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 _____	11/07/2019

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** - 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, facility documentation, staff and resident interviews and policies and procedures, the facility failed to ensure that three out of five sampled residents (#16, #38 and #358) were free from physical abuse. The deficient practice could result in further abuse of residents. Findings include: -Resident #38 was admitted to the facility on (MONTH) 27, 2008, with [DIAGNOSES REDACTED]. Review of the clinical record revealed that resident #38 resided on a high acuity secured behavioral unit. A significant change Minimum Data Set (MDS) assessment dated (MONTH) 15, 2019, revealed a BIMS score of 11, which indicated the resident had moderate cognitive impairment. The MDS also included the resident was independent with transfers and required supervision with bed mobility, walking on the unit and eating. A behavioral care plan updated on (MONTH) 15, 2019 included the resident had disruptive behaviors related to [MEDICAL CONDITION], with a goal that the resident would have one or fewer episodes of disruptive behavior per week through the review period. De-escalation techniques included to eliminate environmental stressors and maintain a low stimulation environment in his room. An intervention included the resident had an assigned seat in the common room to watch television, as a television in his room had created behavioral disturbances in the past. A care plan revised on (MONTH) 20, 2019 included the resident had a history of [REDACTED]. A goal was that the resident would have no injury to self or others. Interventions were to report changes in behavior to the provider and to follow the behavioral care plan interventions. According to two nursing progress notes dated (MONTH) 22, 2019, resident #38 was hit on the back of the head by resident #16, and he denied pain or discomfort. Review of the nurse aide behavioral monitoring dated (MONTH) 22, 2019 revealed that resident #38 was in the day room watching TV, when resident #16 passed by and hit him on the back of the head. The note included that resident #38 responded by hitting resident #16 in the face, before the nurse aide could get to them. -Resident #16 was admitted to the facility on (MONTH) 15, 2006, with [DIAGNOSES REDACTED]. Review of the clinical record revealed that resident #16 resided on a high acuity secured behavioral unit. A care plan included the resident had the potential to demonstrate physical behaviors towards staff and peers related to poor impulse control, with a goal that the resident would demonstrate effective coping skills through the review date. Interventions included to anticipate the resident's needs and to keep the resident a significant distance from peers that were known to cause him to become upset. A quarterly MDS assessment dated (MONTH) 28, 2019, revealed a BIMS score of 12, which indicated the resident had moderate cognitive impairment. The MDS also included the resident required supervision with transfers, bed mobility, walking on the unit and eating. A behavioral care plan updated (MONTH) 13, 2019 included the resident had behaviors of aggression towards peers and staff, and would exhibit minimal behavior change or change in affect, prior to acting out. De-escalation techniques included eliminating environmental stressors and/or triggers to agitation and maintaining a homelike, low stimulation environment in his room. An intervention included to allow the resident the option to return to his room to de-escalate, if triggered in the common area by another resident. A nursing note dated (MONTH) 22, 2019 included that resident #16 was observed hitting resident #38 while walking by him in the day room. The resident denied pain or discomfort at that time. Review of the facility's investigative documentation dated (MONTH) 27, 2019 revealed that on (MONTH) 22, 2019 at approximately 6:35 p.m., resident #38 and #16 were in the day room when resident #38 told resident #16 to f*** off. Resident #16 then walked across the day room and hit resident #38 in the back of the head. Resident #38 stood up and the residents were face to face, when staff reached them. A witness statement written by a Certified Nursing Assistant (CNA/staff #52) was included in the report, which stated that both residents were saying, he hit me. The residents were separated, no injuries were noted, both residents were placed on fifteen minute checks and resident #16 received one-on-one