STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035117	A. BUILDING _____ B. WING _____	**09/19/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PAYSON CARE CENTER	**107 EAST LONE PINE DRIVE PAYSON, AZ 85541**

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 reviews, resident and staff interviews, and policy review, the facility failed to ensure that one of two sampled residents (#2) was free from verbal abuse by another resident (#71). The deficient practice could result in further incidents of resident to resident abuse. Findings include: -Resident #2 was admitted to the facility on (MONTH) 16, (YEAR) with [DIAGNOSES REDACTED]. A review of the quarterly MDS (Minimum Data Set) assessment dated (MONTH) 13, 2019 revealed the resident's BIMS (Brief Interview for Mental Status) score was a 15 indicating the resident had intact cognition. -Resident #71 was readmitted to the facility on (MONTH) 31, (YEAR) with [DIAGNOSES REDACTED]. A review of the quarterly MDS assessment dated (MONTH) 3, 2019 revealed a BIMS score of 15 which indicated the resident had intact cognition. Review of an Activity Participation Note dated (MONTH) 8, 2019 written by the activity director (staff #71) revealed Late entry: On Thursday (MONTH) 4, during the 4th of (MONTH) party, (resident #71) asked for a third helping of food. Not all of the residents had been served so (staff member's name) asked him to wait until all of the other residents had been served. It appeared to this writer, that because he wanted more food, and because he did not believe (staff member's name), he got angry, became belligerent and called her a liar and a 'b----.' This writer was serving food to others, but overheard this conversation as (resident #71) became loud. A second incident occurred at the same party with (resident #71). He raised his voice and began yelling at another resident (resident #2) and stated 'You should never eat in front of people, you are disgusting to watch. You should just leave.' The other resident (#2) appeared to be hurt, embarrassed and he did leave the party. An interview was conducted with the activity director (staff #71) on (MONTH) 17, 2019 at 1:36 p.m. Staff #71 stated that resident #2 had a [MEDICAL CONDITION] and was non-verbal. Staff #71 stated that resident #71 saw resident #2 eating and became upset and said the way resident #2 ate was disgusting. Staff #71 stated that resident #2 stopped eating, got up and walked out of the dining room. Staff #71 stated she told resident #2 to come back to the party and that nothing was wrong with the way he was eating. Staff #71 stated resident #2 was embarrassed and his feelings were hurt. Staff #71 further stated that she knew that resident #2's feelings were hurt but she did not think of the situation as abuse because it was verbal and not physical. An interview was conducted with the administrator (staff #129) on (MONTH) 17, 2019 at 2:18 p.m. Staff #129 stated that he was not notified about this incident and that it should have been reported to him immediately. An interview was conducted with resident #2 and his roommate on (MONTH) 17, 2019 at 2:37 p.m. The roommate stated that he was at the party with resident #2 and that resident #71 stated to resident #2 that he needed to take his tongue and stick it in his hole (referring to his [MEDICAL CONDITION] stoma). The roommate stated that resident #2's tongue comes out when he eats and resident #71 stated we do not need to see that kind of stuff around here. Resident #2 shook his head affirmatively to the roommate's statement. The roommate stated that he told resident #71 that he was really rude and what he said was unacceptable. The roommate stated that resident #71 told him to mind his own business. Resident #2 stated that it made him feel sad and mad. Resident #2 further stated that he left the party and did not come back. Review of the facility's policy Protection of Residents: Reducing the Threat of Abuse and Neglect dated (MONTH) (YEAR) revealed each resident has the right to be free from abuse. Residents must not be subjected to abuse by anyone. It is the policy and practice of this facility that all residents will be protected from all types of abuse. The policy also included .Verbal Abuse- The use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents .

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.