Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035205	A. Building B. Wing	01/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Suncrest Healthcare Center	2211 East Southern Avenue Phoenix, AZ 85040

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** 47669 Based on clinical record reviews, resident and staff interviews, facility documentation, policy, and procedures, the facility failed to ensure that residents (154), (145),(125) and (D1) were free from resident-to-resident abuse. The findings include: Resident (154) was admitted to the facility on [DATE], with diagnosis that consisted of hemiplegia and hemiparesis following cerebral infarction affecting the non-dominant side, paraplegia unspecified, type 2 diabetes mellitus with hyperglycemia, morbid obesity, and adjustment disorder. The resident care plan consisted of the following: Resident involved an altercation with another resident. [NAME] states that she was hit a few times by resident and shirt ripped at neckline. was able to point to areas to the left forehead and to the base of the left eye. The left side of the frontal forehead was slightly raised and intact. There is no bruising present at this time. The area below the left eye appears to be puffy with skin intact. The same can be visualized to the top of the lip. All skin is intact with no open areas. The resident will not have altercations with other residents through the next review. Has behavior of false accusations towards staff, repeated complaints of missing items. Endorses conflicting information, and refuses care such as shower. will display appropriate interaction with peers/staff/visitors, and will remain safe over the next 90 days, anticipate and meet needs promptly, assess for contributing factors for behavior. A review of the resident's Brief Interview of Mental Status (BIMS) revealed the resident had a BIMS of 15 suggesting the resident is cognitively intact. A review of the resident's progress notes revealed the following: December 24, 2024, 1205 hours Nursing Note This writer placed a telephone call to the police regarding the resident to resident altercation that occurred on December 24, 2024, at approximately 1120 hours with this resident and her roommate . Awaiting officers to arrive to speak with the residents and obtain incident report number. December 24, 2024, 1323 hours Nursing Note (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	The resident had an altercation with another resident in the same room. The resident has minor injuries treated by wound nurse. Vitals are well within normal limits. The resident was hit in the head. Neuro checks are within normal limits. The police were called to file a report. Medical Director notified. The other resident was moved to a different room. December 24, 2024, 1327 hours Wound care This nurse in to see resident due to altercation with another resident. Resident Alert and oriented X4 able to make needs known. Resident states that she was hit a few times by resident and shirt was ripped at neckline. Resident was able to point to the area to the left of the forehead and to the base of the left eye. The left side of the frontal forehead was slightly raised and intact. The is not bruising present at this time. The area below the left eye appears to be puffy with skin intact. The same can be visualized to the top of the lip. All skin is intact with no open areas. Educated resident of finding and treatment plan may apply cold compressor ice with 20 minutes on 20 minutes off every 2 hours until swelling subsides. Medical Director is aware of event. December 24, 2024, 2200 hours Nursing Note Police arrived to facility on complaint reference this resident and another getting into altercation. Police did interview resident. Resident (145) was admitted to the facility on [DATE], with diagnosis that consisted of: unspecified arterial fibrillation, cerebral infarction due to unspecified occlusion of stenosis of the left middle cerebral artery, unspecified dementia moderate with anxiety, depression. Accidental bite by another person initial contact. The resident care plan consisted of the following: The Resident had an altercation with another resident residing in the same room. Injury to left forearm is a bite mark sustained by human. Imprint of teeth marks present. The resident will not have altercations with another resident through the next review. The resident moved to another room. Fall risk. Resident with maintain current level of mobility with minimal risk of injury over the next 90 days. Anticipate and meet needs promptly. Antipsychotic drug therapy. Resident will have behaviors managed with minimal side effects over the next 90 days. Administer medications per doctors orders. A review of the resident's Brief Interview of Mental Status (BIMS) revealed the resident had a BIMS of 15 suggesting the resident is cognitively intact. A review of the resident's progress notes revealed the following: December 24, 2024, 1205 hours Nursing Note This writer placed a telephone call to the police department regarding the resident-to-resident altercation that occurred on December 24, 2024, at approximately 1120 hours with this resident and her roommate. Awaiting officers to arrive