STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035245	A. Building B. Wing	03/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunview Respiratory and Rehabilitation	12207 North 113th Avenue Youngtown, AZ 85363

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 clinical record review, staff interviews, resident interviews, facility documentation, and policies and procedures, the facility failed to protect one resident's (#2) right to be free from physical abuse by another resident. The census was 110. The deficient practice could result in continued abuse, and further abuse of other residents Findings include:-Resident #2 (alleged victim) was admitted to the facility on [DATE] with diagnoses of cognitive communication deficit, need for assistance with personal care, dementia without behavioral disturbance, psychotic disturbance, mood disturbance, alcohol use, dizziness and giddiness, and anxiety.The cognition care plan initiated on September 14, 2023 revealed that the resident was at risk for impaired cognitive function/dementia. Interventions included to monitor, document, and report any changes to physician.The communication care plan initiated on September 26, 2023 revealed that the resident is at risk for communication problems due to hearing deficit. Interventions indicated to provide a safe environment and anticipate/meet needs.The Medicare Five-day MDS (Minimum Data Set) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The assessment documented that the resident required extensive two-person assist with cares due to upper and lower extremity impairment on both sides. Per the MDS, the resident utilized a walker and wheelchair as mobility devices. The diagnoses included non-Alzheimer's dementia, and depression.A psychosocial care plan which was initiated September 30, 2023, revealed that the resident has a potential for psychosocial well-being problem related to an assault. The goal was identified as resident will have no indication of psychosocial well-being problem through review date. Interventions included removal of resident to a calm and safe environment when conflict arose.A Nursing progress note dated September 30, 2023, documented a Change of Condition pertaining to an altercation with another resident. Per the note, another resident approached Resident #2's bedside and hit resident in the face. According to the note this resulted in a raised bump to the forehead and small cuts to the upper and lower lips of Resident #2. Residents were immediately separated and the alleged perpetrator was placed on 1:1 supervision to prevent further altercations. Resident #2 reported to staff that he felt safe with the interventions in place.A skin assessment on September 30, 2023 documented small lacerations to upper and lower lips, and a bump on the forehead. No other bruises or lacerations were noted.The Order Summary Report revealed a physician order dated September 30, 2023, which prescribed the following:-Changes of Condition for the lacerations to lips and forehead bump. The order indicated to check every shift for three days;-Change of Condition for psychosocial well-being. The order indicated to check every shift for three days.A Psychiatric Note dated October 2, 2023 documented a follow-up consultation due to resident's depressive symptoms. However, further review of the note did not reveal that the resident's recent resident to resident altercation was discussed.A Psychiatric Note dated October 4, 2023, documented that the resident was seen due to depressive symptoms. The note indicated that the resident was physically assaulted by another resident. Per the note, the resident reported he felt safe and denied any suicidal ideations/self-harm or homicidal ideations.A Social Services Note dated October 9, 2023, documented that resident was doing well and (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	felt safe in the facility. -Resident #4 (alleged perpetrator) was admitted on [DATE] with diagnoses of alcohol abuse, and need for assistance with personal care.A cognition care plan which was initiated July 20, 2023, indicated risk for impaired cognitive function/dementia or impaired thought process. Interventions included monitoring cognition for changes.A behavioral care plan initiated on September 30, 2023, revealed that the resident had a potential to demonstrate physical behaviors towards others related to history of harm to others, and poor impulse control. Interventions included psychiatric consultation, document behaviors and attempt interventions, and observe for side effects of medication. Interventions also directed to guide resident away from distress when agitated and engage calmly in conversationAn admission MDS assessment dated [DATE], revealed a BIMS score of 15 indicating resident was cognitively intact. The MDS documented that the resident was negative for psychosis and behavioral symptoms during the assessment period.A Nursing progress note dated September 30. 2023, stated that Resident #4 was placed on a Change of Condition for an altercation with his roommate. Staff immediately separated the two residents, and placed Resident #4 in another room with a 1:1 sitter. Per the note, a skin assessment was completed and revealed a laceration on the middle finger of the right hand. No further injuries were documented.A subsequent Nursing note also dated September 30, 2023, documented that resident was transferred to the hospital.Further review of the resident's progress notes from the date of admission did not reveal any indication of aggressive behavior prior to the incident.A review of the Order Summary Report revealed physician orders dated September 30, 2023 for the following: Change of Condition for laceration to finger and psychosocial well-being. The order indicated to check every shift for three days.The orders also indicated for resident to have 1:1 sitter at all times every shift due to