STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035071	A. BUILDING _____ B. WING _____	**01/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MISSION PALMS POST ACUTE	**6461 EAST BAYWOOD AVENUE MESA, AZ 85206**

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 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** > Based on staff interviews, record reviews and review of policies and procedures and review of the State Agency Data base, the facility failed to ensure that an allegation of abuse for one resident (resident #1) was reported to the Administrator, and to other officials including AZDHS (Arizona Department of Health Services) and APS (Adult Protective Services). The deficient practice may result in additional allegations of abuse not being reported to the Administrator and to other officials. Findings include: Resident #1 was admitted on (MONTH) 21, 2019 with [DIAGNOSES REDACTED]. A quarterly MDS (Minimum Data Set Assessment) dated (MONTH) 26, 2019 included a BIMS (Brief Interview for Mental Status) score of 14, which indicated that resident #1 was cognitively intact. The assessment included that resident #1 had clear comprehension and understands others, and required limited physical assistance from another person for bed mobility, transferring, walking in the room, toilet use and bathing. Review of the clinical record from (MONTH) 21, 2019 through (MONTH) 8, 2020 did not reveal documented evidence of behavioral symptoms, or behavioral care interventions associated with the resident's diagnosed dementia with behavioral disturbance or depression. Review of the State Agency database revealed that on (MONTH) 8, 2020 a report was received by the State Agency that resident #1 had been touched inappropriately by a CNA (Certified Nursing Assistant) on (MONTH) 6, 2020. The reporting source identified the CNA as staff #87, and included that the Social Services Director was informed of the allegation. The reporting source also included that staff #87 was not removed from duty and completed his shift after the allegation was reported to the Social Services Director. An interview was conducted on (MONTH) 8, 2020 at 1:45 p.m. with staff #87 who stated that he had been assigned to care for resident #1 on (MONTH) 6, 2020. Staff #87 stated that resident #1 functioned independently with care and that he did not provide any hands on care to the resident during his shift. Staff #87 stated that nothing unusual had occurred during his care of resident #1. During an interview conducted on (MONTH) 9, 2020 at 9:00 a.m. with resident #1, she stated repeatedly that she had not been touched inappropriately or mistreated by any staff or other person at the facility. An interview was conducted on (MONTH) 9, 2020 at 9:10 a.m. with the Social Services Director (staff #58) who stated that resident #1 has not voiced any allegations or accusations that any staff or other resident had tried to touch her inappropriately, or asked if they could touch her and has not voiced any allegations of abuse or mistreatment. An interview was conducted on (MONTH) 9, 2020 at 9:58 a.m. with an RN (Registered Nurse/staff #106). The RN stated that on (MONTH) 9, 2020 at 11:00 a.m. resident #1 stated to her that she had been touched and had told the person who touched her don't touch me there. The RN stated that when she asked the resident where she had been touched, the resident pointed to her shoulder and upper chest area near her shoulder. The RN stated that at that moment a CNA (staff #87) was walking by and the resident pointed with her lips at the CNA and stated don't tell anyone. When asked to define what she meant when she stated that the resident had pointed with her lips at the CNA, the RN stated we were speaking in Spanish and she pointed with her lips. The RN stated that she took the resident to the DON's Director of Nursing/staff #125) office and told her the the resident had something to tell her and the DON directed the RN to take the resident to the Social Service office. During the interview conducted on (MONTH) 9, 2020 at 9:58 a.m. with RN/staff #106, the RN did not state at any time that she informed the Administrator or the Director of Nursing that resident #1 had voiced a possible allegation of abuse, or that resident #1 had indicated that a CNA (staff #87) had touched her inappropriately or abused her. An interview was conducted on (MONTH) 9, 2020 at 10:25 a.m. with the Social Services Director (staff #58) who stated that on (MONTH) 6, 2020 an RN (staff #106) had brought resident #1 into her office and told her that resident #1 has something to tell you. Staff #58 stated that the resident who was seated in a wheelchair, looked up at the RN and asked her Now what am I supposed to say and the RN told resident #1 just tell her what you told me and then the RN exited staff #58's office. Staff #58 stated it was now just she and resident #1 in the office and the resident stated that someone had asked if they could touch her. However, staff #58 stated that resident #1 was unable to provide additional details regarding who had asked to touch her, or when, or where this had occurred, or if this had even occurred in the facility. The social worker stated that the RN did not tell her that a CNA/staff #87 had been accused of touching resident #1 inappropriately, and if the RN had told her that, she would have immediately notified the Director of Nursing. During interviews conducted on (MONTH) 9, 2020 with the Director of Nursing/staff #125 she stated the following: -At 10:35 a.m. she stated that on (MONTH) 6, 2020 she saw the RN/staff #106 wheeling resident #1 in front of the Social Service office and that the RN told her that resident #1 had a concern but did not say what the concern was, and the Director told the RN to take resident to see the social worker. The Director stated that RN did not tell her that resident #1 had voiced a possible allegation of abuse, and that later that morning when the social worker told her what resident #1 had said about someone asking to touch her she immediately interviewed resident #1, and that the resident had stated that nobody had touched her inappropriately or had asked to touch her in an inappropriate manner. The Director also stated that she had a private meeting with the RN on (MONTH) 6, 2020 at 4:30 p.m. and that the RN did not tell inform her during the private meeting that resident #1 had voiced an allegation of abuse. -At 1:10 p.m. the Director stated that when a resident voices an allegation of abuse to staff, the staff is to immediately report the allegation to the Administrator, whose phone number is available at the nurses station. The Director stated that if a staff is accused of abuse, the staff is to report to her office immediately, she obtains a statement from the staff, and the staff is removed from duty. The Director stated that the RN did not notify her, or any other staff, including the Administrator, about an allegation of abuse for resident #1, and that because the RN did not follow the protocol for reporting abuse, the allegation was not reported and the accused CNA was not removed from duty that day. Review of a personnel record for the RN/staff #106 revealed a notice dated (MONTH) 1, 2019 and signed by the RN regarding the Elder Justice Act. Further review of the notice revealed a statement that ALL EMPLOYEES have the following responsibilities and rights under Federal Law: If you reasonably suspect that a crime has been committed against a resident or person receiving care in the facility, you MUST report that suspicion to the police AND State Survey Agency within 2 hours after you first suspect that a crime has occurred if the suspected crime involves serious bodily injury to the individual, or within 24 hours if there is no serious injury involved. A policy and procedure titled Reporting Alleged Violations of Abuse, Neglect, Exploitation or Mistreatment included a

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.

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F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) statement that it is the policy of the facility that each resident has the right to be free from abuse, neglect, exploitation and mistreatment. The policy included that the facility will ensure that all alleged violations of abuse, neglect, exploitation and mistreatment are reported within two hours, and that all alleged violations are reported to the Administrator of the facility, the State Survey Agency and Adult Protective Services.
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** > Based on staff interviews, record reviews and review of policies and procedures and review of the State Agency Data base, the facility failed to investigate an allegation of abuse for one resident (#1) and failed to prevent further potential abuse during the investigation, by failing to remove from duty a staff member (#87) who the resident accused of abusing her. The deficient practice may result in additional allegations of abuse not being investigated and residents not being protected from further abuse while an investigation is ongoing Findings include: Resident #1 was admitted on (MONTH) 21, 2019 with [DIAGNOSES REDACTED]. A quarterly MDS (Minimum Data Set Assessment) dated (MONTH) 26, 2019 included a BIMS (Brief Interview for Mental Status) score of 14, which indicated that resident #1 was cognitively intact. The assessment included that resident #1 had clear comprehension and understands others, and required limited physical assistance from another person for bed mobility, transferring, walking in the room, toilet use and bathing. Review of the State Agency database revealed that on (MONTH) 8, 2020 a report was received by the State Agency that resident #1 had been touched inappropriately by a CNA (Certified Nursing Assistant) on (MONTH) 6, 2020. The reporting source identified the CNA as staff #87, and included that the Social Services Director was informed of the allegation. The reporting source also included that staff #87 was not removed from duty and completed his shift after the allegation was reported to the Social Services Director. An interview was conducted on (MONTH) 8, 2020 at 1:45 p.m. with staff #87 who stated that he had been assigned to care for resident #1 on (MONTH) 6, 2020. Staff #87 stated that resident #1 that he did not provide any hands on care to the resident during his shift, and that he did complete his shift, and has not worked since that day. An interview was conducted on (MONTH) 9, 2020 at 9:10 a.m. with the Social Services Director (staff #58) who stated that resident #1 has not voiced any allegations or accusations that any staff or other resident had tried to touch her inappropriately, or asked if they could touch her and has not voiced any allegations of abuse or mistreatment. An interview was conducted on (MONTH) 9, 2020 at 9:58 a.m. with an RN (Registered Nurse/staff #106). The RN stated that on (MONTH) 9, 2020 at 11:00 a.m. resident #1 stated to her that she had been touched and had told the person who touched her don't touch me there. The RN stated that when she asked the resident where she had been touched, the resident pointed to her shoulder and upper chest area near her shoulder. The RN stated that at that moment a CNA (staff #87) was walking by and the resident pointed with her lips at the CNA and stated don't tell anyone. The RN stated that she took the resident to the DON's Director of Nursing/staff #125) office and told her the the resident had something to tell her and the DON directed the RN to take the resident to the Social Service office. During the interview conducted on (MONTH) 9, 2020 at 9:58 a.m. with RN/staff #106, the RN did not state at any time that she informed the Administrator or the Director of Nursing that resident #1 had voiced a possible allegation of abuse, or that resident #1 had indicated that a CNA (staff #87) had touched her inappropriately or abused her, or that she had removed staff #87 from duty when the resident accused him of touching her inappropriately. An interview was conducted on (MONTH) 9, 2020 at 10:25 a.m. with the Social Services Director (staff #58) who stated that on (MONTH) 6, 2020 an RN (staff #106) had brought resident #1 into her office and told her that resident #1 has something to tell you. However, the social worker stated that the RN did not tell her that a CNA/staff #87 had been accused of touching resident #1 inappropriately, and if the RN had told her that, she would have immediately notified the Director of Nursing. During interviews conducted on (MONTH) 9, 2020 with the Director of Nursing/staff #125 she stated the following: -At 10:35 a.m. she stated that on (MONTH) 6, 2020 that RN/staff #106 did not tell her that resident #1 had voiced a possible allegation of abuse, and that during a private meeting with the RN on (MONTH) 6, 2020 at 4:30 p.m. and the RN did not tell inform her during the private meeting that resident #1 had voiced an allegation of abuse. -At 1:10 p.m. the Director stated that when a resident voices an allegation of abuse to staff, the staff is to immediately report the allegation to the Administrator, whose phone number is available at the nurses station. The Director stated that if and a staff is accused of abuse, the staff is to report to her office immediately, she obtains a statement from the staff, and the staff is removed from duty and they start an investigation. The Director stated that because the RN did not notify her, or any other staff, including the Administrator, about an allegation of abuse for resident #1, and did not follow the protocol for reporting abuse, the allegation was not reported and the accused CNA was not removed from duty that day. A policy and procedure titled Reporting Alleged Violations of Abuse, Neglect, Exploitation or Mistreatment included a statement that it is the policy of the facility that each resident has the right to be free from abuse, neglect, exploitation and mistreatment. The policy included that in order to comply with the Facility's obligations as set forth in 42 CFR Section 483.12, it will conduct a prompt, thorough and complete investigation in response to reportable allegations of abuse, neglect, mistreatment, exploitation, or misappropriation of resident property. A policy and procedure titled Abuse: prevention of and Prohibition Against included a statement that if an allegation of abuse, neglect, misappropriation of resident property, or exploitation is reported, discovered or suspected, the facility will take steps to protect all residents from physical and psychological harm during and after the investigation. If the allegation of abuse, neglect, misappropriation of resident property, or exploitation involves and employee, the facility will immediately remove he employee from the care of any resident, and suspend the employee during the pendancy of the investigation.