supervision, while in the day room. The report included that the allegation of abuse against resident #16 was substantiated.An interview was conducted with a Licensed Practical Nurse (LPN/staff #19) on (MONTH) 5, 2019 at 2:27 p.m. She said she was the nurse on duty at the time of the incident. She said resident #16 and #38 were seated in the day room. She said resident #38 was doing some type of behavior that was irritating resident #16. She said resident #16 said something like stop and resident #38 said something like f*** off. She said resident #16 got up like he was walking to his room and as he passed resident #38, he hit him on the head. She said staff immediately helped resident #16 to his room, then they checked resident #38 and he was fine. She said the two residents stayed separated all evening. She said just as quickly as it started, it stopped and there had been no animosity between the residents the next day or since. An interview was conducted with a Certified Nursing Assistant (CNA/staff #52) on (MONTH) 6, 2019 at 8:41 a.m. She said she remembered that resident #16 hit resident #38, who then stood up and the residents were face to face. She said she was not sure if resident #38 hit resident #16 back. She said another staff member, CNA (staff #161) got between the residents and they were separated. An interview was conducted with resident #38 on (MONTH) 6, 2019 at 10:48 a.m. He said resident #16 was telling him to be quiet and he told resident #16 f*** off and shut your mouth. He said resident #16 then hit him on the head and he hit resident #16 in the face, while staff were getting between them. He said no other issues happened afterwards. An interview was conducted with the Director of Nursing (DON/staff #187) and the Administrator (staff #186) on (MONTH) 6, 2019 at 1:42 p.m. Staff #186 stated when an allegation of resident to resident abuse is made, staff should make sure the residents are separated and safe. She said the nurse should assess the residents involved. Staff #187 stated all residents involved and all staff on the unit would be interviewed. Staff #186 stated any other staff or residents who might be able to identify what caused the incident would also have an interview attempted. She said witness statements, observations and investigation findings would be reviewed as a team to determine the cause and how to prevent future occurrences. An interview was conducted with a CNA (staff #161) on (MONTH) 6, 2019 at 2:34 p.m. She stated that she was present when the incident occurred between the two residents. She stated resident #16 was agitated with resident #38 and he got up like he was leaving, so she started moving closer to the residents in anticipation of a problem. She said resident #16 hit resident #38 on the head and resident #38 immediately stood up. She said there was a chair between the two and resident #38 tried to hit resident #16 in the face by reaching over the chair. She said he made contact, but it was not very effective. She said

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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 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) by the time resident #38 got around the chair to resident #16, she and other staff had gotten between the residents. She said resident #16 went to his room after the incident. Regarding an incident between resident #16 and resident #358: -Resident #358 was admitted to the facility on (MONTH) 1, 2019, with [DIAGNOSES REDACTED]. Review of the admission MDS assessment dated (MONTH) 8, 2019, revealed a BIMS score of 14, which indicated the resident was cognitively intact. The MDS included the resident required supervision with bed mobility, transfers, walking on the unit and eating. A nursing progress note dated (MONTH) 23, 2019 revealed the resident was sitting at his assigned table for a meal, when a chair was thrown by resident #16 and grazed the resident's (#358) right arm. Per the note, resident #358 said I was just sitting here eating my dinner and the chair hit my pinky. No injuries were noted. -Review of the clinical record for resident #16 revealed a nursing progress note dated (MONTH) 23, 2019, which included that at approximately 5:30 p.m., resident #16 attempted to sit in a chair by resident #38 in the day room/dining room. Staff attempted to redirect resident #16 away from resident #38, but resident #16 walked over to his table, picked it up and threw it, and then picked up his chair and threw it. The chair grazed the arm of resident #358. Resident #16 then went to his room and