STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035141	A. BUILDING _____ B. WING _____	**02/27/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HERITAGE HEALTH CARE CENTER	**1300 SOUTH STREET GLOBE, AZ 85501**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, staff interviews, and policy and procedure, the facility failed to ensure resident #278 was free from abuse by resident #277. Findings include: -Resident #278 was admitted to the facility on (MONTH) 30, 2013, with [DIAGNOSES REDACTED]. Review of the annual Minimum Data Set (MDS) assessment for resident #278 dated (MONTH) 11, (YEAR), revealed the resident had short term and long term memory problems. The MDS assessment also included the resident had not exhibited any behaviors, hallucinations, or delusions. A nurse's note dated (MONTH) 6, (YEAR) revealed resident #278 was in his wheelchair outside his room when resident #277 came up behind him and pushed his wheelchair with force, pushing him into his room and causing his right thigh to hit the end of his bed. The note included resident #278 moaned when hitting the end of the bed. The note also included no abrasion, redness, or bruising was noted. The note further revealed resident #277 attempted to repeat his action but was stopped by a Certified Nursing Assistant (CNA). -Resident #277 was admitted to the facility on (MONTH) 22, (YEAR), with [DIAGNOSES REDACTED]. Review of the care plan for resident #277 dated (MONTH) 22, (YEAR), revealed the resident had a history of [REDACTED]. Interventions included distracting and/or redirecting the resident, ensuring a calm, quiet environment, and initiating behavior monitoring as needed. Review of the quarterly MDS assessment for resident #277 dated (MONTH) 31, (YEAR), revealed a Brief Interview for Mental Status score of 15, which indicated the resident was cognitively intact. The MDS assessment also revealed the resident had not exhibited any behaviors, hallucinations, or delusions. Review of a social services note dated (MONTH) 8, (YEAR), revealed resident #277 stated that he felt resident #278 was a witch doctor and that he pushed resident #278 away from him so that he could not put witchcraft on him. Review of the facility's investigation report dated (MONTH) 9, (YEAR), revealed that on (MONTH) 6, (YEAR) at approximately 7:00 p.m., staff witnessed resident #277 aggressively push resident #278 in his wheelchair into his room which caused his thigh to hit the bed. Resident #277 attempted to push resident #278 again, but nursing staff intervened and stopped him. Resident #277 told staff, He (resident #278) is a witch doctor. Resident #277 was sent to the hospital on (MONTH) 6, (YEAR), for an evaluation. Behavior monitoring was initiated for resident #277. Resident #278 was assessed to have no injuries and was moved to a room away from resident #277 and closer to the nurse's station. An interview was conducted on (MONTH) 26, 2019 at 11:04 a.m. with the Director of Nursing (DON/staff # 35). She stated that resident #277 thought resident #278 was an evil person. Staff #35 said the next day that she acknowledged the resident to resident incident occurred, but she believed it was unintentional. An interview was conducted on (MONTH) 26, 2019 at 1:56 p.m., with a Certified Nursing Assistant (CNA/staff #63). She stated that she witnessed resident #278 singing or humming and that resident #277 told him to go away. The CNA stated that she then witnessed resident #277 push resident #278 in his wheelchair really, really hard. She stated she told resident #277 to stop, and that he listened. She said that resident #278 was moved to a room farther away. Review of the facility's policy regarding abuse revealed each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation of any type by anyone, including other residents and that all residents will be protected from all types of abuse. The policy included abuse is the willful infliction of injury, intimidation, or punishment with resulting physical harm, pain or mental anguish. The policy also included the facility will identify, correct and intervene in situations in which abuse is more likely to occur.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.