was conducted on November 20, 2024 at 2:37 p.m. with a registered nurse (RN/staff #2), who stated that (LPN/staff #8) told her that (LNA/staff #12) told her that resident #10 exposed himself and resident #7 told the CNA that she was uncomfortable with what had happened.</p> <p>An interview was conducted on November 20, 2024 at 2:57 p.m. with a licensed practical nurse (LPN/staff #8), who stated that (LNA/staff #12) told her that resident #7 stated that she was uncomfortable or didn't like it when resident #10 was in her room. Staff #8 stated that resident #10 visits resident #7's room frequently. She stated that (RN/staff #2) told resident #10 that he had to stay in his room and staff #2 said that he kind of looked guilty. She stated that she only had about an hour left on her shift and charting at the nurse's station when resident #10 tried to go down another hall and she told him no.</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>An interview was conducted with resident #7 on November 22, 2024 at 11:05 a.m. She stated that resident #10 started by coming by her door and then made his way to her room. At first, she told resident #10 that he can't come into her room, but he kept coming by and smiling. She stated that she knew that he was doing something with his private parts and every time, he would have his pants undone and his hand was there. She stated that she is not stupid, she knew what resident #10 was doing and something was wrong. She stated that resident #10 asked her if it bothered her and she told him that it did and he would stop and say that he wouldn't do it again. She stated that when he came to her room, he would do it again. She stated that she couldn't see his penis, but she could see his hand/fingers moving over his crotch. She stated that resident #10's pants were often open and unzipped, but she couldn't see everything because her bed is higher than his wheelchair.</p> <p>An interview was conducted with the Director of Nursing (DON/staff #60) on November 21, 2024 at 11:52 a. m. She stated that she has received training on abuse and sexual abuse includes masturbating in front of another person and the other person doesn't want it. She stated that staff were told that resident #10 could not be in other residents' rooms, but could be in common areas with supervision. She stated that if staff were sitting at the nurse's station while supervising the resident, it would not be sufficient because staff cannot see down the East Hall where the resident room was located. She stated that there were three to four women in rooms on the East Hall at the time of the incident and if the hall wasn't watched, it is possible that resident #10 could have entered one of the females rooms on the East Hall.</p> <p>An interview was conducted on November 21, 2024 at 12:14 p.m. with the Administrator (staff #1). She stated that sexual abuse includes masturbation, someone touching themselves in front of someone else. She stated that the allegation was inconclusive because resident #10 stated that he was scratching himself.</p> <p>The facility policy, Abuse Prevention Program states 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>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>40581</p> <p>Based on documentation, staff interviews, and policy and procedures, the facility failed to report an allegation of sexual abuse to the state agency within the regulated timeframe.</p> <p>Findings include:</p> <p>Review of the online report to the state agency revealed that the facility reported an allegation of sexual abuse that occurred on November 17, 2024 at 3:10 p.m., on November 18, 2024.</p> <p>Review of the 5-day investigation dated November 20, 2024 revealed that on November 17, 2024, between 2:30 p.m. and 3:30 p.m. a licensed nursing aid (LNA/staff #12) informed the Director of Nursing (DON/staff #60) that resident #10 had exposed his private parts to resident #7 in the hallway. A licensed nurse practitioner (LPN/staff #8) stated that they didn't witness the incident and reiterated to with resident #10 that he was not permitted into the hallway. Staff #12 immediately redirected resident #10 back to his room and reported the incident to the Administrator (staff #1). On Monday, November 18, 2024, the Administrator (staff #1) initiated a formal investigation.</p> <p>An interview was conducted on November 21, 2024 at 11:52 a.m. with the Director of Nursing (DON/staff #60), who stated that an allegation for sexual abuse should be reported within two hours of the facility becoming aware of the allegation.</p> <p>An interview was conducted on November 21, 2024 at 12:14 p.m. with the Administrator (staff #1), who stated that sexual abuse included a person masturbating in front of another person and has to be reported to the state agency if it is confirmed as sexual abuse. She stated that she received a call from the facility on November 17, 2024 and reported to the state agency on November 18, 2024.</p> <p>The facility policy, Abuse Prevention Program states that If the events that cause the allegation involve abuse or result in serious bodily injury to a resident, a report must be made immediately and not later than 2 hours after receiving the allegation, If the events that cause the allegation do not involve abuse and do not result in serious bodily injury, the report must be made within 24 hours of receiving the allegation. The facility must report the allegation and not wait until confirmed with an investigative process.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581</b></p> <p>Based on documentation, staff interviews, and policy and procedures, the facility failed to protect residents from further abuse by one resident (#10). The deficient practice could result in residents being abused.