slammed the door. Review of the facility's investigation report revealed that on (MONTH) 23, 2019 at approximately 5:30 p.m., resident #16 was walking across the day room to take a seat by the window and was redirected by staff back to his seat near the hallway. As he returned back to his seat, he picked up his tray table and threw it. Then he picked up his chair and threw it. He then went into his room and slammed the door. The chair grazed the arm of resident #358. Resident #358 said he was hit by the chair, but it did not hurt. Resident #16 was placed on one to one supervision in the day room and a medication review and labs were ordered. The report included that a CNA (staff #128) was in the dining room picking up dinner trays with other staff members, when the resident threw the table and chair. Review of the facility's daily staff assignment sheet dated (MONTH) 23, 2019, revealed that staff #128 was assigned as the one to one on the unit during the time of the incident. An interview was conducted with the Director of Nursing (DON/staff #187) and the Administrator (staff #186) on (MONTH) 6, 2019 at 1:42 p.m. Staff #186 stated that when an allegation of resident to resident abuse is made, staff should make sure the residents are separated and safe. She stated if a resident who is on one to one supervision became physically aggressive, she would expect interventions such as calling the crisis line and trying medication and behavior stabilization. She said she would also consider moving the resident to a different unit. She said the reason these were not considered for resident #16, such as moving to a different unit or calling the crisis line was because the resident's behavior was an outburst related to a trigger that was identified immediately and not directed toward another resident. An interview was conducted with a CNA (staff #128) on (MONTH) 6, 2019 at 2:38 p.m. She stated she remembered the incident in the dining room. She said resident #16 was not happy about something, then he knocked down his table and picked up his chair and threw it, sort of hitting the resident in front of him. She said after that the nurse and other staff intervened and escorted resident #16 back to his room. She said staff made sure the resident who had been hit was not hurt. Another interview was conducted with the Director of Nursing on (MONTH) 7, 2019 at 8:53 a.m. She said based on the daily staff assignment sheet and the CNA documentation from (MONTH) 23, 2019, staff #128 had been assigned as the one to one for resident #16 during the time of the incident. A follow up interview was conducted with staff #128 on (MONTH) 7, 2019 at 9:28 a.m. She stated she did not remember if resident #16 had one to one supervision at the time. She said she may have been assigned to provide one to one supervision, but she did not recall specifically. She said that when she walked away from the resident, that is when he began to throw things. She said she remembered this because she recalled thinking it was fortunate that she had moved away, because if not she would have been struck. A follow up interview was conducted with the Director of Nursing on (MONTH) 7, 2019 at 9:44 a.m. She stated her expectation is the staff member providing one to one supervision should keep the resident within eyesight at all times and to provide all needed care for the resident. She said the staff member providing one to one supervision should have no other assignments on the unit. She said if the resident was in the dining room, the one to one staff could help with cleaning up meal trays, as long as the resident was still within sight. She said it was not an expectation that the staff member should clean up trays, but it was just natural to want to help other staff. She said her overall expectation for a one to one staff member would be to keep the resident within eyesight and to monitor the resident's mood and behaviors. Review of the facility's Abuse Prohibition and Prevention policy revealed that each resident has the right to be free from abuse, including physical abuse and that residents must not be subjected to abuse by anyone, including other residents. The policy included that staff would be trained to prevent, identify and report allegations of abuse. The facility would ensure that all residents were protected during and after investigations, including separating residents and increasing supervision as needed. The policy further included that all incidents of alleged abuse would be promptly investigated and reported to the appropriate authorities.