to speak with the residents and obtain an incident report. December 24, 2024 1239 hours Nursing Note (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident had an altercation with another resident residing in the same room. Resident has minor injuries treated by wound nurse. Vitals are within normal limits. The police were called to file a report. Medical Director notified and ordered to clean and monitor resident's injuries for signs and symptoms of infection. Resident's daughter was notified. Resident was moved to a different room. December 24, 2024, 1253 hours Wound Care Altered by DON (37) and Assistant Director of Nursing (ADON 30) resident in altercation with another resident with injury, Resident is alert and oriented X 4 able to needs known. Resident complains of pain relative to chronic pain and have been previously medicated. This nurse (LPN wound nurse 25) performed assessment and observed injury to left forearm. Injury is a bite mark sustained by a human. Measurement 5. 5cm X 5.0cm. Imprint of teeth marks present. This is superficial open area noted. The open areas are reddened with scant amount of serosanguineous drainage the peri wound intact. Resident complained of pain to touch. The area was washed and Hibecleanse Solution and Bacroban applied covered with foam dressing. Educated resident of treatment plan. Medical Director has been alerted by SN text order Hibecleanse and Bactroban daily. A review of the facility incident report revealed the following: On December 24, 2024, at approximately 1130 hours resident (154) and resident (145) began yelling at each other which led to them hitting each other in the head and chest. Resident (154) stated that resident (145) became verbally aggressive towards her and started to call her vulgar names. Resident (154) stated that resident (145) began accusing her of spraying perfume in the room and that it was making her sick. Resident (154) stated that resident (145) began to hit her in the head and that she also tore the shirt she was wearing. Resident (154) is wheelchair-bound due to diagnosis that that includes hemiplegia and hemiparesis following a cerebral infarction. Resident (154) further stated that she bit resident (145) on the left arm to get her to stop hitting her. Resident (145) stated that resident (154) hit her several times and bit her on the arm. Both residents were separated and aid was rendered. Witness Statements Licensed Practical Nurse, LPN (14), stated residents were having a dispute about a smell in the room. Both residents were saying inappropriate things to each other. LPN (14) was able to separate them and calm the situation down. About 20 minutes later LPN (14) was notified that the residents had an altercation. Receptionist, staff (69) stated that staff (62) had walked passed her desk informing her that resident (154) and resident (145) were arguing. Staff (69) stated maybe 10 to 15 minutes later she heard resident (154) raising her voice. As (69) is about to go check on their room the two residents (145) and (154) come to her desk. Resident (145) put her arm on the table and that's when she noticed the bite mark on resident (145). The two residents began to argue again and staff (69) stood between them and asked resident (154) to go have a smoke. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Housekeeping staff (62) stated he observed resident (145) sitting outside her room with her head in her knees and looking as if she was in pain. Staff (62) stated that he asked LPN, Staff (1) to check on resident (145) and briefly walked with her towards the resident and then walked away. Staff (62) stated that stated that he overheard LPN (1) confirming with resident (145) that she had a bad stomach ache. Staff (62) stated that as he was returning to his cart he happened to hear resident (154) arguing with her nurse about resident (145). Staff (62) further stated that residents (154 & 145) were yelling at each other quite angrily, though he was not sure what was said. Staff (62) stated that resident (154) was raising her voice at her nurse saying you need to listen to me! Certified Nursing Assistant (CNA), staff (3), stated that she entered the room to get her patient up, resident (154), and resident (145) asked if resident (154) could keep it down a bit. Resident (154) asked to hurry up and get out of there. CNA (3) stated that she got resident (154) ready and that resident (154) was yelling at resident (145) about her TV being on all day and that resident (145) got mad. CNA (3) stated that she then left the room. An interview was conducted with resident (154) on January 02, 2025, at approximately 1100 hours. Resident (154) stated that CNA (3) came into the room to help get her up. Resident (154) stated that resident (145) began yelling for them to keep it down. Resident (154) stated that once she got ready and she went to leave the room resident (145) was in the doorway and would not move. Resident (154) stated that she asked resident (145) to move and the two began to argue and resident (145) began hitting her in the head. Resident (154) stated that she then began defending herself by hitting back. Resident (154) stated that she could not get resident (145) to stop hitting