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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035257	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Peaks Health & Rehabilitation	3150 North Winding Brook Road Flagstaff, AZ 86001

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50595 Based on observation, clinical record review, resident and staff interviews, and review of facility policy, the facility failed to ensure one sampled resident (#5) was assessed for medication self-administration. The deficient practice could result in resident not taking or able to take the medication needed for treatment. Findings include: Resident #5 was admitted to the facility on [DATE], with diagnoses of chronic respiratory failure with hypoxia, acute and subacute allergic otitis media, unspecified ear, and acute post hemorrhagic anemia The admission Minimum Data Set assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 12, indicating the resident had moderate cognitive impairment. Reviewed of the care plan revealed no evidence of a focus for medication self-administration. Physician orders revealed the following active medications: - Systane Solution eye drop (ocular lubricant) applied in both eyes with an order date of March 22, 2023; and. - Fluticasone Propionate Suspension (nasal corticosteroid) applied one spray in each nostril with an order date of July 17, 2024. Review of the clinical record revealed no evidence that the resident was assessed for medication self-administration; and that, self-administration was determined to be clinically appropriate for resident #5. During an observation conducted in the resident's room on November 5, 2024 at 9:08 a.m. a bottles of Fluticasone Propionate Suspension nasal spray, and Systane complete eye drop were observed on the resident's bedside table. The resident stated that she liked to keep her nasal spray and eye drops with her so she does not have to ask the nurses in case she needed them. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on November 07, 2024, at 12:11 p.m. with a Registered Nurse (RN/Staff #33) who reviewed the clinical record and stated that Systane eye drops and fluticasone orders were active orders for resident #5. She stated that there was no evidence of an order for the resident to self-administer medication. An interview was conducted with the Director of Nursing (DON/staff #123) on November 7, 2024 at 10:24 a. m. The DON said that she had not been in the resident's room, but eye drops, and nasal spray should never be left at the bedside of a resident. The DON stated that there was absolutely no reason for any medication to be kept at the bedside unless there was an order to do so; and, when medication self-administration assessment was not conducted. The DON stated that this practice was against facility policy; and,the risk could result in someone else taking the medication. The DON further stated that there was no self-administration evaluation found in the clinical record for Resident #5. Review of the facility's policy titled, Self-administration of Medication, revealed that the facility policy is to support each resident's right to self-administer medication. A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51124 Based on observation, interviews, review of clinical record, facility documentation, and facility policy, the facility failed to ensure policies were implemented regarding investigating and timely reporting of allegations of abuse for 3 sampled residents (#13, #19, and #29). The deficient practice could lead to allegations of abuse not being investigated timely, and could lead to continued harm to residents. Findings include: -Resident #13 admitted to the facility on [DATE], with diagnoses that included rheumatoid arthritis, collapsed vertebra, depression, and myasthenia gravis. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) assessment score of 11, indicating moderate cognitive impairment. Review of the clinical record revealed no evidence of any documentation on October 29, 2024, regarding a resident-to-resident incident. A communication note dated October 31, 2024 revealed that an RN and an MDS coordinator spoke with the resident about an incident that happened on October 29, 2024. Per the documentation, Resident #13 reported that another resident (#29) grabbed her left wrist and twisted it; and that, her left wrist hurt. The communication note dated November 1, 2024 revealed that staff called and left a voicemail to the resident's power of attorney (POA) to inform about the alleged abuse. Another communication note dated November 1, 2024 revealed the nurse practitioner was informed of an alleged abuse that a resident (#29) grabbed and twisted the wrist of Resident #13 when they were in the dining area eating lunch. Despite documentation of an allegation of abuse, there was no evidence found that the allegation of abuse was reported to the State Agency (SA). The care plan revised on November 03, 2024, revealed that Resident #13 had an alteration in comfort related to left wrist pain and swelling. Interventions included to administer scheduled pain medications per physician orders and for certified nursing assistants (CNAs) to report pain concerns to nurse. On November 06, 2024 at 7:57 a.m., an interview was conducted with Resident #13 who stated that the incident happened last week; and that, a resident (#29) grabbed her left wrist intentionally. The resident stated that resident #29 was like that and was mad. Resident #13 stated she went back to her room; and, staff asked if she was ok. Resident #13 further stated that her left wrist hurt. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident #29 was admitted on [DATE] with diagnoses that included unspecified fracture of right wrist and hand, hemiplegia affecting the right side, and Alzheimer's disease. Review of the quarterly MDS assessment dated [DATE] revealed the BIMS assessment could not be completed because the resident was rarely understood. The care plan dated July 29, 2024 revealed the resident had the following episodes of physical aggression: -On July 26, 2024, the resident was yelling unintelligible words while swaying her arms to nurse and CNA and tried to grab anything. Per the documentation, resident grabbed her disposable gown and punched her in her abdomen; -On September 20, 2024, while being offered medications, resident smacked the nurse and was screaming at the nurse; and, -On October 26, 2024, resident grabbed another resident's arm trying to stop the other resident from touching her iPad. The care plan revealed interventions to intervene as necessary to protect the rights and safety of others, and to monitor, document, and report any signs and symptoms of resident posing danger to self and others. A nursing note dated September 05, 2024 written by a licensed practical nurse (LPN/Staff #111) revealed that the resident tried to hit other residents that were sitting and eating at her table. Per the documentation, resident hit another resident (#19) and tried to scratch him with her nails but the other resident (#19) was able to move. It also included that redirection was continued. Despite documentation of the incident, the clinical record and facility-provided documentation revealed no evidence that the incident report for the allegation of abuse on September 05, 2024 was reported to any manager and SA; and that, the facility had completed an investigation of the incident. A Behavior Note dated October 16, 2024, revealed that Resident #29 was aggressive towards CNA during brief change. The documentation included that the resident nodded 'Yes' when asked for permission to her change brief; but, then grabbed one of the CNAs by the throat. A Provider Note dated October 25, 2024, revealed that documentation of multiple episodes of aggressive behaviors from June through October 2024 such as hitting, attacking staff, clawing staff with her fingernails, increased agitation and combativeness, and violent at times. Continued review of the clinical record revealed no documentation of any regarding a resident-to-resident incident on October 29, 2024. However, a nursing manager investigation note dated November 1, 2024 included that an incident occurred on October 29, 2024, where Resident #29 grabbed another resident's wrist because the other resident tried to lower the volume of her tablet while they were at the dining room. Per the documentation, an intervention put into place was to not put the involved residents in the same table during meal time or together during activities. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Reportable Event Report dated November 4, 2024 revealed that on October 29, 2024 at 12:15 p.m., Resident #29 was using her tablet at the dining room table when another Resident (#13) reached over to turn the volume down on the resident's tablet. According to the documentation, the resident then grabbed and twisted the other resident's hand and twisted; and that, there were no injury occurred and both residents were immediately separated. The report further revealed that the resident had acted aggressively toward staff in the past, but not toward any other resident until this incident. A Communication note dated November 04, 2024 included that staff had told the resident's family regarding the resident grabbing and twisting another resident's (#13) wrist. -Resident #19 was admitted on [DATE] with diagnoses of Parkinson's disease and dementia. The quarterly MDS assessment dated [DATE], revealed a BIMS score of 11 indicating the resident had moderate cognitive impairment. Review of the care plan revealed no evidence of any adjustments related to an incident of alleged abuse on September 05, 2024. Review of the progress notes revealed no evidence of any notes regarding an incident of alleged abuse on September 05, 2024. However, review of the clinical record for resident #29 revealed a nursing note dated September 05, 2024 that the resident #29 tried to hit other residents that were sitting and eating at her table. Per the documentation, resident #29 hit resident #19 and tried to scratch him with her nails but the resident #19 was able to move. It also included that redirection was continued. There was no evidence that this incident was reported to any manager and SA on September 5, 2024; and that, an investigation of this was completed by the facility. A telephone interview with Resident #29's family was conducted on November 4, 2024 at 1:21 p.m. The family stated that resident #29 and another new resident was sitting in the dining area; and that, resident #29 had her electronic tablet with her and the volume was on high. The family stated that the new resident reached over and tried to grab the tablet, and resident #29 grabbed the other resident's arm to try to defend her property. She stated there was a CNA nearby who reacted and diffused the situation; and that, the other resident was complaining of a sore wrist. The family further stated that the facility told her that resident #29 and the new resident would not be placed together again. On November 6, 2024 at 2:07 p.m. an interview was conducted with the LPN (Staff #111) who stated that she heard that there was an incident between residents #29 and #13. A review of the clinical record was conducted with the LPN who said that she recalled an incident that occurred on September 05, 2024. The LPN stated she was the nurse on the unit that day, and she witnessed Resident #29 hit and attempt to scratch another resident (#19) who was extremely friendly and wanted to be involved in peoples' spaces. The LPN said that she saw Resident #29 make contact with the other resident but that there was not any sort of force behind the contact. Further, the LPN stated that a risk management report was not completed for this incident. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on November 6, 2024 at 3:10 p.m. with the Director of Nursing (DON/ Staff #123) who stated that her expectation was that staff would report any allegation of abuse immediately; and that, mandatory reporting occurs within 2 hours of the incident. The DON stated that she became aware of the incident of regarding Resident #29 twisting the arm of Resident #13 on October 31, 2024 when the receptionist brought it up to management staff. The DON stated that staff have received an in-service since then on abuse reporting. Regarding the resident-to-resident altercation between resident #29 and resident #19 on September 05, 2024, the DON stated that she was not aware of the incident; and that, no staff reported the incident to her. She stated that if she had learned of this incident, she would have separated both residents and reported the incident to the abuse coordinator. The DON further stated that moving forward, to prevent further resident-to-resident incidents, residents #29 and #13 would not sit together; and, staff would monitor for behaviors. An interview was conducted on November 6, 2024 at 3:40 p.m. with the former administrator (Staff #149) who was the administrator at the time of the incident between residents #29 and #19 on September 5, 2024. The former administrator stated that any allegation of abuse should be reported immediately, should be investigated immediately, and should be reported to mandated sources within 2 hours. Regarding the allegation of abuse on September 5, 2024, staff #149 stated that he just found out about it; and that, no staff came to him at the time of the incident to report it. He further stated that there was no investigation done/completed for this incident. An interview was conducted on November 6, 2024 at 4:09 p.m. with the unit manager (Staff #6) who stated that no staff had reported to her the incident of between resident #29 hitting and attempting to scratch resident #19 on September 5, 2024. She stated that an incident report should have been done; however, there were no risk management (incident) report was done/completed for this incident. The unit manager said that if an incident report had been done, it would trigger an alert for an investigation to be completed. Regarding the incident between residents #29 and #13, the unit manager said that the incident was not reported by any staff when the incident occurred. The Unit manager stated that a staff member heard about the incident from another resident; and, it was not reported to management and investigated until October 31, 2024. Further, the unit manager stated that any allegation of abuse should be reported immediately and the investigation should start right away; and that, the importance of timely reporting was so staff could assess for any injuries and protect the resident's safety and wellbeing. The Unit manager further stated that if an incident was not reported timely, the incident could happen again. An interview was conducted on November 7, 2024 at 8:52 a.m. with a CNA (staff #122) who was in the dining room when the incident between resident #13 and #29 occurred. The CNA stated she was in the dining room approximately 2-3 feet away from the two residents; and, she saw Resident #13 turn down the volume on the tablet of Resident #29 who then grabbed the wrist of Resident #13. She stated the contact lasted approximately 1 second and the wrist of resident #13 was not twisted. She stated after the incident, the two residents are to remain separated and supervised in the dining room. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Administrator (Staff #58) was conducted on November 7, 2024 at 11:25 a.m. The administrator stated that staff were to report allegations of abuse immediately and mandatory reporting should be done within 2 hours. He stated that the importance of timely reporting was that it allows the facility to start the investigation and to protect the residents involved. He stated that if the facility's abuse policy was not followed, it allows for continued potential abuse to occur. The Administrator stated that that he was not the Administrator at the time of the incident between residents #29 and #19 occurred on September 5, 2024. He said that he became Administrator on October 01, 2024; and, he just became aware of the incident yesterday when staff was made aware by the state survey agency. He stated that it does not meet his expectation that staff failed to report both incidents (September 5 and October 29, 2024) within the timeframes specified by the abuse policy. Review of the facility's policy titled The Behavioral Management, reviewed October 07, 2024, revealed that inappropriate behaviors that may put the resident, other residents, staff, or guests at risk for injury are identified in an attempt to redirect or modify the behavior so proper treatment can be provided to the resident. The procedures revealed to notify the nurse in charge immediately when a resident is having any inappropriate behaviors, separate affected residents, document the behavior in the resident's medical record, follow through appropriate steps to modify the behavior, and modify the care plan to reflect the current interventions. Review of the facility's policy titled Incidents and Accidents, reviewed October 14, 2024, revealed that licensed staff will utilize the on-line risk management system to report all incidents and accidents and assist with completion of any investigative information to identify root causes. Combative behavior, resident-to-resident altercations, observed accidents, and alleged abuse are listed as incidents / accidents that require a report to be completed. Any injuries will be assessed by the LPN, and the supervisor and/or designee will be notified of the incident / accident. The nurse will enter the documentation of the incident / accident within 24 hours of the occurrence. Review of the facility's policy titled Abuse, Neglect, and Exploitation, reviewed January 11, 2024, revealed each resident has the right to be free from abuse. Abuse is defined as the willful infliction of injury, with 'willful' further defined as deliberate action by an individual. The facility will make reasonable efforts to protect residents after alleged abuse. Allegations of abuse must be reported by staff to the administrator immediately, and allegations involving abuse must be reported to the state survey agency within 2 hours. An investigation should be initiated immediately. Further, the actions taken should be documented in the resident's medical record.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51124 Based on observation, interviews, review of clinical record, facility documentation, and facility policy, the facility failed to ensure alleged violations of abuse were reported to proper authorities within prescribed timeframes for 3 residents (#13, #19, and #29). The deficient practice could lead to allegations of abuse not being investigated timely, and could lead to continued harm to residents. Findings include: -Resident #13 admitted to the facility on [DATE], with diagnoses that included rheumatoid arthritis, collapsed vertebra, depression, and myasthenia gravis. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) assessment score of 11, indicating moderate cognitive impairment. Review of the clinical record revealed no evidence of any documentation on October 29, 2024, regarding a resident-to-resident incident. A communication note dated October 31, 2024 revealed that an RN and an MDS coordinator spoke with the resident about an incident that happened on October 29, 2024. Per the documentation, Resident #13 reported that another resident (#29) grabbed her left wrist and twisted it; and that, her left wrist hurt. The communication note dated November 1, 2024 revealed that staff called and left a voicemail to the resident's power of attorney (POA) to inform about the alleged abuse. Another communication note dated November 1, 2024 revealed the nurse practitioner was informed of an alleged abuse that a resident (#29) grabbed and twisted the wrist of Resident #13 when they were in the dining area eating lunch. Despite documentation of an allegation of abuse, there was no evidence found that the allegation of abuse was reported to the State Agency (SA). On November 06, 2024 at 7:57 a.m., an interview was conducted with Resident #13 who stated that the incident happened last week; and that, a resident (#29) grabbed her left wrist intentionally. The resident stated that resident #29 was like that and was mad. Resident #13 stated she went back to her room; and, staff asked if she was ok. Resident #13 further stated that her left wrist hurt. -Resident #29 was admitted on [DATE] with diagnoses that included unspecified fracture of right wrist and hand, hemiplegia affecting the right side, and Alzheimer's disease. Review of the quarterly MDS assessment dated [DATE] revealed the BIMS assessment could not be completed because the resident was rarely understood. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing note dated September 05, 2024 written by a licensed practical nurse (LPN/Staff #111) revealed that the resident tried to hit other residents that were sitting and eating at her table. Per the documentation, resident hit another resident (#19) and tried to scratch him with her nails but the other resident (#19) was able to move. Despite documentation of the incident, the clinical record and facility-provided documentation revealed no evidence that the incident report for the allegation of abuse on September 05, 2024 was reported to any manager and SA. A Provider Note dated October 25, 2024, revealed that documentation of multiple episodes of aggressive behaviors from June through October 2024 such as hitting, attacking staff, clawing staff with her fingernails, increased agitation and combativeness, and violent at times. Continued review of the clinical record revealed no documentation of any regarding a resident-to-resident incident on October 29, 2024. However, a nursing manager investigation note dated November 1, 2024 included that an incident occurred on October 29, 2024, where Resident #29 grabbed another resident's wrist because the other resident tried to lower the volume of her tablet while they were at the dining room. A Reportable Event Report dated November 4, 2024 revealed that on October 29, 2024 at 12:15 p.m., Resident #29 was using her tablet at the dining room table when another Resident (#13) reached over to turn the volume down on the resident's tablet. According to the documentation, the resident then grabbed and twisted the other resident's hand and twisted; and that, there were no injury occurred and both residents were immediately separated. The report further revealed that the resident had acted aggressively toward staff in the past, but not toward any other resident until this incident. A Communication note dated November 04, 2024 included that staff had told the resident's family regarding the resident grabbing and twisting another resident's (#13) wrist. -Resident #19 was admitted on [DATE] with diagnoses of Parkinson's disease and dementia. The quarterly MDS assessment dated [DATE], revealed a BIMS score of 11 indicating the resident had moderate cognitive impairment. Review of the care plan revealed no evidence of any adjustments related to an incident of alleged abuse on September 05, 2024. Review of the progress notes revealed no evidence of any notes regarding an incident of alleged abuse on September 05, 2024. However, review of the clinical record for resident #29 revealed a nursing note dated September 05, 2024 that the resident #29 tried to hit other residents that were sitting and eating at her table. Per the documentation, resident #29 hit resident #19 and tried to scratch him with her nails but the resident #19 was able to move. There was no evidence that this incident was reported to any manager and SA on September 5, 2024. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On November 6, 2024 at 2:07 p.m. an interview was conducted with the LPN (Staff #111) who stated that she heard that there was an incident between residents #29 and #13. A review of the clinical record was conducted with the LPN who said that she recalled an incident that occurred on September 05, 2024. The LPN stated she was the nurse on the unit that day, and she witnessed Resident #29 hit and attempt to scratch another resident (#19) who was extremely friendly and wanted to be involved in peoples' spaces. The LPN said that she saw Resident #29 make contact with the other resident but that there was not any sort of force behind the contact. Further, the LPN stated that a risk management report was not completed for this incident. An interview was conducted on November 6, 2024 at 3:10 p.m. with the Director of Nursing (DON/ Staff #123) who stated that her expectation was that staff would report any allegation of abuse immediately; and that, mandatory reporting occurs within 2 hours of the incident. The DON stated that she became aware of the incident of regarding Resident #29 twisting the arm of Resident #13 on October 31, 2024 when the receptionist brought it up to management staff. The DON stated that staff have received an in-service since then on abuse reporting. Regarding the resident-to-resident altercation between resident #29 and resident #19 on September 05, 2024, the DON stated that she was not aware of the incident; and that, no staff reported the incident to her. She stated that if she had learned of this incident, she would have separated both residents and reported the incident to the abuse coordinator. The DON further stated that moving forward, to prevent further resident-to-resident incidents, residents An interview was conducted on November 6, 2024 at 3:40 p.m. with the former administrator (Staff #149) who was the administrator at the time of the incident between residents #29 and #19 on September 5, 2024. The former administrator stated that any allegation of abuse should be reported immediately, should be investigated immediately, and should be reported to mandated sources within 2 hours. Regarding the allegation of abuse on September 5, 2024, staff #149 stated that he just found out about it; and that, no staff came to him at the time of the incident to report it. He further stated that there was no investigation done/completed for this incident. An interview was conducted on November 6, 2024 at 4:09 p.m. with the unit manager (Staff #6) who stated that no staff had reported to her the incident of between resident #29 hitting and attempting to scratch resident #19 on September 5, 2024. She stated that an incident report should have been done; however, there were no risk management (incident) report was done/completed for this incident. The unit manager said that if an incident report had been done, it would trigger an alert for an investigation to be completed. Regarding the incident between residents #29 and #13, the unit manager said that the incident was not reported by any staff when the incident occurred. The unit manager stated that a staff member heard about the incident from another resident; and, it was not reported to management and investigated until October 31, 2024. Further, the unit manager stated that any allegation of abuse should be reported immediately and the investigation should start right away; and that, the importance of timely reporting was so staff could assess for any injuries and protect the resident's safety and wellbeing. The unit manager further stated that if an incident was not reported timely, the incident could happen again. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Administrator (Staff #58) was conducted on November 7, 2024 at 11:25 a.m. The administrator stated that staff were to report allegations of abuse immediately and mandatory reporting should be done within 2 hours. He stated that the importance of timely reporting was that it allows the facility to start the investigation and to protect the residents involved. He stated that if the facility's abuse policy was not followed, it allows for continued potential abuse to occur. The Administrator stated that that he was not the Administrator at the time of the incident between residents #29 and #19 occurred on September 5, 2024. He said that he became Administrator on October 01, 2024; and, he just became aware of the incident yesterday when staff was made aware by the state survey agency. He stated that it does not meet his expectation that staff failed to report both incidents (September 5 and October 29, 2024) within the timeframes specified by the abuse policy. Review of the facility's policy titled Abuse, Neglect, and Exploitation, reviewed January 11, 2024, revealed each resident has the right to be free from abuse. Abuse is defined as the willful infliction of injury, with 'willful' further defined as deliberate action by an individual. The facility will make reasonable efforts to protect residents after alleged abuse. Allegations of abuse must be reported by staff to the administrator immediately, and allegations involving abuse must be reported to the state survey agency within 2 hours. An investigation should be initiated immediately. Further, the actions taken should be documented in the resident's medical record.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51124 Based on clinical record review, resident and staff interviews, facility documentation and policy review, the facility failed to ensure an allegation of abuse was thoroughly investigated, and to prevent further abuse from occurring during the investigation for two residents (#19 and #29). The deficient practice could lead to allegations of abuse not being investigated thoroughly, and residents not being protected from further abuse and retaliation. Findings include: -Resident #13 admitted to the facility on [DATE], with diagnoses that included rheumatoid arthritis, collapsed vertebra, depression, and myasthenia gravis. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) assessment score of 11, indicating moderate cognitive impairment. Review of the clinical record revealed no evidence of any documentation on October 29, 2024, regarding a resident-to-resident incident. A communication note dated October 31, 2024 revealed that an RN and an MDS coordinator spoke with the resident about an incident that happened on October 29, 2024. Per the documentation, Resident #13 reported that another resident (#29) grabbed her left wrist and twisted it; and that, her left wrist hurt. The communication note dated November 1, 2024 revealed that staff called and left a voicemail to the resident's power of attorney (POA) to inform about the alleged abuse. Another communication note dated November 1, 2024 revealed the nurse practitioner was informed of an alleged abuse that a resident (#29) grabbed and twisted the wrist of Resident #13 when they were in the dining area eating lunch. Despite documentation of an allegation of abuse, there was no evidence found that the facility conducted an investigation of this incident. On November 06, 2024 at 7:57 a.m., an interview was conducted with Resident #13 who stated that the incident happened last week; and that, a resident (#29) grabbed her left wrist intentionally. The resident stated that resident #29 was like that and was mad. Resident #13 stated she went back to her room; and, staff asked if she was ok. Resident #13 further stated that her left wrist hurt. -Resident #29 was admitted on [DATE] with diagnoses that included unspecified fracture of right wrist and hand, hemiplegia affecting the right side, and Alzheimer's disease. Review of the quarterly MDS assessment dated [DATE] revealed the BIMS assessment could not be completed because the resident was rarely understood. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing note dated September 05, 2024 written by a licensed practical nurse (LPN/Staff #111) revealed that the resident tried to hit other residents that were sitting and eating at her table. Per the documentation, resident hit another resident (#19) and tried to scratch him with her nails but the other resident (#19) was able to move. Despite documentation of the incident, the clinical record and facility-provided documentation revealed no evidence that the incident was thoroughly investigated by the facility. A Provider Note dated October 25, 2024, revealed that documentation of multiple episodes of aggressive behaviors from June through October 2024 such as hitting, attacking staff, clawing staff with her fingernails, increased agitation and combativeness, and violent at times. Continued review of the clinical record revealed no documentation of any regarding a resident-to-resident incident on October 29, 2024. However, a nursing manager investigation note dated November 1, 2024 included that an incident occurred on October 29, 2024, where Resident #29 grabbed another resident's wrist because the other resident tried to lower the volume of her tablet while they were at the dining room. A Reportable Event Report dated November 4, 2024 revealed that on October 29, 2024 at 12:15 p.m., Resident #29 was using her tablet at the dining room table when another Resident (#13) reached over to turn the volume down on the resident's tablet. According to the documentation, the resident then grabbed and twisted the other resident's hand and twisted; and that, the resident had acted aggressively toward staff in the past, but not toward any other resident until this incident. A Communication note dated November 04, 2024 included that staff had told the resident's family regarding the resident grabbing and twisting another resident's (#13) wrist. -Resident #19 was admitted on [DATE] with diagnoses of Parkinson's disease and dementia. The quarterly MDS assessment dated [DATE], revealed a BIMS score of 11 indicating the resident had moderate cognitive impairment. Review of the care plan revealed no evidence of any adjustments related to an incident of alleged abuse on September 05, 2024. Review of the progress notes revealed no evidence of any notes regarding an incident of alleged abuse on September 05, 2024. However, review of the clinical record for resident #29 revealed a nursing note dated September 05, 2024 that the resident #29 tried to hit other residents that were sitting and eating at her table. Per the documentation, resident #29 hit resident #19 and tried to scratch him with her nails but the resident #19 was able to move. It also included that redirection was continued. There was no evidence that the facility investigated this incident on September 5, 2024. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On November 6, 2024 at 2:07 p.m. an interview was conducted with the LPN (Staff #111) who stated that she heard that there was an incident between residents #29 and #13. A review of the clinical record was conducted with the LPN who said that she recalled an incident that occurred on September 05, 2024. The LPN stated she was the nurse on the unit that day, and she witnessed Resident #29 hit and attempt to scratch another resident (#19) who was extremely friendly and wanted to be involved in peoples' spaces. The LPN said that she saw Resident #29 make contact with the other resident but that there was not any sort of force behind the contact. Further, the LPN stated that a risk management report was not completed for this incident. An interview was conducted on November 6, 2024 at 3:10 p.m. with the Director of Nursing (DON/ Staff #123) who stated that her expectation was that staff would report any allegation of abuse immediately; and that, mandatory reporting occurs within 2 hours of the incident. The DON stated that she became aware of the incident of regarding Resident #29 twisting the arm of Resident #13 on October 31, 2024 when the receptionist brought it up to management staff. The DON stated that staff have received an in-service since then on abuse reporting. Regarding the resident-to-resident altercation between resident #29 and resident #19 on September 05, 2024, the DON stated that she was not aware of the incident; and that, no staff reported the incident to her. She stated that if she had learned of this incident, she would have separated both residents and reported the incident to the abuse coordinator. The DON further stated that moving forward, to prevent further resident-to-resident incidents, residents An interview was conducted on November 6, 2024 at 3:40 p.m. with the former administrator (Staff #149) who was the administrator at the time of the incident between residents #29 and #19 on September 5, 2024. The former administrator stated that any allegation of abuse should be reported immediately, should be investigated immediately, and should be reported to mandated sources within 2 hours. Regarding the allegation of abuse on September 5, 2024, staff #149 stated that he just found out about it; and that, no staff came to him at the time of the incident to report it. He further stated that there was no investigation done/completed for this incident. An interview was conducted on November 6, 2024 at 4:09 p.m. with the unit manager (Staff #6) who stated that no staff had reported to her the incident of between resident #29 hitting and attempting to scratch resident #19 on September 5, 2024. She stated that an incident report should have been done; however, there were no risk management (incident) report was done/completed for this incident. The unit manager said that if an incident report had been done, it would trigger an alert for an investigation to be completed. Regarding the incident between residents #29 and #13, the unit manager said that the incident was not reported by any staff when the incident occurred. The unit manager stated that a staff member heard about the incident from another resident; and, it was not reported to management and investigated until October 31, 2024. Further, the unit manager stated that any allegation of abuse should be reported immediately and the investigation should start right away; and that, the importance of timely reporting was so staff could assess for any injuries and protect the resident's safety and wellbeing. The unit manager further stated that if an incident was not reported timely, the incident could happen again. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Administrator (Staff #58) was conducted on November 7, 2024 at 11:25 a.m. The administrator stated that staff were to report allegations of abuse immediately and mandatory reporting should be done within 2 hours. He stated that the importance of timely reporting was that it allows the facility to start the investigation and to protect the residents involved. He stated that if the facility's abuse policy was not followed, it allows for continued potential abuse to occur. The Administrator stated that that he was not the Administrator at the time of the incident between residents #29 and #19 occurred on September 5, 2024. He said that he became Administrator on October 01, 2024; and, he just became aware of the incident yesterday when staff was made aware by the state survey agency. He stated that it does not meet his expectation that staff failed to report both incidents (September 5 and October 29, 2024) within the timeframes specified by the abuse policy. Review of the facility's policy titled Abuse, Neglect, and Exploitation, reviewed January 11, 2024, revealed each resident has the right to be free from abuse. Abuse is defined as the willful infliction of injury, with 'willful' further defined as deliberate action by an individual. The facility will make reasonable efforts to protect residents after alleged abuse. Allegations of abuse must be reported by staff to the administrator immediately, and allegations involving abuse must be reported to the state survey agency within 2 hours. An investigation should be initiated immediately. Further, the actions taken should be documented in the resident's medical record.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48814 Based on observation, clinical record review, staff interview, and policies and procedures, the facility failed to ensure a comprehensive person-centered care plan with interventions was developed and implemented related to dialysis care and assessment for one resident (#22); and, oxygen use for one resident (#29). The deficient practice could result in staff not being aware of changes in interventions and asessments. Findings include: Resident #22 was readmitted to facility September 9, 2024 with diagnoses of urinary tract infection, type 2 diabetes mellitus, end stage renal disease (ESRD) and kidney disease. A review of physician orders dated September 9, 2024 revealed the following: - Dialysis appointment: Patient on hemodialysis (Tuesday, Thursday, Saturday) at (US Renal) Dialysis Center. Please complete pre-dialysis form and fax to dialysis center then place the form in MD box. - POST DIALYSIS: Assess dialysis site Q 30 mins x 4 hours post dialysis treatment. Assess for bruit/thrill and for sign/symptom bleeding, infections, or any issues. Document in nurses note if any issues are present and Notify MD. The care plan dated September 10, 2024 revealed that the resident had a potential for alteration in skin integrity related to ESRD on Dialysis. The care plan revealed no evidence of interventions related to pre and post dialysis care as ordered. Review of the Treatment Administration Records (TAR) from September through November, 2024, revealed that the resident was receiving dialysis every Tuesday, Thursday and Saturday as ordered, and upon return, vital signs and the assess site were monitor per order. The Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 10 which indicated the resident had moderate cognitive impairment. Active diagnoses included ESRD, dependence on renal dialysis and that the resident was receiving dialysis on admission and while a resident. Review of the clinical record September through November 2024 revealed no evidence of post dialysis access site monitoring. An interview was conducted on November 6, 2024 at 7:31 a.m. with the resident who stated that he goes to dialysis three times a week and that staff checks his vitals when he returns from dialysis. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Quality Infection Control (QIC/ staff #6) on November 6, 2024 at 3:08 p. m. The QIC stated that the care plan must be triggered within 24 hr. by the admission nurse and reviewed by a unit manager and MDS coordinator. The QIC reviewed the clinical record and stated that there was no evidence in the care plan related to dialysis or interventions for dialysis that included vital signs and assessment of assess site; and, there should be. An interview was conducted with the Director of Nursing (DON/ staff #123) on November 7, 2024 at 8:51 p. m. The DON said that the care plan was specific to each individual resident. A review of the clinical record was conducted with the DON who stated that there was no evidence in the care plan that related specifically to dialysis interventions of post dialysis vital sign monitoring and assessment of the dialysis assess site. She said that the facility did not follow our policy; and, risk of not having the care plan could result in staff not having full information regarding residents. The DON further stated that the care plan for resident #22 was corrected yesterday. Review of the facility policy titled, Dialysis Communication and Site Monitoring, reviewed on October 14, 2023, revealed that when a resident is admitted and requires dialysis as a part of their care, dialysis care plan interventions will be implemented to list the specific cares needed. 51124 -Resident #29 admitted on [DATE], with diagnoses of fracture of right wrist and hand, hemiplegia affecting the right side, and Alzheimer's disease. A physician order dated June 14, 2024 included for oxygen therapy, titrated between 1-5 L (liters) via nasal cannula to maintain oxygen saturation at or above 90%; and, may wean to room air as appropriate. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had received oxygen therapy. A nurse practitioner (NP) note dated October 28, 2024 revealed the resident remained on 2 liters of oxygen via nasal cannula. Despite documentation that the resident was on oxygen, there was no evidence found that care plan with interventions for the use of oxygen was developed and implemented. An observation was conducted on November 5, 2024 at 10:34 a.m. Resident #29 was self-propelling in her wheelchair to the doorway of her room with a portable oxygen tank hanging on the back of her wheelchair. The oxygen cannula tubing was not on the resident's face, but was wrapped around the left armrest of her wheelchair. Another observation was conducted on November 6, 2024 at 12:22 a.m. and revealed Resident #29 lying in bed, wearing an oxygen nasal cannula connected to an oxygen concentrator at bedside. A telephone interview was conducted on November 4, 2024 at 1:21 p.m. with the resident's family who stated that three separate occasions, she had noticed resident #29 wearing the oxygen cannula tubing, but the portable oxygen tank was not on. She stated that she requested staff to address this, and on each time, staff took the tank, and would refill it. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on November 5, 2024 with a certified nursing assistant (CNA /Staff #122) who stated that Resident #29 was always on oxygen. On November 7, 2024 at 10:52 a.m., an interview was conducted with an MDS coordinator (staff #61) who stated that she assists in editing and adjusting resident's care plans and uses the care area triggers from the MDS assessment as a guide to know what the resident needs on their care plan. She stated if a resident was on oxygen, the staff will usually add this to the resident's care plan. In an interview with the unit manager (staff #6) conducted on November 7, 2024 at 10:58 a.m., the unit manager stated that care items that need to be addressed on a resident's care plan would be a resident's code status, narcotic use, anticoagulant use, fall risk interventions, and oxygen therapy. A review of the clinical record was conducted with the unit manager who stated that she could not find the care plan for oxygen use for resident #29; and that, it should have been in the resident's care plan. The unit manager stated that a potential outcome of not having necessary care items on a care plan may affect the continuity of care between staff members. An interview was conducted on November 7, 2024 at 11:06 a.m. with the Director of Nursing (DON / Staff #123) who stated that oxygen use should be on a resident's care plan. A review of the clinical record was conducted with the DON stated that resident #29 had a care plan for oxygen use added on November 7, 2024. The DON stated that the resident did not have a care plan for oxygen use prior to November 7, 2024. Further, the DON stated that a resident having a physician order for oxygen but no care plan for oxygen use, did not meet her expectation. The DON stated that the importance of having patient-centered care plans was that it lets the caregivers know how to care for the residents appropriately. Review of the facility's policy on Care Plan Revisions Upon Status Change, reviewed October 14, 2024, revealed that the care plan will be modified with the new or modified intervention, that care plans will be modified as needed by the MDS Coordinator or other designated staff member, and the Unit Manager or other designated staff member will communicate care plan interventions to all staff involved in a resident's care.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48814 Based on clinical record review, staff interviews, and policy and procedures, the facility failed to ensure that a care plan was revised after each fall for two sampled residents (#18 and #22). The deficient practice could result in resident not getting the appropriate care they need. Findings include: -Resident #22 was readmitted to facility September 9, 2024 with diagnoses of urinary tract infection, type 2 diabetes mellitus, end stage renal disease (ESRD) and kidney disease. An admission evaluation dated September 9, 2024 revealed that the resident was a fall risk related to poor vision. Interventions included the following: -4P's rounding (pain concerns, positioning needs, personal items are within reach and personal needs are being met) -Mat next to bed -Hi/low bed A care plan initiated on September 10, 2024 revealed the resident had the potential for falls related to ESRD, T2 DM and PVD. Interventions included 4P's rounding (pain concerns, positioning needs, personal items are within reach and personal needs are being met); to anticipate needs as able; call light within reach when in room; to educate and/or provide cues, prompts, and reminders regarding safety precautions as needed; Fall Risk Assessment on Admission and Quarterly; to observe for sign and symptom of drug related side effects and report to physician; to orient resident to new surrounding as applicable; and, therapy screen/evaluation as ordered or as needed. Further review of the actual care plan revealed that the resident had fall incidents on October 9 and November 4, 2024; and that, the resident with pain on right side of the body. However, the care plan revealed no evidence that interventions were revised. A post fall progress note dated October 14, 2024 revealed that current preventive measures were in place: 4P rounding, Hi/low bed, PT/OT/ST Keep wheelchair close to bed; and that, there were no new interventions required at this time. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 10 which indicated resident had moderate cognitive impairment. The assessment also included impaired vision, need partial/moderate assistance with chair/bed to chair transfer A post fall progress note dated November 5, 2024 revealed that current preventive measures were in place: Call light education, 4P's, high/low bed, mat next to bed, frequent checks. No new interventions required at this time. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the resident on November 4, 2024, at 12:44 p.m., who stated that he fell this morning and his back to the head was hurting. He stated that two staffs were present when he fell and no pain medication was given so far. An interview was conducted with the resident on November 6, 2024, at 7:31 a.m. who stated that he was getting up on November 4 and that a provider and a male staff were present in the room. He said that the provider was assisting his roommate when while he was dressing up he fell and hit on wall between the bed and table. The resident said that few minutes later, the male staff came and pulled his shirt out and stated that there was no bruise and put me back on bed. The resident also said that his lower back started hurting and they rushed him to the hospital; and that, he was given a shot at the hospital and he came back at the facility on the same day around noon. He further stated that he was not on any medication for fall. An interview with a certified nurse assistance (CNA/staff # 137) was conducted on November 6, 2024, at 7:31 a.m. The CNA stated that resident #22 was a stand by assist and does not need any help getting up; but, staff want to ensure the resident was safely getting up without any obstruction in his path and also no loose cloth to prevent tripping. The CNA said that staff usually assist resident #22 in the morning to get him up in wheelchair; and that, the resident was mostly independent rest of the evening. Regarding resident #22, the CNA said that the resident was not a fall risk, did not have injury due to a fall, does not have any pain and does not refuse any fall intervention. The CNA stated that if the resident refuses intervention then the CNA was not sure what to do and whom to ask. The CNA said that resident #22 had fall on November 4 and the CNA was not sure who was present with the resident in the room at the time of the incident. The CNA said that the facility then took measures such as frequent monitoring every 4 hr. In an interview conducted with Registered Nurse (RN/staff 8) on November 6, 2024 at 12:32 p.m., the RN stated that staff would always tell resident #22 to wait for a CNA; but, the resident always wanted to do things by himself. The RN said that on November 4, 2024, the resident tried to stand up and hit his right side of trunk of body; however, there was no bruise, cut or open wound were found. The RN stated that interventions put in place after a fall included for CNAs to be on high alert, answering call lights and lowering the resident's bed. The RN further stated that he thinks the interventions were working; and that, the resident does not have any pain. An interview was conducted with Quality Infection Control (QIC/ staff #6) on November 6, 2024 at 03:08 p.m. The QIC stated that the care plan must be triggered within 24 hr. by the admission nurse and reviewed by a unit manager and MDS coordinator. Regarding resident #22, the QIC said that the resident had two falls since admission and the resident did not report the incidents immediately. The QIC said that during admission, the resident was assessed for fall risk due to poor vision; and, interventions put in place included high or low bed and mat next to bed. The QIC also said that after the resident's fall on October 14, interventions included call light educations, high or low bed and activities/exercises. The QIC also said that the resident had a second fall on November 4 and had a head strike. She said that 911 was called, vital signs were monitored and resident was given some pain pills, family/provider were notified, and lab result was negative. The QIC further stated that there were no new interventions required at this time which means intervention in place were basically the same. She further stated that the facility/staff had used and exhausted all its resources and was using the same intervention. The QIC further stated that if a care plan was not updated then will not able to provide continuity of care. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON/ staff #123) conducted on November 7, 2024 at 8:51 p. m., the DON stated that the care plan was specific to each individual resident. A review of the clinical record was conducted with the DON who stated that there was no intervention was changed or added in the resident's care plan after the fall on October 14 and November 4, 2024. She said that the facility did not follow our policy; and, risk of not having the care plan could result in staff not having full information regarding residents. The DON further stated that the care plan for resident #22 was corrected yesterday. Review of the facility's policy titled Care Plan Revisions Upon Status Change, reviewed October 14, 2024, revealed that the care plan will be modified with the new or modified intervention, that care plans will be modified as needed by the MDS Coordinator or other designated staff member, and the Unit Manager or other designated staff member will communicate care plan interventions to all staff involved in a resident's care. 51239 -Resident #18 was admitted on [DATE] with diagnoses of sacral fracture, Type 2 Diabetes Mellitus, history of fall, transient ischemic attack (TIA), and cerebral infarction. The progress note dated June 16, 2024 revealed the resident was found on the floor with an increased pain; and that, 911 was called for further evaluation and transfer to the hospital. Review of a care plan initiated on June 19, 2024 included the resident had potential for falls. The goal was that the resident will be free from fall related injury through the next review. Interventions included educate/ reminders regarding safety precautions, fall risk assessment admission and quarterly, therapy screen/evaluation as ordered. On June 23, 2024, the resident was found on the floor next to his bed which was in the lowest position. Immediate actions included pain and skin assessments. The report also revealed that there was a skin abrasion on left elbow and the resident was reeducated on call light use. The Care Plan initiated on June 25, 2024 revealed that the resident had an actual fall on June 16, 2024 with major injury that resulted in nondisplaced anterior S2 fracture. Interventions included to continue interventions on the at-risk plan. However, there was no evidence that the care plans were evaluated for the effectiveness of its interventions; and, there was no evidence that it was revised with each fall to include new interventions to prevent recurrent falls. The documentation on June 30, 2024 included that the resident was found on the floor, and trying to reach his milk. The clinical record revealed that the resident was non-compliant with fall prevention, confused at times, ordered fall mattress, process e-examined and corrected. The progress note dated July 1, 2024 included that the current preventive measures in place were call light education, 4Ps, Hi/lo bed, Therapy evaluation, frequent checks and scoop mattress. Per the documentation, there were no new interventions required at this time. A progress note dated July 12, 2024 revealed the resident was found on the floor and did not have skid socks on. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Peaks Health & Rehabilitation	3150 North Winding Brook Road Flagstaff, AZ 86001

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On August 21, 2024, the resident was found on the floor; and, the resident reported that he was trying to get out of bed to go to the bathroom. Per the documentation, there were no injury reported. The documentation on September 4, 2024 revealed that the resident was found on the floor beside his bed; and that, the resident reported that he was trying to get off of his blanket. It also included that the resident did not have any injury. A progress note dated September 6, 2024 included that the resident was found on the floor beside his bed; and that, the resident wanted to crawl down from bed because wanted sleep on floor. Per the documentation, there were no injuries noted. The clinical record documentation dated September 9, 2024 revealed the resident had two falls with no injury. On September 11, 2024, the resident was found lying on the floor on stomach on fall mat and had no injury. The quarterly Admission Minimum Data Set (MDS) assessments dated September 24, 2024 revealed a Brief Interview for Mental Status (BIMS) score of 14 which indicated the resident had mild cognitive impairment. The MDS also included that the resident displays behaviors of rejection evaluation of care for 1 to 3 days, and the resident had two or more falls since admission or prior to assessment. Despite documentation that the resident had multiple falls, there was no evidence found that fall care plan interventions were revised to include new interventions and revised with each fall to include new interventions to prevent recurrent falls after June 25, 2024. There was no evidence that the care plans were evaluated for the effectiveness of its interventions. An interview was conducted on November 6, 2023 at 11:10 a.m. with a Licensed Practical Nurse (LPN/Staff #111) who stated that the intervention for the June, 16, 2024 fall sending the resident to the hospital; and, it should have been documented in the care plan. She also stated that new interventions should been placed in to the care plan after the falls on June 30, July 12, September 4, and September 9, 2024. The LPN stated that the risks for not having no new interventions would be that the resident will be in higher risk for recurrent falls and cause injuries. An interview was conducted on November 6, 2024 at 12:24 p.m. with the Director of Nursing (DON/Staff #123) who stated that the facility process for care planning was to complete initial and baseline care plan upon admission, and add interventions as necessary. In another interview with the DON conducted on November 6, 2024 at 12:42 p.m., the DON stated that she oversees the residents' care plan; however, she was not able read the care plan for resident #22. She also stated that floor nurse was expected to put interventions on to the care plan and update the care plan as necessary. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy titled, Care plan revision upon change, reviewed on October 14, 2024, revealed that the purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change. The comprehensive care plan will be reviewed, and revised as necessary.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50887 Based on observations, staff interviews, and review of facility policy, the facility failed to ensure that care and services met professional standards of practice regarding medication administration for one of six sampled residents (#3). The deficient practice could result in residents not receiving the appropriate medication and for additional errors in medication administration. Findings include: Resident #3 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes without complications, essential hypertension, hyperlipidemia, and Alzheimer's disease. Review of physician order summary revealed the following active orders: -Ascorbic Acid (supplement) tablet 500 milligrams (mg) give two tablets by mouth one time a day for supplement; -Bupropion hydrochloride (antidepressant) ER (extended release) give 150 mg orally in the morning for mood disorder; -Levothyroxine (thyroid hormone) 50 mcg (microgram), take one tablet by mouth once daily in the morning and to take one hour before a meal on an empty stomach for hypothyroid; -Atorvastatin Calcium (anticholesterol) oral tablet 40 mg give one tablet orally in the morning for hyperlipidemia; -Oxybutynin chloride ER (anticholinergic) tablet 10 mg, give one tablet by mouth in the morning for overactive bladder (OAB); and, -Metoprolol Succinate ER (beta blockers) oral tablet 25 mg, give 0.5 tablet by mouth one time a day for congestive heart failure (CHF). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a medication administration observation conducted with a Registered Nurse (RN/staff #8) on November 6, 2024 at 7:23 a.m., the RN dispensed one ascorbic acid 500 mg tablet into a medication cup; however, the physician's order indicated two tablets. While dispensing the medication the RN was interrupted by a NP to look up another resident's orders and put in orders in for that resident. After dispensing all medications, the RN did not dispense the atorvastatin calcium 40 mg tablet into the medication cup. While preparing to place medication into the medication cup the RN was interrupted by a CNA who provided vital sign information about a different resident. The RN then placed the medication card back into the medication cart without dispensing the the atorvastatin medication. The RN stated that he was ready to administer the medications to resident #3; and that, the RN counted the medications that were dispensed into the medication cup and stated that he had only one ascorbic acid tablet in the medication cup. The RN then reviewed the physician's order for ascorbic acid and stated that there should have been two tablets dispensed. He then dispensed another ascorbic acid tablet into the medication cup. The RN then stated he had prepared all the medications for the resident. He pulled the atorvastatin medication card from the medication cart and verified that atorvastatin tablet was not in the medication cup. The RN then dispensed the tablet into the medication cup. During the same observation, the RN administered one levothyroxine sodium 50 micrograms (mcg) to the resident #3 after the resident had eaten breakfast. The RN did not ask resident #3 whether or not the resident had eaten breakfast. Resident #3 stated that she ate some oatmeal and milk prior to the medication administration observation. However, the physician orders was for levothyroxine to be administered one hour before a meal on an empty stomach. During the same observation, the RN crushed and administered one Bupropion (ER) 150 mg tablet, one Metoprolol Succinate ER tablet, and one Oxybutynin Chloride ER tablet to the resident and mixed it in the chocolate pudding. However, review of the drug specification documentation provided by the facility revealed the following: -Bupropion hydrochloride ER tablets were not to be chewed, cut, or crushed; and, the tablets must be swallowed whole; -Oxybutynin ER tablets must be swallowed whole with the aid of liquids, and must not be chewed, divided, or crushed; and, -Metoprolol succinate ER tablets are scored and can be divided. However, the whole or half tablet should be swallowed whole and not chewed or crushed. In an interview with RN (staff #8) on November 6, 2024 at 9:43 a.m., the RN stated that he double checks everything during medication administration including counting the pills to make sure he has the accurate amount; and, that, he should not have missed the second ascorbic acid and atorvastatin tablet. He stated that it was normal for other staff members to interrupt while he is in the middle of medication administration. The RN also said that medications could be crushed if there was an order to crush them; and that, there were medications that cannot be crushed and it usually states not to crush them in the order. The RN stated that ER means extended release but was not sure if extended release medications could be crushed or not. The RN also stated that Levothyroxine should be given after breakfast, and stated that the resident (#3) told him she did not eat. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on November 7, 2024 at 9:48 a.m. with the Director of Nursing (DON/Staff #123) who stated that the process for medication administration included making sure it was the right resident, right route, right medication, right dose, following physician orders as it was written, and following manufacturers recommendations about medication administration. The DON also stated that extended release medications should not be crushed, and that the risk to the resident would result in resident receiving the whole dose of the medication immediately rather than it being absorbed over a period of time. She further stated that for metoprolol succinate ER specifically the risks could be cardiac issues and arrythmias. The DON stated that levothyroxine should be administered before the resident eats breakfast; and the risk of administering after the resident eats would be that it interferes with the absorption of the medication. The DON stated that it does not meet the facility's expectation is staff does not administer medications/treatment as ordered by the physician. During a telephone interview with the Nurse Practioner (NP/Staff #60) on November 6, 2024 at 3:05 p.m., she stated that extended release medications should not be crushed; and that, the outcome of the resident receiving crushed extended release medications would be that the dose would be stronger and be released faster, and the resident could overdose on the medication. She also stated that she expected staff to follow orders as written and to contact her to discuss an order if they had questions. She further stated that levothyroxine would be given thirty minutes to an hour before the resident eats in the morning. Review of the facility's policy, Medication Administration, dated October 14, 2024, revealed that medications are administered in accordance with the written orders of the attending physician. It also revealed that crushing may be done using standards of practice; and crushing of long acting or enteric-coated medications is allowable only when there is a specific physicians order to do so. Review of the facility's policy, Medication Error Monitoring, revision #4, revealed that the facility shall ensure medications will be administered as follows: according to physician orders, per manufacture's specifications regarding the preparation and administration of the drug or biological, and in accordance with accepted standards and principles which apply to professionals providing services.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 50887 Based on observation, staff interviews, and review of facility policy, the facility failed to ensure that one medication was disposed of in accordance with professional standards of practice, the deficient practice could result in medications not being disposed of properly. The sample was 28 medication administrations observed. Findings include: During a medication administration observation with a Registered Nurse (RN/Staff #8) conducted on November 6, 2024 at 7:23 AM, the RN dispensed a multiple vitamins capsule into a medication cup with other medications and then verified on the order that it was the incorrect medication. The RN then used gloved hands to retrieve the capsule and put it back into the multiple vitamins container. An interview was conducted with a RN (Staff #8) on November 6, 2024 at 9:43 AM who stated that he usually does not put the medication back into the container after it being dispensed and that he would dispose of it in the drug buster. He further stated that he should not have put the capsule back into the container because of aseptic technique and that it could be contaminated by touching the other medications that were already dispensed into the medication cup. During an interview with the Director of Nursing (DON/Staff #123) on November 7, 2024 at 9:48 AM, the DON stated that the process for disposing non-controlled medications would be to discard the medication and not put it back into the container. She also stated the risks of placing the medication back into the container after it was dispensed would be that it could contaminate the other vitamins that are in the container. She further stated that this did not meet facility expectations. The facility provided documentation that there was not a policy for disposition of non-controlled medications and that medications are placed in the Drug Buster per standards of practice.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50887 Based on observations, staff interviews, record review, and policy review, the facility failed to ensure the medication error rate was not 5% or greater, by failing to administer medications as ordered for one resident (#3). The medication error rate was 21.43%. Six medication administration errors were identified out of 28 opportunities during medication administration observation. The deficient practice could result in further medication errors. Findings include: Resident #3 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes without complications, essential hypertension, hyperlipidemia, and Alzheimer's disease. Review of the physician order dated March 6, 2024 revealed an order for Ascorbic Acid tablet 500 mg give two tablets by mouth one time a day for supplement Review of the physician order summary revealed an order for the following: -Atorvastatin Calcium oral tablet 40 mg give one tablet orally in the morning for hyperlipidemia. -Bupropion hydrochloride (antidepressant) ER (extended release) give 150 mg orally in the morning for mood disorder; -Oxybutynin chloride ER (anticholinergic) tablet 10 mg, give one tablet by mouth in the morning for overactive bladder (OAB); and, -Metoprolol Succinate ER (beta blockers) oral tablet 25 mg, give 0.5 tablet by mouth one time a day for congestive heart failure (CHF). Review of the drug specification documentation provided by the facility revealed the following: -Bupropion hydrochloride ER tablets were not to be chewed, cut, or crushed; and, the tablets must be swallowed whole; -Oxybutynin ER tablets must be swallowed whole with the aid of liquids, and must not be chewed, divided, or crushed; and, -Metoprolol succinate ER tablets are scored and can be divided. However, the whole or half tablet should be swallowed whole and not chewed or crushed. During a medication administration observation on November 6, 2024 at 7:23 AM with a Registered Nurse (RN/Staff #8), the RN was observed to administer the following: -One Ascorbic Acid 500 milligram (mg) tablet; (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-One Bupropion Extended Release (ER) 150mg tablet, one Metoprolol Succinate ER tablet, and one Oxybutynin Chloride ER tablet were crushed and administered to the resident in chocolate pudding; and, -One Levothyroxine sodium oral tablet 50 micrograms (mcg) was administered after resident ate breakfast. The RN (staff #8) also pulled the Atorvastatin medication card from the medication cart, was interrupted by a CNA, and then was observed to place the medication card back into the medication cart without dispensing the medication into the medication cup. The RN verified that the Atorvastatin tablet was not in the medication cup and then dispensed the tablet into the medication cup. The RN (staff #8) counted the medications that were dispensed into the medication cup and verified that he had only one ascorbic acid tablet. The RN reviewed the physician's order and stated that there should have been two tablets dispensed. The RN did not ask resident #3 whether or not the resident had eaten breakfast. Resident #3 stated that she ate some oatmeal and milk prior to the medication administration observation. During an interview conducted on November 6, 2024 at 9:43 a.m., the RN (staff #8) stated that medications could be crushed if there is an order to crush them, and stated that there are medications that cannot be crushed and it usually states not to crush them in the order. The RN further stated that ER means extended release but was not sure if extended release medications could be crushed or not. He also stated that he should not have missed the second ascorbic acid and atorvastatin tablet. The RN further stated that Levothyroxine should be given after breakfast, and stated that the resident (#3) told him she did not eat. An interview was