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** Based on clinical record reviews, facility documentation, staff interviews and policy review, the facility failed to implement their policy regarding investigating an allegation of abuse involving resident (#16) and resident (38). The sample size was one of five sampled residents. The deficient practice could result in further abuse investigations not being thoroughly completed, resulting in possible causes not being identified and corrective action taken. Findings include: -Resident #16 was admitted to the facility on (MONTH) 15, 2006, with [DIAGNOSES REDACTED]. -Resident #38 was admitted to the facility on (MONTH) 27, 2008, with [DIAGNOSES REDACTED]. Review of the facility's investigative report revealed that on (MONTH) 22, 2019 at approximately 6:35 p.m., resident #38 and #16 were in the day room when resident #38 told resident #16 to f*** off. Resident #16 walked across the day room and hit resident #38 in the back of the head. Resident #38 stood up, and the residents were face to face when staff reached them. A witness statement written by a Certified Nursing Assistant (CNA/staff #52) was included in the report, which stated that both residents were saying he hit me. However, further review of the investigative report revealed no evidence of an investigation into the allegation that resident #38 hit resident #16. Furthermore, the report did not include evidence of an interview or witness statement from one of the staff members who had witnessed the incident (staff #161). The report included that the residents were separated, no injuries were noted, both residents were placed on fifteen minute checks and resident #16 received one-on-one supervision while in the day room. The report further included that the allegation of abuse against resident #16 was substantiated. The report did not include findings regarding an allegation of abuse against resident #38. An interview was conducted with the Director of Nursing (DON/staff #187) and the Administrator (staff #186) on (MONTH) 6, 2019 at 1:42 p.m. Staff #187 stated that when investigating an allegation of abuse, all residents involved and all staff on the unit would be interviewed. Staff #186 stated that to ensure the investigation was thorough, any other staff or residents who might be able to identify what caused the incident would also have an interview attempted. She also said the investigation would consider the environment and try to look at all of the angles. She said witness statements, observations and investigation findings would be reviewed as a team to determine the cause, how to prevent future occurrences, and to ensure the investigation was thorough. Staff #187 said factors such as medication changes, diagnostic lab results and resident behavior cycles would be considered. Staff #186 said this incident occurred prior to her starting work at the facility, and she could only comment on the current process of investigating, which included interviewing all staff on the unit and a daily practice of reading behavior monitoring documentation from the previous day in the morning meetings. An interview was conducted with a CNA (staff #161) on (MONTH) 6, 2019 at 2:34 p.m. She stated she witnessed the incident and she remembered that resident #16 hit resident #38 and resident #38 hit resident #16 back. She said she did not remember writing a witness statement, but she gave her report to the nurse and the nurse had written things down. She said she also thought she had been called and interviewed regarding the incident. Review of the facility's abuse prohibition and prevention policy revealed that the investigation and report would include

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F 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) interviews with the alleged victim, the alleged perpetrator, with any witnesses to the alleged incident, with facility staff members who had contact with the residents during the period of the alleged incident, and a review of all events leading up to the alleged incident. Regarding reporting the allegations, the policy stated the facility would report allegations of abuse to the State Survey Agency even if there was no reasonable suspicion of the allegation.
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 clinical record reviews, facility documentation, staff and resident interviews and policy review, the facility failed to ensure that an allegation of abuse involving two residents (#16 and #38) was thoroughly investigated. The deficient practice could result in inaccurate findings and possible abuse not being identified. Findings include: -Resident #16 was admitted to the facility on (MONTH) 15, 2006, with [DIAGNOSES REDACTED]. Review of the clinical record revealed that resident #16 resided on a high acuity secured behavioral unit. A nursing note dated (MONTH) 22, 2019 revealed that resident #16 was observed hitting resident #38, while walking by him in the day room. Review of the nurse aide behavioral monitoring dated (MONTH) 22, 2019, revealed that resident #16 was going to his normal seat when another resident (#38) suddenly got in his face. The documentation included that resident #16 reported that resident (#38) hit him in the face. -Resident #38 was admitted to the facility on (MONTH) 27, 2008, with [DIAGNOSES REDACTED]. Review of the clinical record revealed that resident #38 resided on a high acuity secured behavioral unit. Review of two nursing progress notes dated (MONTH) 22, 2019, revealed that resident #38 was hit on the back of the head by another resident (#16) and he denied pain. Review of the nurse aide behavioral monitoring dated (MONTH) 22, 2019, revealed that resident #38 was in the day room watching TV, when another