STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035125	A. BUILDING _____ B. WING _____	05/02/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIDGECREST HEALTHCARE	16640 NORTH 38TH STREET PHOENIX, AZ 85032

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 -** 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, hospital records, facility documentation, resident and staff interviews, review of the State Agency Complaint/Incident Tracking System, and review of policies and procedures, the facility failed to ensure that multiple residents on the Sedona Unit were protected from mental, verbal, and sexual abuse by one resident (#1), and that one resident (#2) was free from mental and sexual abuse from resident #1 which resulted in psychosocial harm. The sample size was two residents.
Findings include:
-Resident #2 was admitted to the facility on (MONTH) 25, 2019 and readmitted on (MONTH) 22, 2019. [DIAGNOSES REDACTED].
A written care plan initiated on (MONTH) 29, 2019 included that resident #2 had behaviors including paranoid statements, territorial behaviors and that she was afraid of men. Also, she had hallucinations that men come into her room at night. The care plan included a goal that the resident would have fewer than daily episodes of behaviors. The care plan interventions included to intervene as necessary to protect the rights and safety of others, to monitor behavior episodes and attempt to determine underlying causes, and to consider the location, time of day, persons involved, and situations.
An Admission MDS (Minimum Data Set) assessment dated (MONTH) 31, 2019 included that resident #2 had a BIMS (Brief Interview for Mental Status) score of 3 which indicated that the resident had severely impaired cognition. The MDS assessment included that the resident had symptoms of [MEDICAL CONDITION] that included hallucinations and delusions. Behavioral symptoms included verbal behaviors directed at others which put the resident at risk for significant injury, interfered with care, and interfered with participation in social interactions.
Review of a hospital psychosocial assessment dated (MONTH) 4, 2019 included that the resident had a lifelong history of mental illness, including multiple past suicide attempts. The assessment included that resident #2 had made references to having been sexually assaulted at age 16, stating I was raped as a [AGE] year old and that the sexual assault had affected her life ever since.
A behavioral plan updated on (MONTH) 17, 2019 included that resident #2 may be at risk for being traumatized due to poor orientation to place and situation, and that her history was significant for kidnapping and rape by several men which had a profound effect on her psychological well being. The plan included that resident #2 had difficulty interacting with most male staff and residents.
A health status note dated (MONTH) 23, 2019 included that at 3:00 p.m. resident #2 had gone to the nurses station screaming and hollering that the crazy guy showed her his penis. Resident #2 identified resident #1 as the resident who had showed his penis to her. The note included that resident #1 was immediately placed on 1:1 (one to one) observation with staff, and that resident #2 had been walking up and down the hallway screaming for the entire shift.
-Resident #1 was admitted on (MONTH) 7, 2019 with [DIAGNOSES REDACTED].
Review of the clinical record revealed a psychiatric evaluation completed prior to the resident's admission, dated (MONTH) 2, 2019. The evaluation included that resident #1 had been hypersexual, and had engaged in sexual activities at another other nursing facility.
Review of a form titled Placement Referral Form completed prior to the resident's admission, dated (MONTH) 3, 2019, revealed that resident #1 constantly asks for sex and sexual acts from others and that he had masturbated in front of peers. The form included that resident #1 had a sexual encounter with a peer, and that police and APS (Adult Protective Services) had been notified.
An admission MDS dated (MONTH) 14, 2019 included that resident #1 had a BIMS score of 3 which indicated that the resident had severely impaired cognition. The assessment included that resident #1 was ambulatory with supervision and had delusions that put him at risk for illness or injury and interfered with his care and participation in social interactions. The assessment included that the resident was intrusive to others and that his behavior significantly disrupted the living environment.
Review of the behavior care plan, revised on (MONTH) 14, 2019, revealed the resident had behaviors including sexual requests, disrobing in public areas, inappropriate antisocial and sexual behaviors, and intrusive wandering. The care plan included a goal that resident #1 will have episodes of behaviors less than daily. Interventions included the following:
-Administer medications as ordered.
-Alarm placed above the resident's door to alert staff when the resident is exiting his room.
-Assist the resident to develop more appropriate methods of coping and interacting with peers. Encourage him to express feelings appropriately.
-Attempt to redirect sexual stimulation within the privacy of his room.
-Caregivers to provide opportunity for positive interaction and attention. Stop and talk with him as passing by.
-If reasonable, discuss his behavior. Explain/reinforce why (his) behavior is inappropriate and/or unacceptable to him.
-Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to an alternative location as needed.
-Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes.
-Staff to redirect as needed.
An annual history and physical note dated (MONTH) 25, 2019 included that staff reported ongoing sexual behaviors towards self, staff and peers and the resident was receiving 1:1 monitoring. The note also included a plan that the resident would continue to receive close supervision and 1:1 monitoring until the behavior resolved.
Review of the clinical record did not reveal additional documentation the the resident was provided close, or 1:1 supervision for sexual behaviors.
A psychiatric progress note dated (MONTH) 26, 2019 included that staff reported resident #1 had been hypersexual. The note included that resident #1 had been pulling out his penis in public, urinating outside in front of others, propositioning female staff and residents to engage in sexual activity with him, and going into female resident's rooms and staring at them while they sleep. The note included that the resident continued to exhibit these behaviors despite repeated redirection from staff members, and that his [MEDICAL CONDITION] have been more frequent and severe. The note included that medications had been reviewed and changes made to the resident's psychoactive medications.
A behavioral care progress note dated (MONTH) 8, 2019 for the p.m. shift included that resident #1 was very sexual acting, he had been observed in the courtyard and hallway taking out his penis and had tried to go into other resident rooms.

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

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F 0600 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) A behavioral progress note dated (MONTH) 12, 2019 for the p.m. shift included that resident #1 had been pacing in the hallway with his hands in his pants, and had asked a female resident for some pussy. Review of the clinical record did not reveal any additional information regarding the female peer, or if staff had intervened. A behavioral progress note dated (MONTH) 16, 2019 at 11:00 a.m. included that resident #1 was harassing all of the residents, walked up to a resident and pulled down his pants and exposed himself right next to a resident. The note included that resident #1 pulled his pants down a total of 3 times, stole food from another resident, and that he was getting uncomfortably close to many residents. The note also included he did not listen to any of us which included CNA's (Certified Nursing Assistants) and a nurse. Review of the clinical record, facility documentation, and the State Agency Complaint/Incident Tracking System data revealed that the incidents on (MONTH) 8, 12, and 16, 2019 regarding the resident exposing himself to other residents and using sexual language to residents were not reported to the State Agency and there was no evidence that resident #1 was provided increased monitoring and supervision, including 1:1 close observation, or that the resident's care plan had been updated to include any additional interventions to prevent additional [MEDICAL CONDITION] towards peers. A health status note dated (MONTH) 21, 2019 at 9:01 p.m. included that resident #1 had made several sexual attempts towards other female residents, and that the resident had exposed his private parts five times to other residents and staff. The note included that the resident needed close monitoring around other residents. Continued review of the clinical record did not reveal any additional documented information regarding increased supervision or monitoring that had been provided to resident #1, including 1:1 or close observation for the resident's sexual behavior towards peers, or that the resident's care plan was updated at that time to include any additional interventions to prevent further sexual behavior towards peers. A health status note dated (MONTH) 23, 2019 at 9:49 p.m. included that at approximately 3:00 p.m. a resident (#2) had approached the nurses station and stated that another resident (#1) had exposed his penis to her. Resident #1 was immediately placed on 1:1 supervision and facility management was notified. Resident #1 was then transferred to another unit. Review of two investigative reports dated (MONTH) 25, 2019 included the following information: -During a clinical review on (MONTH) 22, 2019 a nurses progress note was found dated (MONTH) 21, 2019 at 9:00 p.m. that resident #1 had made sexual acts towards peers and flashed his private parts five times to staff and peers. An investigation was conducted, and the facility concluded that resident #1 had not acted sexually towards other residents, and that no other residents were involved in the incidents. -On (MONTH) 23, 2019 at 3:30 p.m. resident #1 and #2 were outside on the patio area. A CNA was monitoring the patio entrance to the hallway, and the CNA was watching resident #2 when she started screaming. The CNA entered the patio and saw resident #1 with his pants open. Resident #2 entered the hallway and reported that she had seen the private areas of resident #1 to the nurse. Resident #1 was placed on 1:1 supervision and moved to another unit. Education was provided to staff regarding the protocol for 1:1 supervision with residents. The report included that there was no intent to harm resident #2 when resident #1 exposed himself to her. However, the report stated that staff monitoring and redirection were unsuccessful with preventing resident #1 from disrobing. Review of the clinical record revealed a Discharge MDS dated (MONTH) 26, 2019 that included resident #1 had been discharged to a psychiatric hospital. An interview was conducted on (MONTH) 1, 2019 at 12:25 p.m. with a CNA/staff #48. Staff #48 stated that resident #2 was very afraid of men, and that resident #1 was known to take his pants down when he was outside on the patio. She stated that the residents on the Sedona Unit were confused and that two of them were able to answer questions. She stated resident #2 was one of the residents who was able to answer questions. An interview was conducted on (MONTH) 1, 2019 at 12:30 p.m. with resident #2. During the interview, staff #48 (who was female) remained in the room, standing next to the State Agency interviewer (who was male) due to the resident's fear of men. The resident stated she remembered two incidents that involved resident #1. She stated that one day when she was outside on the patio, resident #1 came outside and pulled his pants down in front of her and she became scared. She stated she shouted at him and a staff person who was at the door to the patio came and took resident #1 away. She stated repeatedly during the interview that resident #1 took down his pants in front of her and showed his thing to her and that she was scared. During the interview, she became increasingly fearful and anxious, and then stated I can't talk about this anymore. An interview was conducted on (MONTH) 1, 2019 at 2:14 p.m. with an RN (Registered Nurse/staff #93). He stated that he was the nurse on the afternoon shift on (MONTH) 21, 2019 and that resident #1 pulled his pants down and exposed himself to a male peer in a wheelchair, and the male resident did not react. He stated resident #1 had also walked around the dining room, repeatedly exposing himself to peers making statements the he wanted someone to lick or suck on his penis, and that he pulled his penis out of his pants and showed it to other residents. He stated that staff had redirected resident #1 repeatedly that afternoon, and that the resident continued to expose himself to residents and staff. He also stated the residents who he had exposed himself to did not react to his behavior and did not say anything as they were confused. The RN stated that it was his first day on the job, and although he had been provided abuse prevention training during orientation prior to his first day, he did not know what he was supposed to do. During an interview with the administrator/staff #185 conducted on (MONTH) 1, 2019 at 2:45 p.m. she stated that the note describing the behavior of resident #1 on (MONTH) 21, 2019 was discovered the next day during the morning meeting, and that it was investigated. She stated that none of the residents who were interviewed expressed that they had been abused. However, despite a witness statement that resident #1 had purposely targeted multiple residents when he exposed himself and made sexual comments, the administrator stated that through the facility investigation it was determined that resident #1 had not targeted other residents when he exposed himself. The administrator further stated that resident #1 was not placed on 1:1 supervision at that time, because when he had exposed himself multiple times on (MONTH) 21, 2019, his behavior was directed at staff and not other residents. She stated that resident #1 was placed on 1:1 supervision with staff after he had exposed himself to resident #2 on (MONTH) 23, 2019. An interview was conducted on (MONTH) 1, 2019 at 3:00 p.m. with an LPN (Licensed Practical Nurse/staff #117). She stated that on (MONTH) 23, 2019 when she was at the nurses station on the Sedona Unit resident #2 came running up to the nurses station screaming in the hallway he pulled it out. She described that resident #2 was very agitated and that a CNA (staff #85) had witnessed resident #1 pull his penis out and show it to resident #2. She stated that resident #1 was placed on 1:1 supervision, escorted to his room and remained in his room until he was moved to another unit. She stated that resident #2 remained anxious and upset for the remainder of the afternoon shift. She stated that when the incident occurred resident #1 was not being provided increased supervision or monitoring due to his known recent history of sexual behavior directed towards other residents. An interview was conducted on (MONTH) 1, 2019 at 3:30 p.m. with CNA/staff #85. She stated that on (MONTH) 23, 2019 resident #2 was on the patio and resident #1 also wanted to go onto the patio, she tried to discourage him from going on to the patio because resident #2 was there. She stated she was unable to prevent resident #1 from entering the patio because he became aggressive and she was the only staff at the end of the hallway. She stated she remained in the doorway of the patio, where she could monitor the patio and the hallway on the Sedona Unit. She stated resident #1 went behind the patio door and she could not see what he was doing. Resident #2 began screaming, and when she looked behind the door she saw resident #1 staring at resident #2, and he had his pants down as though he was showing his penis to resident #2. She stated that resident #1 was definitely hiding behind the door, and that he was purposefully showing his penis to resident #2. She immediately told resident #2 to leave the courtyard and to tell the nurse what had happened, and when she tried to assist resident #1 to pull his pants up he began to fight her. She stated resident #1 would not leave the courtyard until staff assistance arrived and he was escorted to his room. An interview was conducted on (MONTH) 2, 2019 at 8:50 a.m. with the ADON (Assistant Director of Nursing/staff #98) she stated that the reason resident #1 had not been placed on 1:1 supervision on (MONTH) 21, (YEAR) after he had exposed himself multiple times to other residents was that it sounded like the resident's behavior was directed at staff and not at other residents. She stated it was possible that resident #1 may have been placed on increased supervision at that time, she was not sure. She stated that if resident #1 had been placed on increased supervision on (MONTH) 21, 2019 the care plan

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F 0600 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) for resident #1 would have been updated, and the increased level of supervision would have been communicated directly to the staff. She stated that resident #2 had a history of [REDACTED].#2 had [MEDICAL CONDITION] and was afraid of men. Review of a policy and procedure titled Abuse Prohibition and Prevention included a policy statement that the facility prevents abuse and exploitation of residents, each resident has the right to be free from mental/emotional, verbal, and sexual abuse, and residents must not be subjected to abuse by anyone including other residents. The policy noted that the supervisor shall immediately intervene, correct, and report identified situations where abuse may occur, conduct ongoing resident assessments and care planning for appropriate interventions to monitor resident needs, and address behaviors such as verbally aggressive behavior, intimidating sexually aggressive behavior including saying sexual things and inappropriate touching. The policy noted that facility staff will be able to identify the different types of abuse including mental/verbal and sexual abuse. The policy noted that occurrences, patterns, and trends will be assessed by administrative staff, licensed staff, and the interdisciplinary team to determine the corrective action based on the results of the investigation.
F 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on clinical record review, resident and staff interviews, facility documentation, and review of the State Agency data base the facility failed to implement policies and procedures that prohibited, prevented, investigated and reported multiple allegations of mental, verbal and sexual abuse of multiple residents on the Sedona Unit by one resident (#1). The sample size was one resident. Findings include: -Resident #2 was admitted to the facility on (MONTH) 25, 2019 and readmitted on (MONTH) 22, 2019. [DIAGNOSES REDACTED]. An Admission MDS (Minimum Data Set) assessment dated (MONTH) 31, 2019 included that resident #2 had a BIMS (Brief Interview for Mental Status) score of 3 which indicated that the resident had severely impaired cognition. The MDS assessment included that the resident had symptoms of [MEDICAL CONDITION] that included hallucinations and delusions. Behavioral symptoms included verbal behaviors directed at others which put the resident at risk for significant injury, interfered with care and interfered with participation in social interactions. A health status note dated (MONTH) 23, 2019 at 9:39 p.m. included that at 3:00 p.m. resident #2 had gone to the nurses station screaming and hollering that the crazy guy showed her his penis. Resident #2 identified resident #1 as the resident who had showed his penis to her. The note included that resident #1 was immediately placed on one to one observation with staff, and that resident #2 had been walked up and down the hallway screaming for the entire shift. -Resident #1 was admitted on (MONTH) 7, 2019 with [DIAGNOSES REDACTED]. An admission MDS (Minimum Data Set Assessment) dated (MONTH) 14, 2019 included that resident #1 had a BIMS (Brief Interview for Mental Status) score of 3 which indicated that the resident had severely impaired cognition. The assessment included that resident #1 was ambulatory with supervision, had delusions that put him at risk for illness or injury and interfered with his care and participation in social interactions. The assessment included that the resident was intrusive to others and that his behavior significantly disrupts the living environment. A psychiatric progress note dated (MONTH) 26, 2019 included that staff reported resident #1 had been hypersexual. The note included that resident #1 had been pulling out his penis in public, urinating outside in front of others, propositioning female staff and residents to engage in sexual activity with him, and going into female resident's rooms and staring at them while they sleep. The note included that the resident continued to exhibit these behaviors despite repeated redirection from staff members, and that his [MEDICAL CONDITION] have been more frequent and severe. The note included that medications had been reviewed and changes made to the resident's psychoactive medications. Review of records did not reveal any documented evidence that staff reports that the resident had had been pulling out his penis in public, and propositioning female residents to engage in sexual activity with him had been reported by staff or investigated by the facility. A behavioral progress note dated (MONTH) 12, 2019 for the P.M. shift included that resident #1 had been pacing in the hallway with his hands in his pants, and had asked a female resident for some pussy. Review of records did not reveal any additional information that the incident on (MONTH) 12, 2019 had been reported by staff or investigated by the facility. A behavioral progress note dated (MONTH) 16, 2019 at 11:00 a.m. included that resident #1 was harassing all of the residents, walked up to a resident and pulled down his pants and exposed himself right next to a resident. The note included that resident #1 pulled his pants down a total of 3 times, stole food from another resident, and that he was getting uncomfortably close to many residents. The note also included he did not listen to any of us which included CNA's (Certified Nursing Assistants) and a nurse. Continued review of records (including the State Agency base) did not reveal any documented evidence that the sexual abuse of multiple residents described in the behavioral note was reported immediately or within 2 hours to the DON (Director of Nursing), or the Administrator, to the State Agency, to law enforcement or to any required agency, and there was no evidence that the sexual abuse abuse of multiple residents on (MONTH) 16, 2019 was investigated by the facility. A health status note dated (MONTH) 21, 2019 at 9:01 p.m. included that resident #1 had made several sexual attempts towards other female residents, and that the resident had exposed his private parts five times to other residents and staff. The note included that the resident needed close monitoring around other resident's. Continued review of the records did not reveal any additional documented evidence that the sexual abuse of multiple residents described in the behavioral note was reported immediately or within 2 hours to the DON (Director of Nursing), or the Administrator, to the State Agency, to law enforcement or to any required agency. A health status note dated (MONTH) 23, 2019 at 9:49 p.m. included that at approximately 3:00 p.m. a resident (#2) had approached the nurses station and stated that another resident had exposed his penis to her. Resident #2 identified as the resident #1 who had exposed himself to her. Resident #1 was immediately placed on 1:1 supervision, and facility management was notified. Review of two investigative reports dated (MONTH) 25, 2019 included the following information: -During a clinical review on (MONTH) 22, 2019 a nurses progress note was found dated (MONTH) 21, 2019 at 9:00 p.m. that resident #1 had made sexual acts towards peers and flashed his private parts five times to staff and peers. An investigation was conducted, and the State Agency, Law enforcement and other entities were notified on (MONTH) 22, 2019. Education was provided to staff regarding the protocols for types of abuse, and responsibilities of timely reporting of abuse incidents. -On (MONTH) 23, 2019 at 3:30 p.m. resident #1 and #2 were outside on the patio area. A CNA was monitoring the patio entrance to the hallway, and the CNA was watching resident #2 when she started screaming. The CNA entered the patio and saw resident #1 with his pants open. Resident #2 entered the hallway and reported that she had seen the private areas of resident #1 to the nurse. An interview was conducted on (MONTH) 1, 2019 at 2:14 p.m. with an RN (Registered Nurse/staff #93). He stated that he was the nurse on the afternoon shift on (MONTH) 21, 2019 and that resident #1 pulled his pants down and exposed himself to a male peer in a wheelchair, and walked around the dining room repeatedly exposing himself to peers making statements the he wanted someone to lick or suck on his penis, and that he pulled his penis out of his pants and showed it to other residents. The RN stated that it was his first day on the job, and although he had been provided abuse prevention training during orientation prior to his first day, he did not know what he was supposed to do, and he did not notify anyone. During an interview with the Administrator/staff #185 conducted on (MONTH) 1, 2019 at 2:45 p.m. she stated that the note describing the behavior of resident #1 on (MONTH) 21, 2019 was discovered the next day during the morning meeting, and that it was investigated and reported on (MONTH) 22, 2019. An interview was conducted on (MONTH) 1, 2019 at 3:00 p.m. with an LPN (Licensed Practical Nurse/staff #117). She stated that on (MONTH) 23, 2019 she was at the nurses station on the Sedona Unit and resident #2 came running up to the nurses station screaming in the hallway he pulled it out. She described that resident #2 was very agitated and that a CNA (staff #85) had witnessed resident #1 pull his penis out and show it to resident #2. She stated that resident #2 remained upset for the remainder of the afternoon shift. An interview was conducted on (MONTH) 1, 2019 at 3:30 with CNA/staff #85. She described that on (MONTH) 23, 2019 resident #2

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F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) was on the patio and began screaming. She stated that when she looked behind the door of the patio, resident #1 was definitely hiding behind the door, and that he was purposefully showing his penis to resident #2. An interview was conducted on (MONTH) 2, 2019 at 8:50 a.m. with the ADON (Assistant Director of Nursing/staff #98) she stated that the RN/staff #93 should have reported that resident #1 had pulled his pants down and exposed himself repeatedly to multiple peers and made sexual statements to them on (MONTH) 21, 2019 immediately to the DON (Director of Nursing) or the Administrator. She stated that staff are supposed to report any allegations abuse including sexual abuse immediately to the DON (Director of Nursing) or the Administrator and that all of the staff have been educated on the reporting requirements. She stated that if staff cannot reach the DON or the Administrator by phone, they must make the notifications themselves (including to law enforcement). Review of a policy and procedure titled Abuse Prohibition and Prevention included a policy statement that the facility prevents abuse and exploitation of residents, each resident has the right to be free from mental/emotional, verbal, and sexual (abuse), and residents must not be subjected to abuse by anyone including other residents. The policy also included the following: -The supervisor shall immediately intervene, correct and report identified situations where abuse is at risk for occurring, and ongoing resident assessments and care planning for appropriate interventions are performed to monitor resident needs and address behaviors such as verbally aggressive behavior such as intimidating, sexually aggressive behavior such as saying sexual things, and inappropriate touching. -Facility staff are able to identify the different types of abuse (including) mental/verbal, and sexual abuse. Occurrences, patterns and trends will be assessed by Administrative staff, licensed staff, interdisciplinary team to determine the corrective action based on the results of the investigation. -All employees will be oriented to their role in abuse prevention as mandated reporters and that abuse will not be tolerated in this facility. Facility staff are Mandatory Reporters and all mandated reporters will report reasonable suspicion of a crime against a resident when it is objectively reasonable for a person to entertain a suspicion of conduct that appears to be treatment resulting in mental suffering. -Examples of crimes that would be reported include but are not limited to assault, and sexual abuse. The facility will report allegations of abuse even if there is no reasonable suspicion immediately-no later than 2 hours-for all abuse (actual, alleged or potential) to law enforcement, the State Survey Agency, the Ombudsman, and APS. -All incidents of suspected abuse or alleged abuse will be promptly investigated by the assigned staff, who will be informed of the nature of the incident and continue the investigation process. Occurrences, patterns and trends will be assessed by Administrative staff, licensed staff, Interdisciplinary Team to determine the corrective action based on the results of the investigation
F 0608 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement policies and procedures to ensure (1) employees report any suspicion of a crime against any resident, according to timelines; (2) post the notice of employee rights; and (3) prohibit and prevent retaliation for reporting.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on clinical record review, staff interviews, facility documentation, and review of policies and procedures, the facility failed to report a reasonable suspicion of a crime on multiple occasions to law enforcement regarding verbal, mental and sexual abuse abuse of residents on the Sedona Unit by one resident (#1). The sample size was one resident. Findings include: Resident #1 was admitted on (MONTH) 7, 2019 with [DIAGNOSES REDACTED]. An admission MDS (Minimum Data Set Assessment) dated (MONTH) 14, 2019 included that resident #1 had a BIMS (Brief Interview for Mental Status) score of 3 which indicated that the resident had severely impaired cognition. The assessment included that resident #1 was ambulatory with supervision, had delusions that put him at risk for illness or injury and interfered with his care and participation in social interactions. The assessment included that the resident was intrusive to others and that his behavior significantly disrupts the living environment. A psychiatric progress note dated (MONTH) 26, 2019 included that staff reported resident #1 had been hypersexual. The note included that resident #1 had been pulling out his penis in public, urinating outside in front of others, propositioning female staff and residents to engage in sexual activity with him, and going into female resident's rooms and staring at them while they sleep. The note included that the resident continued to exhibit these behaviors despite repeated redirection from staff members, and that his [MEDICAL CONDITION] have been more frequent and severe. The note included that medications had been reviewed and changes made to the resident's psychoactive medications. Review of records did not reveal any documented evidence that staff reports that the resident had had been pulling out his penis in public, and propositioning female residents to engage in sexual activity with him had been reported to law enforcement. A behavioral progress note dated (MONTH) 12, 2019 for the P.M. shift included that resident #1 had been pacing in the hallway with his hands in his pants, and had asked a female resident for some pussy. Review of the clinical record did not reveal any additional information regarding the female peer, or if staff had intervened or reported the incident to law enforcement. A behavioral progress note dated (MONTH) 16, 2019 at 11:00 a.m. included that resident #1 was harassing all of the residents, walked up to a resident and pulled down his pants and exposed himself right next to a resident. The note included that resident #1 pulled his pants down a total of 3 times, stole food from another resident, and that he was getting uncomfortably close to many residents. The note also included he did not listen to any of us which included CNA's (Certified Nursing Assistants) and a nurse. Continued review of records (including the State Agency data base) did not reveal any documented evidence that the sexual abuse of multiple residents described in the behavioral note on (MONTH) 16, 2019 was reported to law enforcement . A health status note dated (MONTH) 21, 2019 at 9:01 p.m. included that resident #1 had made several sexual attempts towards other female residents, and that the resident had exposed his private parts five times to other residents and staff. The note included that the resident needed close monitoring around other resident's. Continued review of the clinical record did not reveal any additional documented information that that the sexual abuse of multiple residents described in the behavioral note on (MONTH) 21, 2019 was reported to law enforcement. Review of two investigative reports dated (MONTH) 25, 2019 included that during a clinical review on (MONTH) 22, 2019 a nurses progress note was found dated (MONTH) 21, 2019 at 9:00 p.m. that resident #1 had made sexual acts towards peers and flashed his private parts five times to staff and peers. The investigation was started and the Phoenix Police were notified on (MONTH) 22, 2019 of that incident. An interview was conducted on (MONTH) 1, 2019 at 2;14 p.m. with an RN (Registered Nurse/staff #93). He stated that he was the nurse on the afternoon shift on (MONTH) 21, 2019 and that resident #1 pulled his pants down and exposed himself to a male peer in a wheelchair, and walked around the dining room repeatedly exposing himself to peers making statements the he wanted someone to lick or suck on his penis, and that he pulled his penis out of his pants and showed it to other residents. The RN stated that it was his first day on the job, and although he had been provided abuse prevention training during orientation prior to his first day, he did not know what he was supposed to do, and he did not notify anyone. During an interview with the Administrator/staff #185 conducted on (MONTH) 1, 2019 at 2:45 p.m. she stated that the note describing the behavior of resident #1 on (MONTH) 21, 2019 was discovered the next day during the morning meeting, and that it was investigated and the police were notified at that time. During an interview conducted on (MONTH) 1, 2019 at 3:10 p.m. with the DSD (Director of Staff Development/staff #66) she stated that new hire staff are provided orientation prior to their first day working with residents that includes definitions of abuse, and to report all abuse allegations within 2 hours to the state Agency, Ombudsman, APS and the Administrator. She stated that is the facility policy. An interview was conducted on (MONTH) 2, 2019 at 8:50 a.m. with the ADON (Assistant Director of Nursing/staff #98) she stated that staff are to immediately report any allegations of abuse including sexual abuse immediately to the DON

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035125	A. BUILDING _____ B. WING _____	**05/02/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIDGECREST HEALTHCARE	**16640 NORTH 38TH STREET PHOENIX, AZ 85032**

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 0608 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) (Director of Nursing) or the Administrator and that all of the staff have been educated on the reporting requirements. She stated that if staff cannot reach the DON or the Administrator by phone, they must make the notifications themselves (including to law enforcement). Review of a policy and procedure titled Abuse Prohibition and Prevention included a policy statement that the facility prevents abuse and exploitation of residents, each resident has the right to be free from mental/emotional, verbal, and sexual (abuse), and residents must not be subjected to abuse by anyone including other residents. The supervisor shall immediately intervene, correct and report identified situations where abuse is at risk for occurring. All employees will be oriented to their role in abuse prevention as mandated reporters and that abuse will not be tolerated in this facility. Facility staff are Mandatory Reporters and all mandated reporters will report reasonable suspicion of a crime against a resident when it is objectively reasonable for a person to entertain a suspicion of conduct that appears to be treatment resulting in mental suffering. Examples of crimes that would be reported include but are not limited to assault, and sexual abuse. The facility will report allegations of abuse even if there is no reasonable suspicion immediately-no later than 2 hours-for all abuse (actual, alleged or potential) to law enforcement.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 clinical record review, staff interviews, facility documentation, and review of policies and procedures, the facility failed to report all alleged violations involving abuse not later than 2 hours after the allegation is made, by failing to report multiple allegations of verbal, mental and sexual abuse abuse of multiple residents on the Sedona Unit by one resident (#1) to the Administrator, the State Agency and APS (Adult Protective Services) within 2 hours. The sample size was one resident. Findings include: Resident #1 was admitted on (MONTH) 7, 2019 with [DIAGNOSES REDACTED]. An admission MDS (Minimum Data Set Assessment) dated (MONTH) 14, 2019 included that resident #1 had a BIMS (Brief Interview for Mental Status) score of 3 which indicated that the resident had severely impaired cognition. The assessment included that resident #1 was ambulatory with supervision, had delusions that put him at risk for illness or injury and interfered with his care and participation in social interactions. The assessment included that the resident was intrusive to others and that his behavior significantly disrupts the living environment. A psychiatric progress note dated (MONTH) 26, 2019 included that staff reported resident #1 had been hypersexual. The note included that resident #1 had been pulling out his penis in public, urinating outside in front of others, propositioning female staff and residents to engage in sexual activity with him, and going into female resident's rooms and staring at them while they sleep. The note included that the resident continued to exhibit these behaviors despite repeated redirection from staff members, and that his [MEDICAL CONDITION] have been more frequent and severe. The note included that medications had been reviewed and changes made to the resident's psychoactive medications. Review of records did not reveal any documented evidence that staff reports that the resident had had been pulling out his penis in public, and propositioning female residents to engage in sexual activity with him had been reported to the Administrator, the State Agency or APS. A behavioral progress note dated (MONTH) 12, 2019 for the P.M. shift included that resident #1 had been pacing in the hallway with his hands in his pants, and had asked a female resident for some pussy. Review of the clinical record did not reveal any additional information regarding the female peer, or if staff had intervened or reported the incident to to the Administrator, the State Agency or APS. A behavioral progress note dated (MONTH) 16, 2019 at 11:00 a.m. included that resident #1 was harassing all of the residents, walked up to a resident and pulled down his pants and exposed himself right next to a resident. The note included that resident #1 pulled his pants down a total of 3 times, stole food from another resident, and that he was getting uncomfortably close to many residents. The note also included he did not listen to any of us which included CNA's (Certified Nursing Assistants) and a nurse. Continued review of records (including the State Agency data base) did not reveal any documented evidence that the sexual abuse of multiple residents described in the behavioral note on (MONTH) 16, 2019 was reported to to the Administrator, the State Agency or APS. A health status note dated (MONTH) 21, 2019 at 9:01 p.m. included that resident #1 had made several sexual attempts towards other female residents, and that the resident had exposed his private parts five times to other residents and staff. The note included that the resident needed close monitoring around other resident's. Continued review of the clinical record did not reveal any additional documented information that that the sexual abuse of multiple residents described in the behavioral note on (MONTH) 21, 2019 was reported to to the Administrator, the State Agency or APS. Review of two investigative reports dated (MONTH) 25, 2019 included that during a clinical review on (MONTH) 22, 2019 a nurses progress note was found dated (MONTH) 21, 2019 at 9:00 p.m. that resident #1 had made sexual acts towards peers and flashed his private parts five times to staff and peers. The investigation was started and the Phoenix Police were notified on (MONTH) 22, 2019 of that incident. An interview was conducted on (MONTH) 1, 2019 at 2;14 p.m. with an RN (Registered Nurse/staff #93). He stated that he was the nurse on the afternoon shift on (MONTH) 21, 2019 and that resident #1 pulled his pants down and exposed himself to a male peer in a wheelchair, and walked around the dining room repeatedly exposing himself to peers making statements the he wanted someone to lick or suck on his penis, and that he pulled his penis out of his pants and showed it to other residents. The RN stated that it was his first day on the job, and although he had been provided abuse prevention training during orientation prior to his first