her so she bit her on the left arm. Resident (154) stated that staff then arrived and separated them. An interview was conducted with resident (145) on January 02, 2025, at approximately 1110 hours. Resident (145) stated that resident (154) came at her with her wheelchair and that she, resident (145) hit resident (154) and then the two began hitting each other. Resident (145) stated that resident (154) hit her on the arm in the process. Resident (145) stated that staff separated them and that medical attention was given to her bite mark. Interview with the Director of Nursing DON, (37), conducted on January 02, 2025, at approximately 1300 hours. DON (37) advised that while she did not personally witness the incident she did see the video. The DON (37) stated that both residents were hitting each other. The DON (37) advised that there had not been any previous incidents between the two residents. Resident (145) was moved to another room. The expectation is that the residents will be free from abuse. Incident related to residents D1, and 125 Resident (D1) was admitted to the facility on [DATE], with diagnosis that consisted of: restlessness and agitation, unspecified dementia unspecified severity without behavioral disturbance psychotic disturbance mood disturbance and anxiety, unspecified dementia moderate with other behavioral disturbance, cortical age-related cataract left eye. Physician orders consisted of: doxycycline monohydrate tablet 100mg, keflex capsule 500mg, keppra tablet 500mg, Lasix tablet 20mg, risperidone tablet 25mg, and tramadol tablet 50mg. The resident care plan consisted of: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the resident's Brief Interview of Mental Status (BIMS) revealed the resident had a BIMS of 06 suggesting severe cognitive impairment. A review of the resident progress notes revealed the following: December 07, 2024, 1001 hours Nurse Practitioner Reason for visit: Follow-up visit to evaluate behavioral symptoms and response to newly initiated medication citalopram. Subjective: The patient presents for follow-up regarding ongoing agitation and dysregulation. Initial symptoms included combative behavior such as hitting staff and throwing objects. He was started on citalopram to address these behaviors. The patient's nurse reports no significant improvement in these behaviors since the last visit. December 09, 2024, 0722 hours Nursing Note This is a late entry, resident has been acting very angry at various individuals and his behavior at times has been violent towards staff. This resident hit me (LPN 12) and cursed me out when I told the night shift nurse about his behaviors, she confessed that he had kicked her too. I sent a text message to Nurse Practitioner and told her about his violent behavior and asked her to evaluate him so that he could be treated with medication for his anger and behavior. December 10, 2024, 1646 hours Nursing Note Resident continues with bad behavior. Came out of his room walking without his wheelchair or walker. I went to his room and followed him with his wheelchair and when he turned around and saw me, he tried again to hit me. Resident has been sitting in front of the nurse's station talking about how tough he is and how this place is no good. December 13, 2024, 0456 hours Nursing Note Resident noted on this writer shift displaying an aggressive/confused attitude and attempting to be combative with staff. Resident walking around without walker/wheelchair with limited stability. December 13, 2024, 1348 hours Nursing Note This writer place a telephone call to the resident's daughter. A message left for her to call this writer/facility (plans are to discuss residents onset of aggressive behavior as evidenced by yelling, trying to strike out at staff and being verbally abusive towards staff, staff advised that resident was observed trying to kick out glass door, awaiting a return phone call from daughter. December 13, 2024, 1352 hours Nursing Note This writer place telephone call to psych provider regarding residents behavior as evidenced by being aggressive towards staff, including trying to kick out glass door. New order received to obtain a urine for urinalysis and urine for culture and sensitivity. Start risperidone 0.25mg 1 po bid. Order noted and will be implemented. Edited By: ADON (30) on 12/13/2024 03:38 PM Reason: Incorrect data (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This writer place telephone call to psych provider regarding residents behavior as evidenced by being aggressive towards staff, including trying to kick out glass door. New order received to obtain a urine for urinalysis and urine for culture and sensitivity. Start risperidone 0.5mg 1 po bid. Order noted and will be implemented. December 13, 2024 1522 hours Nursing Note Residents' daughter returned the phone call. Residents' aggressive behavior was discussed with daughter including that resident had an altercation with another Resident. Resident was observed by peers hitting another resident. Daughter was advised that the NP had ordered medication to try for aggression (Risperidone 0.25mg a small dose twice a day) and to obtain a urine specimen for analysis to see if he may have urinary tract infection. Daughter