resident (#16) passed by and hit him on the back of the head. The note included that resident #38 responded by hitting resident #16 in the face before the nurse aide could get to them. Review of the facility's investigative report dated (MONTH) 27, 2019, revealed that on (MONTH) 22, 2019 at approximately 6:35 p.m., resident #38 and #16 were in the day room when resident #38 told resident #16 to f*** off. Resident #16 walked across the day room and hit resident #38 in the back of the head. Resident #38 stood up and the residents were face to face, when staff reached them. A witness statement written by a Certified Nursing Assistant (CNA/staff #52) was included in the report, which included that both residents were saying he hit me. However, further review of the investigative report revealed no evidence of an investigation into the allegation that resident #38 hit resident #16 on the back. Furthermore, the report did not include evidence of an interview or witness statement from one of the staff members who had witnessed the incident (staff #161), and the report did not include evidence that the nurse aide behavioral monitoring documentation had been reviewed, as part of the investigation. The report further revealed that the residents were separated, no injuries were noted, both residents were placed on fifteen minute checks and resident #16 received one-on-one supervision, while in the day room. Per the report, the allegation of abuse against resident #16 was substantiated. The report did not include findings regarding an allegation of abuse against resident #38. An interview was conducted with a Licensed Practical Nurse (LPN/staff #19) on (MONTH) 5, 2019 at 2:27 p.m. She said she was the nurse on duty at the time of the incident. She said residents #16 and #38 were seated in the day room. She said resident #38 was doing some type of behavior that was irritating resident #16. She said resident #16 said something like stop, and resident #38 said something like f*** off. She said resident #16 got up and as he passed resident #38, he hit him on the head. She said staff immediately assisted resident #16 to his room. She stated that resident #38 was checked and he was fine. An interview was conducted with a CNA (staff #52) on (MONTH) 6, 2019 at 8:41 a.m. She said that resident #16 hit resident #38, who then stood up and the residents got face to face. She said she was not sure if resident #38 hit resident #16 back. She said another staff member (staff #161) got between the residents and they were separated. An interview was conducted with resident #38 on (MONTH) 6, 2019 at 10:48 a.m. He said resident #16 was telling him to be quiet and he told resident #16 f*** off and shut your mouth. He said resident #16 hit him on the head and then he hit resident #16 on the face, while staff were getting between them. An interview was conducted with the Director of Nursing (DON/staff #187) and the Administrator (staff #186) on (MONTH) 6, 2019 at 1:42 p.m. Staff #187 stated that when investigating an allegation of abuse, all residents involved and all staff on the unit would be interviewed. Staff #186 stated that to ensure the investigation was thorough, any other staff or residents who might be able to identify what caused the incident would also have an interview attempted. She further said the investigation would consider the environment and try to look at all of the angles. She said witness statements, observations and investigation findings would be reviewed as a team to determine the cause, how to prevent future occurrences, and to ensure the investigation was thorough. Staff #187 said factors such as medication changes, diagnostic lab results and resident behavior cycles would be considered. Staff #186 said this incident occurred prior to her working at the facility, and she could only comment on the current process for investigating, which included interviewing all staff on the unit and a daily practice of reading behavior monitoring documentation from the previous day in the morning meetings.An interview was conducted with a CNA (staff #161) on (MONTH) 6, 2019 at 2:34 p.m. She stated she was present when the incident occurred between the two residents. She stated resident #16 was agitated with resident #38. She said resident #16 got up like he was leaving, so she started moving closer to the residents in anticipation of a problem. She said resident #16 then hit resident #38 on the head and resident #38 immediately stood up. She said there was a chair between the two, and resident #38 tried to hit resident #16 in the face by reaching over the chair. She said he made contact, but it was not very effective. She said by the time resident #38 got around the chair to resident #16, she and other staff had gotten between the residents. She said that she did not remember writing a witness statement, but she gave her report to the nurse and the nurse had written things down. She said she also thought she had been called and interviewed regarding the incident.Review of the facility's Abuse Prohibition and Prevention policy revealed that each resident has the right to be free from abuse, including from other residents. Regarding investigations of allegations of abuse, the policy included that the investigation and report would include interviews with the alleged victim, the alleged perpetrator, with any witnesses to the alleged incident, with facility staff members who had contact with the residents during the period of the alleged incident, and a review of all events leading up to the alleged incident. The policy included that all incidents of alleged abuse would be promptly investigated and reported to the appropriate authorities and that the investigation report would document the findings of the investigation.
