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	02/12/2026

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** Based on interviews, clinical record review, and review of facility policy and procedures, the facility failed to protect the rights of one of three sampled residents (#38) to be free from abuse by another resident (#21). The deficient practice resulted in a resident-to-resident physical altercation with documented injuries and had the potential to result in ongoing abuse and further harm to other residents.Findings include:Regarding Resident #38:Resident #38 (alleged victim) was admitted to the facility on [DATE], with diagnoses that included disorder of mineral metabolism, pneumonitis due to inhalation of food and vomit, hypertensive urgency, fluid overload, end-stage renal disease, protein-calorie malnutrition, generalized muscle weakness, difficulty walking, asthma, anemia in chronic kidney disease, hyperlipidemia, epilepsy, heart failure, and dependence on renal dialysis.A hospital discharge, Minimum Data Set (MDS) assessment dated [DATE], revealed that the Brief Interview for Mental Status (BIMS) assessment was not recorded. The MDS indicated that Resident #38's cognitive skills for daily decision-making were severely impaired and that he rejected care one to three days during the assessment period. The MDS further noted that Resident #38 used a manual wheelchair for mobility.A care plan, initiated November 4, 2025, identified a focus on fall risk related to decreased mobility and strength. Interventions included medication review for sedatives, antihypertensives, and psychotropics.A nursing progress note entered on January 29, 2026, by Licensed Practical Nurse (LPN) Staff #25 documented that Resident #38's primary physician and nurse practitioner were notified regarding an incident involving another resident.On January 30, 2026, a BIMS assessment was conducted for Resident #38, which revealed a score of 11, indicating moderate cognitive impairment.Attempts were made to interview Resident #38 on February 12, 2026, at 11:20 a.m., 12:13 p.m., and 12:50 p.m.; he was sleeping during each attempt. At 1:52 p.m., Resident #38 declined to speak about the event.-Regarding Resident #21:Resident #21 (alleged perpetrator) was admitted to the facility on [DATE], with diagnoses that included diffuse traumatic brain injury with loss of consciousness of unspecified duration, muscle weakness, difficulty walking, anxiety disorder, insomnia, heartburn, pseudobulbar affect, major depressive disorder, hemiplegia, schizoaffective disorder, depression, seizures, and therapeutic drug level monitoring.A quarterly MDS assessment dated [DATE], revealed a BIMS score of 11, indicating moderate cognitive impairment. The MDS documented no behaviors directed toward others during the assessment period and indicated that Resident #21 used a wheelchair for mobility.A care plan, initiated October 10, 2025, identified verbal and physical aggression, intrusive behaviors, and outbursts as areas of focus. The care plan included the incident that occurred on January 29, 2026.Orders for Resident #21 dated January 8, 2026 included behavior charting every day and evening shift for behavioral monitoring.On January 30, 2026, a nursing progress note was entered into the clinical record for Resident #21 stating that he had behavior issues but was redirected to his room.During an interview conducted with Resident #21 at 11:15 a.m., Resident #21 stated that on January (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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(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	29, 2026, he was outside on the facility patio speaking with another resident when Resident #38 entered the conversation and began arguing with him. Resident #21 stated that he instigated the physical altercation and that the two began fighting. He further stated that he held Resident #38 down during the confrontation and that the fight continued until they were separated by other residents and staff.The facility's five-day investigation dated February 2, 2026, revealed documentation of a skin assessment for Resident #38 noting a knot on his left hand, a bruise and scrape on his right hand, a scrape on his right knee, and a bruise with two knots on his left leg. The investigation report indicated that the residents were separated, assessed, and monitored after the incident.An interview was conducted on February 12, 2026 at 11:54 a.m., with Licensed Practical Nurse (LPN) Staff #25, who stated that on January 29, 2026, at approximately 6:00 p.m., while the nursing shift was in the middle of shift change, she heard residents on the patio calling for help and that she and two other nurses responded. She further stated that upon arrival, the residents had stopped fighting, and several other residents, including Resident #22 who observed the incident. Staff #25 stated she escorted Resident #38 inside and assessed him and she observed swelling and multiple knots on his hands, and noted bleeding from his knuckles. A telephonic interview was conducted on February 12, 2026 at 12:30 p.m., with an LPN (Staff #41), who stated that she had just arrived to begin her shift shortly after 6:00 p.m. on January 29, 2026, when she responded to the residents' calls for help. She stated that both residents were back in their wheelchairs upon her arrival. She assisted Resident #21, who complained of pain in his finger; however, she observed no visible injury.An interview was conducted on February 12, 2026 at 12:58 p.m. with Resident #22, who stated that on January 29, 2026, she observed Resident #38 verbally confronting Resident #21. She stated that Resident #21 stood up from his wheelchair and grabbed Resident #38, and the two residents began physically fighting. Resident #22 stated that she maneuvered her wheelchair between Residents #21 and #38 in an attempt to separate them while other residents called for help. A review of Resident #22's quarterly MDS dated [DATE], revealed a BIMS score of 15, indicating she was cognitively intact. An interview was conducted with the facility Administrator and Abuse Coordinator (Staff #72) on February 12, 2026, at 1:58 p.m. The administrator stated that unwanted physical contact met the definition of physical abuse. She further stated that the incident between Residents #38 and #21 on January 29, 2026, would be considered abuse and failed to meet the facility's expectations. The Administrator also stated that risks of physical abuse would depend on the circumstances but could include physical injury and psychosocial harm. A facility policy titled, Abuse Prevention, Identification, Investigation, and Reporting Policy, implemented October 1, 2025, revealed that it was the policy of the facility to provide care to all residents in an environment free from abuse.