</p> <p>Findings include:</p> <p>Review of the 5-day investigation dated November 20, 2024 revealed that on November 17, 2024, between 2:30 p.m. and 3:30 p.m. a licensed nursing aid (LNA/staff #12) informed the Director of Nursing (DON/staff #60) that resident #10 had exposed his private parts to resident #7 in the hallway. A licensed nurse practitioner (LPN/staff #8) stated that they didn't witness the incident and reiterated to with resident #10 that he was not permitted into the hallway. Staff #12 immediately redirected resident #10 back to his room and reported the incident to the Administrator (staff #1). On Monday, November 18, 2024, the Administrator (staff #1) initiated a formal investigation. The Administrator interviewed resident #7, who stated that she did not recall the incident. During the interview with resident #10, he denied intentionally exposing himself, but acknowledged scratching his genital area. On Tuesday, November 19, 2024 resident #10 was discharged from the facility. Given that resident #10 had a similar history of behavior in other facilities, he was discharged promptly.</p> <p>Review of facility documentation and the floor map, revealed that resident #10's room [ROOM NUMBER] was located on the East Hall along with three female residents (#37, #45, and #58) in rooms #28 and #30. The nurse's station was located in the middle of the building and the resident would need to cross by the nurse's station to access the Central Hall where resident's #7 and #4 reside.</p> <p>An observation conducted on November 22, 2024 at 10:58 a.m. revealed that the staff had a limited view of the East Hall from the nurse's station. It was observed that residents' #10, #37, #45, and #58 were not visible from the nurse's station.</p> <p>An interview was conducted with (LNA/staff #12) on November 20, 2024 at 12:22 p.m., who stated that she has received training on abuse, which includes sexual abuse and emotional abuse. She stated that resident #10 visits resident #7 in her room. Staff #12 stated that the door was open and resident #10 was in his wheelchair facing away from the door towards the resident, who was in bed, when she entered the room looking for wipes. She stated that resident #7 looked a little red as if she was blushing and the two residents were talking, but she couldn't hear what they were saying. Staff #12 glanced over and saw resident's #10's penis was out and in his hand. Staff #12 reached up on the dresser to get the wipes and when she turned around, resident #10 had put his penis back in his pants. Staff #12 told resident #10 to leave the room. She asked resident #7 if she knew what resident #10 was doing and the resident was babbling and then said, well, I told him to put it away. Staff #12 stated that she believes that (LPN/staff #8) told resident #10 not to leave his hallway, not to go past the nurse's station and imagined that he was in his room. She stated that resident #10 has visited another female resident (#4), but doesn't think that she would remember anything because she has severe dementia. She stated that resident #10 wanders up and down the East Hall to the Central Hall.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on November 20, 2024 at 2:37 p.m. with a registered nurse (RN/staff #2), who stated that (LPN/staff #8) told her that (CNA/staff #12) told her that resident #10 exposed himself. Staff #2 told resident #10 that he had to stay on the East Hall and was not to pass the nurse's station. Staff #2 stated that she informed resident #10 that there was an allegation about him and he didn't ask any questions and seemed nervous. She stated that there were three female residents on the East Hall at the time of the incident where resident #10's room was located. She stated that she has received training about abuse and the staff are supposed to keep the residents safe. The staff were told to keep an eye on resident #10, but no one sat at the nurse's station the entire time and it is possible that resident #10 went somewhere if staff were not present at all times.</p> <p>An interview was conducted on November 20, 2024 at 2:57 p.m. with a licensed practical nurse (LPN/staff #8), who stated that (LNA/staff #12) told her that resident #7 stated that she was uncomfortable or didn't like it when resident #10 was in her room. Staff #8 stated that resident #10 visits resident #7's room frequently. She stated that (RN/staff #2) told resident #10 that he had to stay in his room and staff #2 said that he kind of looked guilty. She stated that she only had about an hour left on her shift and charting at the nurse's station when resident #10 tried to go down another hall and she told him no.</p> <p>An interview was conducted with the Director of Nursing (DON/staff #60) on November 21, 2024 at 11:52 a. m. She stated that she has received training on abuse and sexual abuse includes masterbating in front of another person and the other person doesn't want it. She stated that staff were told that resident #10 could not be in other residents' rooms, but could be in common areas with supervision. She stated that if staff were sitting at the nurse's station while supervising the resident, it would not be sufficient because staff cannot see down the East Hall where the resident room was located. She stated that there were three to four women in rooms on the East Hall at the time of the incident and if the hall wasn't watched, it is possible that resident #10 could have entered one of the females rooms on the East Hall.</p> <p>An interview was conducted on November 21, 2024 at 12:14 p.m. with the Administrator (staff #1), who stated that sexual abuse included a person masterbating in front of another person. She stated that she strongly recommended that staff not allow resident #10 back into the hallway, he was to remain in his room. She wanted to protect resident #7 from resident #10 and stated that when the allegation was reported to her, she didn't know about protecting the female residents on the East Hall. She also stated that if the staff were monitoring resident #10 from the nurse's station, staff would not have been able to see down the East Hall.</p> <p>The facility policy, Abuse Prevention Program states that the facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p>		