STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035225	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/04/2024
NAME OF PROVIDER OR SUPPLIER: Sun City Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE: 9940 West Union Hills Drive Sun City, AZ 85373	

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 - Some	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** 48814 Based on clinical record review, staff interviews, and facility policy and procedures, the facility failed to ensure that two residents (#620 and # 600) was free from abuse of another. The deficient practice could result on resident being physically and psychosocially harmed by other residents. Finding includes: -Regarding Resident # 620 Resident #620 (alleged victim) was admitted to facility on October 5, 2023 with diagnosis included senile degeneration of brain, muscle weakness, depression, obstructive, and reflux uropathy. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a BIMS score of 06 indicating that the resident has severe cognitive impairment. The MDS also indicated that the resident has not exhibited psychosis or behavioral symptoms during the assessment period. Review of the care plan initiated on September 14, 2023 revealed the resident at risk for experiencing adjustment issues related to change in customary lifestyle and routines and/or difficulty accepting placement in center. Interventions included review ADL status for impact on social involvement and provide ADL assistance, as needed, to increase social involvement. Review of resident #620 progress note on December 30, 2023 at 4:10p.m. from nurse revealed that certified nursing assistant (CNA) witnessed resident #725 punch resident #620 in his face at the doorway to room [ROOM NUMBER]. Resident #725 admits to punching resident #620 and stated that he found resident #620 in his bed. He further stated that resident #620 pushed him when he attempted to pull resident #620 out of his bed. Resident #620 had a small tear on left cheek and a bruise to left hand. Resident #725 had no noted injuries or bruises, neither he lost balance or fell . Resident #620 son arrived few minutes after incident and stated that he feels his father is fine and has no concern. Review of the entity reported incident revealed that incident occurred on December 30, 2023 at 3:30p.m. It further stated that a small skin tear was noted to left cheek of the resident #620, no other injury noted. An observation of resident #620 was made on January 4, 2024 at 9:25 a.m., and there was bruise in his left cheek. (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 - Some	-Resident # 725 (alleged perpetrator) was admitted to facility on June 26, 2023 with diagnosis included cervical disc disorder, peripheral vascular diseases, unspecified dementia, psychotic disturbance, mood disturbance and anxiety. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a BIMS score of 12 indicating that the resident is moderately impaired. The MDS also indicated that the resident has not exhibited psychosis or behavioral symptoms during the assessment period. Review of resident #725 progress note on December 30, 2023 at 4:10p.m. from nurse revealed that certified nursing assistant (CNA) witnessed resident #725 punch resident #620 in his face at the doorway to room [ROOM NUMBER]. Resident #725 admits to punching resident #620 and stated that he found resident #620 in his bed. He further stated that resident #620 pushed him when he attempted to pull resident #620 out of his bed. Resident #620 had a small tear on left cheek and a bruise to left hand. Resident #725 had no noted injuries or bruises, neither he lost balance or fell . Resident #620 son arrived few minutes after incident and stated that he feels his father is fine and has no concern. Review of the entity reported incident revealed that incident occurred on December 30, 2023 at 3:30p.m. It further stated that altercation involved - resident #725 found resident #620 in his bed and a small skin tear was noted to left cheek of the resident #620, no other injury noted. An Interview was conducted with Registered Nurse (RN, staff #525) on January 3, 2024 at 3:44p.m., and he stated that resident #620 wander halls at night and he did not recall of any altercation happened between either resident. An interview was conducted with resident #725 on January 4, 2024 at 8:42 a.m., and he stated that he came to his room and found resident #620 was sleeping in his bed. I just asked resident #620 to get up and pull him with his wrist. It did not last long and resident #620 went back. An Interview was conducted with licensed practical nurse (LPN, staff #500) on January 4, 2024 at 9:13 a.m., and she stated that she heard from night nurse staff #525 that resident #620 got punched in his face by resident #725 because resident #620 was on wrong bed and mark on resident face was very visible. Resident #620 dementia is very advanced and he may not recall the incident. An Interview was conducted with social service director (staff #555) on January 4, 2024 at 9:41 a.m., and he stated that resident #620 was lying on resident #725 bed and resident #725 told resident #620 to get out of his bed and that is how altercation happened, no one got injured. An interview was conducted with resident #620 son on January 4, 2024 at 12:01 p.m., and he stated that he went to facility on December 30, 2023 at random visit and observe injury in his father left side of face and small skin tear in his left hand. He further stated that his father is safe at facility and he is not highly concern and facility is doing great job. Review of the facility policy Freedom from Abuse, Neglect and Exploitation revised 10/2022 stated that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. ----------- (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Regarding Resident # 600 Resident # 600 (alleged victim) was admitted to facility on June 30, 2023 and discharged on [DATE]. Resident diagnosis included malignant neoplasm of prostate, unspecified hearing loss, legal blindness, sepsis, acute kidney failure, unspecified dementia, and schizoaffective disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a BIMS score of 14 indicating that the resident is cognitively intact. The MDS also indicated that the resident has not exhibited psychosis or behavioral symptoms during the assessment period. Review of the care plan initiated on July 18, 2023 revealed the resident at risk for complications related to the use of psychotropic drugs and is prescribed antianxiety medication. Interventions included monitor for side effects of anti-anxiety. Review of the entity reported incident revealed that incident occurred on October 5, 2023 at 9:15 a.m. It further stated that certified nursing assistant (CNA) heard banging coming from room [ROOM NUMBER], when she went into room then resident #600 stated that resident #705 hit him with TV remote control, but CNA did not witness. -Resident # 705 (alleged perpetrator) was admitted to facility on April 4, 2023 with diagnosis included displaced intertrochanteric fracture of right femur, type 2 diabetes mellitus with diabetic neuropathy, unspecified dementia, and anxiety disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a BIMS score of 12 indicating that the resident is cognitively intact. The MDS also indicated that the resident has not exhibited psychosis or behavioral symptoms during the assessment period. Review of the care plan initiated on October 28, 2023 revealed the resident at risk for complications related to the use of psychotropic drugs and is prescribed anti-depressant and antianxiety medication. Review of resident #705 progress note on October 8, 2023 at 2:05p.m. from behavior revealed Patient refused all medications this shift. Patient observed by this RN trying to go into patient's room across the hall. This RN stopped patient and patient stated that he was going in there to tell the patient to shut up. This RN redirected patient and patient said F you to this RN. Later patient was heard telling his roommate to get out of the room. This RN tried to redirect patient once again and received same response. Review of the entity reported incident revealed that incident occurred on October 5, 2023 at 9:15 a.m. and resident #705 interviewed stated that he did not recall event. Resident became agitated and stated that he did not want to talk any further. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with Social Service Director (staff #555) on January 4, 2024 at 9:41 a.m., and he stated that during his investigation he interviewed both residents. Resident #600 mentioned that he did complained about resident #705 not using his call light. Resident #600 further stated that on day of incident he asked resident #705 not to slam and use call light because he is watching TV and then resident #705 got offended and grab resident #600 and pushed him. Resident #600 did not report that. Both residents separated and moved to different hallway. No injuries to either resident. An interview was conducted with Director of Nursing (DON, staff #560) January 4, 2024, and she stated that she was not aware of the incident and came to know today. When asked if criteria are present, should that be substantiated or unsubstantiated then she stated that it depends on if it was seen, witnessed, injury, or indication of self-inflicted or self-harm. Review of the facility policy Freedom from Abuse, Neglect and Exploitation revised 10/2022 stated that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation.