| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 035205 | A. Building<br>B. Wing | 07/03/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Suncrest Healthcare Center | 2211 East Southern Avenue<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>(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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff and resident interviews, and facility policy, the facility failed to protect the rights of four out of the seven sample residents to be free from abuse by another resident. The deficient practice could result in other residents being abused.Findings Include: - Regarding a resident-to-resident altercation that occurred on June 20, 2025 involving Resident # 35, Resident #13, and Resident #72. -Regarding Resident #35Resident # 35 was re-admitted to the facility on [DATE], with diagnoses of anxiety disorder, urinary tract infection, and heart failure. A quarterly MDS (Minimum Data Set) assessment, dated February 2, 2025, revealed a BIMS (Brief Interview for Mental Status) score of 12, indicating moderately impaired cognition. -Regarding Resident #13Resident #13 was admitted to the facility on [DATE], with diagnoses of major depressive disorder, hyperlipidemia, and hypothyroidism A quarterly MDS assessment dated [DATE], revealed that resident #13 had a BIMS score of 15, which indicated that the resident is cognitively intact. -Regarding Resident #72Resident #72 was admitted to the facility on [DATE], with diagnoses of paraplegia, edema, and urinary tract infection. An admission assessment MDS dated [DATE], revealed resident #72 had a BIMS score of 15, which indicated the resident is cognitively intact. A progress note for Resident #35 dated June 21, 2025, revealed that on June 20, 2025, Resident #35 and Resident #13 were relocating kittens across the courtyard to prevent them from being injured, and Resident #72 became verbally and physically aggressive. A progress note for Resident #13 dated June 21, 2025 a, indicated that Resident # 13 reported an incident that had happened the day before. This progress note also noted that resident #13 stated to staff that resident # 72 was in a wheelchair and was attempting to enter the gated area. The progress note also indicated that Resident #13 stated that Resident #72 was informed she could not enter the restricted areas for cats, and that's when Resident # 72 became verbally aggressive and began using profanity towards Resident #13. The progress note revealed that Resident #13 stated that Resident #72 attempted to hit him, he stepped back, and that's when Resident #72 attempted to grab Resident #13's G-tube. This progress note indicated that Resident #35 intervened to prevent Resident #72 from pulling Resident #13's G-tube. In this progress note, Resident #13 also stated that Resident #72 began using her fist and the gate to cause injury to Resident #35. This progress note also revealed that there was a resident who was sent to get staff for assistance. The progress note revealed that the resident had notified nursing staff, and a CNA (Certified Nursing Assistant) arrived at the scene. A late entry progress note for Resident #35 dated June 22, 2025, stating there was an attraction with another resident. Further review of the progress notes revealed that the incident occurred on June 20, per a report from the day shift nurse. Progress further revealed that the resident had bruising on her right arm. The progress note also revealed that this incident was reported to the police, and the police came to the facility on June 21, the day after the incident. The progress note also noted that the Police indicated the situation was a behavioral issue. A progress note for Resident #72 dated June 22, 2025, noted that when the officer came to re-address the previous incident that happened on June 20, the police were not able to interview Resident #72 due to aggressive behaviors exhibited. The progress further noted that Residents #13 and Resident #35 were able to be interviewed. A late entry progress note for Resident #72 dated June 22, 2025, revealed that the resident had an altercation with another resident. The progress note further revealed that the resident was seen attacking another resident by hitting that resident through the gated fence and grabbing another resident's feeding tube, which was witnessed by (CNA/Staff #44). An interview was conducted via phone on July 02, 2025, at 1:21 PM with a Licensed Practical Nurse (LPN/Staff #33) who stated that the incident happened Friday night and she went into work Saturday morning. The LPN (Staff #33) stated that when she was performing resident #35's blood sugar testing, the resident mentioned to her that there had been an incident that had happened the previous night. She also stated that the resident mentioned to her that she was in pain. She further stated that she observed Resident #35's skin and had noticed in 4 different areas on her arm. She also stated that there were 3 indentations from the gate. Additionally, the LPN stated that resident #35 told her that resident #72 was holding a baby cat, all while resident #35 and resident #13 were wanting to move the cats to their designated area. Staff # 33 also stated that Resident #35 explained to her that the reason for moving the cats was that there is a resident who likes to kick the cats. (LPN/Staff #33) stated that Resident #35 told her Resident #13 was trying to enter