

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035214	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER Quiburi Mission Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 850 South Highway 80 Benson, AZ 85602	

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. (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, resident and staff interviews, and policy review, the facility failed to protect the rights of one resident (#100) to be free from abuse by another resident (#200). This deficient practice could result in further instances of resident to resident abuse. Findings include:-Resident #100 (Perpetrator) was admitted to the facility on [DATE], with diagnosis that include Alzheimer's disease, epilepsy, and depression. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 0 which indicated the resident had severe cognitive impairment. A review of a behavior care-plan Initiated November 19, 2025 revealed that resident #100 has a behavior problem related to agitation and aggression towards other residents and staff, with a goal of the resident will have fewer episodes of behaviors, and noted interventions of anticipate and meet the resident's needs, and minimize potential for the resident's disruptive behavior by offering tasks which divert resident's attention.-Resident #200 (Victim) was admitted to the facility on [DATE], with diagnoses that include weakness, acute kidney failure, Wernicke's encephalopathy, and dementia. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 0 which indicated the resident had severe cognitive impairment. A review of progress notes for resident #100 dated November 28, 2025 at 8:00 p.m. revealed resident #100 had been aggressive with another resident, and was seen having resident #200 pushed up against the door to our quiet room. It further documented that resident #200 stated that resident #100 hit resident #200 in the right rib cage. The note concludes that resident #100 was sent to the hospital to find appropriate placement for him. A review of a change of condition assessment for resident #200 dated November 28, 2025 at 10:14 p.m. revealed resident #200 was involved in a resident to resident altercation and alleges that resident #100 punched him in the ribs. It also revealed they ordered an x-ray to rule out injuries for resident #100, and to monitor for bruising and apply cold packs as needed. However, nothing was noted on the skin assessments in the resident clinical record, and no x-ray results were found. A review of provider progress notes for resident #100 dated November 29, 2025 at 8:03 a.m. revealed resident #100, since admission, had been noted to be increasingly restless with aggressive responses, and per the nursing staff incidents occur if he gets too close to another resident and they tell him to back off he will become verbally aggressive. The note also revealed the resident also once grabbed a butter knife during a prior incident. However, there are no details related to that incident present elsewhere in the clinical record. An interview was conducted with a Certified Nursing Assistant (CNA/staff #5) on December 5, 2025 at 10:54 a.m. The CNA stated that normally resident #100 is usually [NAME], but sometimes he would get agitated and they would just redirect him. The CNA stated he didn't witness the altercation between resident's #100 and #200 but he heard about it, and that it was an altercation. The CNA also stated it was the first time he knew of that resident #100 got physical with another resident. The CNA concluded that there are several types of abuse, including physical, verbal, neglect, and that abuse is doing something others wouldn't want them to do. An interview was conducted with a Registered Nurse (RN/staff #10) on December 5, 2025 at 11:02 a.m. The RN stated that she was familiar with the altercation, and that she wasn't sure if the police got involved following the incident. The RN stated that resident #100 was very restless, constantly pacing, and lacked understanding of boundaries. She further stated that resident #100 tended to irritate other residents. The RN further stated after the incident resident #100 was sent to the hospital due to needing placement. The RN stated she was the one who put the note in on resident #100 about the altercation. The RN stated that absolutely this falls under abuse, and that abuse is anything that negatively affects the physical or mental health of the resident. The RN concluded that she feels resident #100 was provoked, but it was not acceptable. An interview was conducted with the Assistant Director of Nursing (RN/staff #15) was conducted on December 5, 2025 at 11:39 a.m. The RN stated that resident #100 is young to be a resident, and has Alzheimer's. She stated that it was hard for him, because he's very physically fit but needed his brain to be busy, and before his diagnosis of Alzheimer's he was on the go constantly, and thinks he was a mechanic. The RN stated that resident #100 tended to sundown, and was high anxiety and easy to set off from things like loud voices. She noted that even things like dietary staff cleaning and scraping plates could set him off. The RN stated she was familiar with the incident, and that resident #100 was found pressing resident #200 up against a door, and that resident #200 stated he was punched in the ribs by resident #100. The RN stated they did an x-ray to rule out injuries but that during</p>		