physical aggression; Resident was medically cleared for discharge.A telephonic interview with a Certified Nursing Assistant (CNA/staff #20) was attempted on March 31, 2026 at 1:25 p.m. The CNA could not be reached. A telephonic interview with CNA (staff # 21) was attempted on March 31, 2026 at 1:32 p.m. The CNA could not be reached.A telephonic interview with Registered Nurse (RN/staff #22) was attempted on March 31, 2026 at 1:36 p.m. The RN could not be reached. A second attempt at a telephonic interview with staff #20 was made on March 31, 2026 at 2:16 p.m. The CNA could not be reached.A second attempt at a telephonic interview with staff #21 was made on March 31, 2026 at 2:18 p.m. The CNA could not be reached. A second attempt at a telephonic interview with staff #22 was made on March 31, 2026 at 2:20 p.m. The RN could not be reached.An interview resident #3 was conducted on March 31, 2026 at 1:54 p.m. The resident stated she felt safe in the facility, and had no concerns with staff or other residents. If some type of incident ever occurred, this resident would push the call light and report to the nurse.An interview with resident #5 was conducted on March 31, 2026 at 1:57 p.m. The resident stated that she felt safe in the facility. Additionally the resident indicated no concerns with other residents or staff, but would report it to staff if it ever occurred.An interview with resident #7 was conducted on March 31, 2026 at 1:59 p.m. Per the resident, he felt safe in the facility, had no concerns with other residents or staff, and would report any issues to staff.In an interview with the Administrator (staff #10) on March 31, 2026 at 2:40 p.m., the Administrator stated that the current practice is to hopefully avoid resident to resident altercations. If physical contact occurs, staff are to separate the residents and make sure they are safe. If abuse occurs, staff report the abuse to the required state agencies and investigates within five business days. Staff #10 was unable to verify that the Abuse policy dated October 2022 was still in effect, and recommended to speak with the Director of Nursing (DON).An interview with the DON (staff #12) was conducted on March 31, 2026 at 2:43 p.m. The DON verified that the October 2022 policy was the correct policy being used by the facility. Clinical Resource (staff #11) was also present and concurred that the policy is in effect.A follow-up interview with the Administrator (staff #10) was conducted on March 31, 2026 at 3:09 p.m. The Administrator stated that staff should report suspected abuse to him and the DON. They then investigate and write the five-day report. Per the Administrator, they provide staff with abuse trainings upon hire and annually. The Administrator said that staff have his direct number to call any (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	time day or night. According to the Administrator, his expectation is that staff ensure that residents involved in altercations are safe. They are separated and have room changes if they had been roommates. A clinical assessment is done, and then initial reports submitted to state agencies, the physician, and law enforcement. The written report must be completed in five days. They determine if the incident occurred or did not occur. They do not include a substantiated or unsubstantiated determination in their report.The DON was interviewed on March 31, 2026 at 3:16 p.m. The DON stated that abuse could be described as any kind of verbal, physical, or neglect that creates harm or intent to create harm. It can be resident to resident, staff to staff, or staff to resident. All staff are trained at hire and annually, plus in-serviced throughout the year. When an incident occurs, procedure is for staff to assess scene safety first, then report to their supervisor who reports to the Abuse Coordinator (Staff #10). Any allegation of resident to resident altercation is taken seriously and investigated. They ensure resident safety by separating the residents, removing one from the room if roommates, and sending to the emergency room if needed. Additionally, the incident is reported to the police, and all other required reporting agencies. Per the DON, assessments for any propensity to abuse are done upon admission to screen for possible triggers like PTSD (Post-traumatic Stress Disorder) or other behavior triggers. Supervision of residents with a potential for abuse to other residents depends on the individual person. Every care plan is tailored to that resident. They identify triggers and tailor the care plan to that individual. Care plans are also updated as needed.A review of the FRI (Facility-reported Incident) report dated September 30. 2023 revealed a resident to resident altercation between Residents #2 and #4. According to the report Resident #2 refused care from a CNA, who left the room to get a male CNA. When the CNAs returned, Resident #4 stated He didn't want to comply with care so I took care of it for you guys. The report documented that blood was noted on the floor and on the bed sheet of Resident #2. Resident # 4 was immediately removed from the room and placed in another room with a 1:1 sitter. Resident #4 had a small laceration to the middle finger of the right hand. Resident #2 had a small hematoma in the center of the forehead and cut to the inner lower lip. The FRI noted that reports were made to the state agencies, Sheriff's office, Ombudsman, the provider and the responsible party. The report did not indicate whether the allegation of abuse was verified or not verified. However, the report indicated that Resident #4 was sent to the hospital and will not be accepted back into the facility.The Abuse policy last reviewed in October 2022, revealed the policy of the facility is that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. Per the policy residents also have the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.