the designated area for cats. She further stated that Resident #35 also told her that Resident #72 called her, and Resident # 13 was racist Staff #33 stated that Resident #35 told her that |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, facility documentation, and policy review, the facility failed to report alleged violations involving abuse for two residents (#35 and #13 ). The deficient practice resulted in allegations of abuse not being reported, not investigated, and residents not being protected from further abuse.Regarding a resident-to-resident altercation that occurred on June 20, 2025 involving Resident # 35, Resident #13, and Resident #72. -Regarding Resident #35Resident # 35 was re-admitted to the facility on [DATE], with diagnoses of anxiety disorder, urinary tract infection, and heart failure. A quarterly MDS (Minimum Data Set) assessment, dated February 2, 2025, revealed a BIMS (Brief Interview for Mental Status) score of 12, indicating moderately impaired cognition.A progress note for Resident #35 dated June 21, 2025, revealed that on June 20, 2025, Resident #35 and Resident #13 were relocating kittens across the courtyard to prevent them from being injured, and Resident #72 became verbally and physically aggressive. A late entry progress note for Resident #35 dated June 22, 2025, stated there was an interaction with another resident. Further review of the progress notes revealed that the incident occurred on June 20, per a report from the day shift nurse. The progress note also revealed that this incident was reported to the police, and the police came to the facility on June 21, the day after the incident, despite the incident having occurred on despite the incident occurring on June 20, 2025. -Regarding Resident #13Resident #13 was admitted to the facility on [DATE], with diagnoses of major depressive disorder, hyperlipidemia, and hypothyroidism A quarterly MDS assessment dated [DATE], revealed that resident #13 had a BIMS score of 15, which indicated that the resident is cognitively intact. A progress note for Resident #13 dated June 21, 2025, indicated that Resident # 13 reported an incident that occurred the day before. The progress note indicated that resident #13 stated to staff that resident # 72 was in a wheelchair and was attempting to enter the gated area. Resident #13 stated that Resident #72 was informed she could not enter the restricted areas for cats, and Resident # 72 became verbally aggressive and began using profanity towards Resident #13. The progress note revealed that Resident #13 stated that Resident #72 attempted to hit him, he stepped back, and that's when Resident #72 attempted to grab Resident #13's G-tube. This progress note indicated that Resident #35 intervened to prevent Resident #72 from pulling Resident #13's G-tube. The progress note further indicated that Resident #13 stated that Resident #72 began using her fist and the gate to cause injury to Resident #35. The note relayed that a resident had notified nursing staff, and a CNA (Certified Nursing Assistant) arrived at the scene. -Regarding Resident #72:Resident #72 was admitted to the facility on [DATE], with diagnoses of paraplegia, edema, and urinary tract infection. An admission assessment MDS dated [DATE], revealed resident #72 had a BIMS score of 15, which indicated the resident is cognitively intact. A progress note for Resident #72 dated June 22, 2025, noted that when the officer came to re-address the previous incident that happened on June 20, the police were not able to interview Resident #72 due to aggressive behaviors. The progress note further noted that Residents #13 and Resident #35 were able to be interviewed. A late entry progress note for Resident #72 dated June 22, 2025, revealed that the resident was seen attacking another resident by hitting that resident through the gated fence and grabbing another resident's feeding tube. The Progress Note indicated the altercation was witnessed by (CNA/Staff #44). An interview was conducted on July 2, 2025, at 1:06 PM with a Certified Nursing Assistant (CNA/Staff #777) stated that the abuse training she received covered what to do if they witness abuse and the reporting guidelines. She also stated that abuse would be reported to the nursing staff, the Director of Nursing(DON), and the Assistant Director of Nursing(ADON). She stated that during her abuse training, she learned about physical, financial, and sexual abuse. She stated that physical abuse is when a person gets touched in a manner that they do not approve of. She stated verbal abuse is anything degrading, threatening, or humiliating to a resident.An interview was conducted on July 2, 2025, at 3:13 PM with the Director of Nursing (DON/Staff #22), who stated that the incident between resident # 35 and resident # 72 occurred on Friday evening, and that she was not aware of this incident until Saturday when Staff # 33 called her on the phone. She further stated that the incident occurred in the smoking area around the corner, through the gate, where the cats were, and that resident # 35 was going to take the cats behind the gate. The DON stated that a CNA (Staff # 44) saw the incident and reported it to a nurse. The DON stated that when she came to the facility, an LPN (staff #33) had not called the police or the State Agency. The DON further stated that she instructed the LPN to call the police. The DON stated that when she came to the |