conducted on November 7, 2024 at 9:48 a.m. with the Director of Nursing (DON/Staff #123) who stated that the process for medication administration included making sure it was the right resident, right route, right medication, right dose, following physician orders as it was written, and following manufacturers recommendations about medication administration. The DON also stated that extended release medications should not be crushed, and that the risk to the resident would result in resident receiving the whole dose of the medication immediately rather than it being absorbed over a period of time. She further stated that for metoprolol succinate ER specifically the risks could be cardiac issues and arrythmias. The DON stated that levothyroxine should be administered before the resident eats breakfast; and the risk of administering after the resident eats would be that it interferes with the absorption of the medication. The DON stated that it does not meet the facility's expectation is staff does not administer medications/treatment as ordered by the physician. During a telephone interview with the Nurse Practioner (NP/Staff #60) on November 6, 2024 at 3:05 p.m., she stated that extended release medications should not be crushed; and that, the outcome of the resident receiving crushed extended release medications would be that the dose would be stronger and be released faster, and the resident could overdose on the medication. She also stated that she expected staff to follow orders as written and to contact her to discuss an order if they had questions. She further stated that levothyroxine would be given thirty minutes to an hour before the resident eats in the morning. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy, Medication Administration, dated October 14, 2024, revealed that medications are administered in accordance with the written orders of the attending physician. It also revealed that crushing may be done using standards of practice; and crushing of long acting or enteric-coated medications is allowable only when there is a specific physicians order to do so. The policy indicated that medication time may be altered to meet resident and facility needs all while following medical doctors (MD) orders. Review of the facility's policy, Medication Error Monitoring, revision #4, revealed that the facility shall ensure medications will be administered as follows: according to physician orders, per manufacture's specifications regarding the preparation and administration of the drug or biological, and in accordance with accepted standards and principles which apply to professionals providing services. The policy also indicated that the facility must ensure that it is free of medication error rates of 5% or greater as well as significant medication error events.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50595 Based on observations, staff interviews, and policy review, the facility failed to ensure that medications the facility failed to ensure that medications were not left at bedside for one residents (#5); and failed to ensure that expired medications and supplies were discarded and readily available for resident use. The facility census was 41, and the sample was 13 residents. The deficient practice could result in adverse effects and residents, staff, and visitors having access to medications. Findings include: -Resident #5 was admitted to the facility on [DATE], with diagnoses that include chronic respiratory failure with hypoxia, acute and subacute allergic otitis media, unspecified ear, acute post hemorrhagic anemia A physician order dated March 22, 2023 revealed an order for Systane Solution eye drop in both eyes. A physician order dated July 17, 2024 included Fluticasone propionate suspension, one spray in each nostril. During an observation of the resident's room conducted on November 5, 2024, at 9:08 a.m., there was a bottle containing Fluticasone Propionate Suspension nasal spray and Systane complete eye drop at the resident's bedside table. In another observation conducted on November 6, 2024 at 9:39 a.m. Fluticasone and Systane eye drops were on the resident's bedside table. An observation was conducted November 7, 2024, at 8:38 a.m. and revealed that the Fluticasone and Systane eye drops were observed on the resident's bedside table. An interview was conducted on November 5, 2024, at 9:10 a.m. with with the Resident #5 who stated that she liked to keep the nasal spray and eye drops with her so she did not have to ask the nurses for them in case she needed them. An interview was conducted with a Registered Nurse (RN/Staff #33) on November 7, 2024, at 12:11 p.m. A review of the clinical record was conducted with the RN who stated that the orders for the Systane Solution eye drops and Fluticasone Propionate were active. The RN further stated that there was no evidence of an order for Resident #5 to self-administer medication. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the Director of Nursing (DON/staff #123) was conducted on November 8, 2024 at 10:24 a.m., the DON stated that she had not been in the resident's room, but eye drops and nasal spray should never be left at the bedside per facility policy. The DON stated that there was no reason for any medication to be kept at the bedside unless there was an order to do so. The DON further stated that there was no evidence that a medication self-administration was conducted for resident #5. The DON stated that the risk of leaving medication at the bedside could result in someone else taking the medication. The facility policy on Medication Storage (Medication Cart/Narcotics), included that it was their policy is to ensure that all medications housed on our premises are stored in the pharmacy and/or Medication rooms according to the manufacturer's recommendations and sufficient to ensure security. 50887 -During a medication room observation conducted with a Registered Nurse (RN/staff #6), on November 6, 2024 at 12:39 p.m., there were two Semglee insulin glargine pens in Ekit #1 in the fridge with an expiration date of June 2024; and, Moderna covid-19 vaccines in a black locked box in the fridge had a sticker on the box indicating the expiration date to be June 30, 2023. During the medication room observation with RN (staff #6) conducted on November 6, 2024 at 12:39 p.m., the following supplies were found having exceeded their expiration date: -Autoshield duo cap for insulin pen in Ekit #1 from fridge with an expiration date of February 2023; -Statlock intravenous kit with an expiration date of December 28, 2023; -Entraflo safety spike plus pump set with enfit with an expiration date of June 28, 2023; -Powerloc port access kit with an expiration date of October 31, 2024; and, -Even care blood glucose test strips with an expiration date of September 6, 2024 In an interview with RN (staff #6) conducted on November 6, 2024 at 12:39 p.m., the RN stated that the medications, vaccines and supplies found in the medication room exceeded their expiration date and would be disposed of immediately. The RN further stated they were trying to figure out where to send the expired vaccines instead of disposing of them. During an interview with the Director of Nursing (DON/staff #123) conducted on November 7, 2024 at 10:09 a.m., the DON stated that the risks of using expired medications or supplies on a resident would affect the efficay of the medications and supplies. The facility policy on Expired Drugs/Supplies, revealed that expired drugs and supplies should be disposed of with proper record keeping and prior to expiration date. The policy also indicated that the medication room supplies should be randomly checked and discarded prior to expiration date, and stock medications are to be discarded prior to expiration date.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035257	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Peaks Health & Rehabilitation	3150 North Winding Brook Road Flagstaff, AZ 86001

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48814 Based on interviews, record review, facility document review, and facility policy review, the facility failed to ensure that one sampled resident (#342) did not receive a pneumococcal vaccine. The deficient practice could result in residents not receiving vaccines. Findings included: Resident #342 was admitted on [DATE] with diagnoses of type 2 diabetes mellitus, fracture of unspecified part of neck of right femur, and muscle weakness. A progress note dated September 20, 2024, revealed that the resident would like to receive a pneumococcal vaccination during skilled nursing facility stay. The admission Minimal Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 11 indicating moderate cognitive impairment. Review of an Immunization Informed Consent-V7 form dated October 29, 2024, revealed a signed consent by the resident's sister to receive the pneumonia vaccine Prevnar 20. Despite documentation that the family agreed to the vaccination, there was no evidence that the medical record of a physician order for the pneumonia vaccine Prevnar 20. Progress note dated October 29, 2024 to November 7, 2024 revealed no evidence that the vaccine had been administered or ordered. An interview was conducted with Quality Infection Control (QIC/ staff #6) on November 7, 2024 at 12:13 p.m. , who stated that the resident consented for pneumonia on October 29, 2024. She further stated that immunizations are offered upon admission and during the flu season. The QIC reviewed the clinical record and stated that the resident did not receive the pneumonia vaccine. She further stated that she did not place the order for pneumonia into the resident's record. She then stated that the risk could result resident's getting pneumonia. An interview was conducted with the Director of Nursing (DON/ staff #123) on November 7, 2024 at 12:47 p. m., who stated that the facility conducts a yearly flu/pneumonia clinic in September. She also stated that the resident's pneumonia vaccination was missed, and that she will order it. She further stated that the risk could resulted in residents becoming sick with pneumonia and flu. Review of facility policy titled, Pneumococcal vaccine (series), reviewed on October 16, 2023, revealed that each resident will be offered a pneumococcal immunization unless it is medically contraindicated or the resident has already been immunized. Following assessment for any medical contraindications the immunization may be administered in accordance with physician-approved standing orders.