day, he did not know what he was supposed to do, and he did not notify anyone. During an interview with the Administrator/staff #185 conducted on (MONTH) 1, 2019 at 2:45 p.m. she stated that the note describing the behavior of resident #1 on (MONTH) 21, 2019 was discovered the next day during the morning meeting, and that it was investigated and notifications were made at that time. During an interview conducted on (MONTH) 1, 2019 at 3:10 p.m. with the DSD (Director of Staff Development/staff #66) she stated that new hire staff are provided orientation prior to their first day working with residents that includes definitions of abuse, and to report all abuse allegations within 2 hours to the state Agency, Ombudsman, APS and the Administrator. She stated that is the facility policy. An interview was conducted on (MONTH) 2, 2019 at 8:50 a.m. with the ADON (Assistant Director of Nursing/staff #98) she stated that staff are to immediately report any allegations of abuse including sexual abuse immediately to the DON (Director of Nursing) or the Administrator and that all of the staff have been educated on the reporting requirements. She stated that if staff cannot reach the DON or the Administrator by phone, they must make the notifications themselves (including to the State Agency and APS). Review of a policy and procedure titled Abuse Prohibition and Prevention included a policy statement that the facility prevents abuse and exploitation of residents, each resident has the right to be free from mental/emotional, verbal, and sexual (abuse), and residents must not be subjected to abuse by anyone including other residents. The supervisor shall immediately intervene, correct and report identified situations where abuse is at risk for occurring. All employees will be oriented to their role in abuse prevention as mandated reporters and that abuse will not be tolerated in this facility. Facility staff are Mandatory Reporters and all mandated reporters will report reasonable suspicion of a crime against a resident when it is objectively reasonable for a person to entertain a suspicion of conduct that appears to be treatment resulting in mental suffering. Examples of crimes that would be reported include but are not limited to assault, and sexual abuse. The facility will report allegations of abuse even if there is no reasonable suspicion immediately-no later than 2 hours-for all abuse (actual, alleged or potential) to the State Survey Agency, the Ombudsman, and APS.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** >

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035125	A. BUILDING _____ B. WING _____	**05/02/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIDGECREST HEALTHCARE	**16640 NORTH 38TH STREET PHOENIX, AZ 85032**

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 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 5) Based on clinical record review, facility documentation, staff interviews, and review of policies and procedures, the facility failed to investigate an allegation of mental, verbal and sexual abuse that involved multiple residents on the Sedona Unit by one resident (#1). The sample size was one resident. Findings include: Resident #1 was admitted on (MONTH) 7, 2019 with [DIAGNOSES REDACTED]. An admission MDS (Minimum Data Set Assessment) dated (MONTH) 14, 2019 included that resident #1 had a BIMS (Brief Interview for Mental Status) score of 3 which indicated that the resident had severely impaired cognition. The assessment included that resident #1 was ambulatory with supervision, had delusions that put him at risk for illness or injury and interfered with his care and participation in social interactions. The assessment included that the resident was intrusive to others and that his behavior significantly disrupts the living environment. A psychiatric progress note dated (MONTH) 26, 2019 included that staff reported resident #1 had been hypersexual. The note included that resident #1 had been pulling out his penis in public, urinating outside in front of others, propositioning female staff and residents to engage in sexual activity with him, and going into female resident's rooms and staring at them while they sleep. The note included that the resident continued to exhibit these behaviors despite repeated redirection from staff members, and that his [MEDICAL CONDITION] have been more frequent and severe. The note included that medications had been reviewed and changes made to the resident's psychoactive medications. Review of records did not reveal any documented evidence that staff reports that the resident had had been pulling out his penis in public, and propositioning female residents to engage in sexual activity with him had been investigated by the facility. A behavioral progress note dated (MONTH) 12, 2019 for the P.M. shift included that resident #1 had been pacing in the hallway with his hands in his pants, and had asked a female resident for some pussy. Review of records did not reveal any additional information that the incident on (MONTH) 12, 2019 had been investigated by the facility. Review of a policy and procedure titled Abuse Prohibition and Prevention included a policy statement that the facility prevents abuse and exploitation of residents, each resident has the right to be free from mental/emotional, verbal, and sexual (abuse), and residents must not be subjected to abuse by anyone including other residents. The supervisor shall immediately intervene, correct and report identified situations where abuse is at risk for occurring. Facility staff are able to identify the different types of abuse-mental/verbal abuse and sexual abuse. All incidents of suspected abuse or alleged abuse will be promptly investigated by the assigned staff, who will be informed of the nature of the incident and continue the investigation process. Occurrences, patterns and trends will be assessed by Administrative staff, licensed staff, Interdisciplinary Team to determine the corrective action based on the results of the investigation.