states that she is remorseful that her father hit another Resident and is okay with Resident having medications that would help with stabilizing his behavior if needed. December 13, 2024, 1734 hours Nursing Note Nurse Practitioner was called and notified of this resident's altercation with another resident. No further orders at this time. December 13, 2024, 1827 hours Registered Nurse Note Patient continues to be combative, pt. throwing diner tray and makes attempt to enter other patient's room. Concern for UTI and pt. behavior not within baseline. Nurse Practitioner Psych, called and okay to send patient to hospital for evaluation. Patient refuses to get vitals and transportation called and estimated time of arrival 1 and 1/2 hr. Resident (125) was admitted to the facility on [DATE] with diagnosis that consisted of: acuter systolic heart failure, rash and other nonspecific skin eruption, depression unspecified, anxiety disorder due to unknown physiological condition, chronic obstructive pulmonary disease. Physician orders consisted of the following: acetaminophen tablet 325 mg, famotidine tablet 20mg, melatonin tablet 3mg, milk of magnesia 400mg5mL 30min. A review of the resident's Brief Interview of Mental Status (BIMS) revealed the resident had a BIMS of 12 suggesting moderate cognitive impairment. Resident progress notes revealed the following: December 13, 2024, 1531 hours Wound Care Alerted by SN res was struck in the back of head by another res. Res has small contusion to the back of the head measurement 0.3cm x 0.3cm raised area. Resident is alert and oriented x3 At the center of the contusion is a small pin sized open area. Hair was trimmed away to visualize. there was a scant amount of serous drainage. There is no bruising present. Res does c/o pain to touch. This nurse cleansed area with wound cleanser and TAO applied to wound bed and left open to air. Res is currently up in w/c with ability navigate appropriately. SN will continue to monitor for COC and to notify MD (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	December 13, 2024, 1617 hours Registered Nurse Note Res was beat up by another res at the smoking area. A small pin size open area was noted to the back of the head. Vitals: Bp-129/79, P-91, RR-18, Temp-97.7, Pox-96%RA., NP was notified. December 16, 2024 0745 hours Wound Care This nurse in to see res for follow of contusion to the Right back of the head. Res is a/O x3able to make needs known. Res denies any pain. There is no sign of open area present. There is no bruising or evidence of bruising. Resident did not c/o pain when touched. %100 of epithelial tissue present. Discussed with res of healed area. Res stated that he is fi ne. no further treatment necessary TX order closed/resolved. A review of the facility incident report revealed the following: On December 13, 2024, at approximately 1600 hours it was reported to staff that an altercation occurred in the smoking area involving two residents. Resident (D1) was observed striking resident (125) several times in the head. Witness statement from the DON (37): This resident (D1) was in a fight with another resident (reported to me) This resident hit another resident (125) in the head- he had a cut to his head. Resident (D1) was very angry and aggressive. He was saying he was going to kill people. Witness statement from Social Services Director (38): I observed through video surveillance that resident (D1) struck fell ow resident (12) in the head and face area. The incident occurred within the smoking area and was unprovoked. Immediate attention was given to both following occurrence. Medical assessment was properly administered to resident (125). Both parties were monitored for further psychosocial impact. Witness statement from Company President (29): I, (29) witnessed an incident involving residents (125) and (D1). During the incident, I observed (D1) striking (125) in the head and face area. This assault occurred without any provocation from (125). (D1) also stated to me (29) that if I touched his wheelchair he was going to strike me and kill me. Witness statement from resident (150): I, (150) witnessed the incident in the smoking area involving residents (125) and (D1). During the event, I observed (D1) striking (125) in the head and face area. This assault occurred without provocations from (125). Witness statement from RN (4): I observed patient (D1) striking another patient (125) multiple time to his head. Victim was hit with fist from (D1) 3 plus times. Noted bump/open laceration on victim's head after patient was hit multiple times. Patient continued aggressive behavior. Patient thru dinner tray to the floor in the evening as well. Attempted to console but patient (D1) remained aggressive thru shift. Witness statement from resident (107): I, (107), witnessed an incident involving residents (125) and (D1). During the incident I observed (D1) striking (125) in the head and face area. (D1) was not himself. Witness statement from resident (124): I, (124), witnessed an incident involving residents (125) and (D1) During the incident I observed (D1) striking (125) in the head and face area. (continued on next page)

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