F 0641 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews, review of the Resident Assessment Instrument (RAI) manual, and policy and procedures, the facility failed to ensure the Minimum Data Set (MDS) assessments for two residents (#55 and #408) accurately reflected their status. Findings include: -Resident #55 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of an annual MDS assessment dated [DATE], revealed that resident #55 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated severe cognitive impairment. The MDS also included that the resident does not smoke. However, review of the clinical record revealed smoking assessments dated 1/29/18, 7/29/18, 12/22/2018, 3/22/2019 and 6/22/2019, which included that resident #55 smokes. Resident #55 was unable to be interviewed, due to severe cognitive impairment. During an interview with the MDS Coordinator (staff #60) on 11/5/19 at 8:44 a.m., she stated the resident has never smoked. However, she reviewed the smoking assessments and confirmed that the MDS dated [DATE] was inaccurate, as the resident did smoke. -Resident #408 was admitted on (MONTH) 2, 2019 with [DIAGNOSES REDACTED]. A MDS Entry Tracking Record dated (MONTH) 2, 2019 included that resident #408 had been admitted from an acute hospital. A Skilled Evaluation dated (MONTH) 2, 2019 included that resident #408 was readmitted with multiple skin wounds, including

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F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) an open area to the left ischium. A written Care Plan initiated on (MONTH) 3, 2019 included a focus that the resident has a DTI (Deep Tissue Injury) to the left ischium. The goals included that the DTI on the left ischium would show signs of healing and there would be no complications. A Skin/Wound Note dated (MONTH) 5, 2019 revealed the resident was a new admission and had been admitted with a DTI to the Left Ischium. A Discharge Return Anticipated MDS assessment dated (MONTH) 8, 2019, included the resident had been discharged to an acute hospital. The assessment included in Section M (Skin Conditions) that the resident was coded with a 0 for Unstageable-Deep tissue: suspected deep tissue injury in evolution. A MDS Entry Tracking Record dated (MONTH) 16, 2019 included that resident #408 had been readmitted from an acute hospital. An Assessment Summary dated (MONTH) 16, 2019 included the resident had been readmitted with multiple skin wounds, including an open area to the left ischium. A Skin/Wound Note dated (MONTH) 17, 2019 revealed the resident was readmitted and continued to have a healing open DTI to his left ischium. A Discharge Return Anticipated MDS assessment dated (MONTH) 20, 2019 included the resident had been discharged to an acute hospital. The assessment included in Section M (Skin Conditions) that the resident was coded with a 0 for Unstageable-Deep tissue: suspected deep tissue injury in evolution. During an interview conducted on (MONTH) 5, 2019 at 1:57 p.m. with the MDS Coordinator (staff #60), she stated that she collects information for the MDS assessments from multiple sources including nursing notes, wound assessments and skin wound notes. Staff #60 stated the DTI was mentioned in the nursing assessments and should have been included in the discharge MDS assessments on (MONTH) 8, and (MONTH) 20, 2019. Review of a policy titled, Resident Assessment Instrument (RAI/MDS) revealed the Resident Assessment instrument will be completed timely and accurately per Federal Guidelines, and will serve as a foundation for the comprehensive care planning process.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation and staff interviews, the facility failed to ensure that adequate supervision was provided to one resident (#16) with physically aggressive behaviors, regarding an incident involving another resident (#358). The deficient practice could result in further incidents and possibly resulting in injury to residents. Findings include: -Resident #358 was admitted to the facility on (MONTH) 1, 2019, with [DIAGNOSES REDACTED]. Review of the admission Minimum Data Set (MDS) assessment dated (MONTH) 8, 2019, revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. A nursing progress note dated (MONTH) 23, 2019, revealed resident #358 was sitting at his assigned table for a meal and that a chair thrown by another resident (#16) grazed the resident's right arm. Per the note, the resident said I was just sitting here eating my dinner and the chair hit my pinky. No injuries were noted. -Resident #16 was admitted to the facility on (MONTH) 15, 2006, with [DIAGNOSES REDACTED]. Review of the clinical record revealed that resident #16 resided on a high acuity secured behavioral unit. A care plan included the resident had the potential to demonstrate physical behaviors towards staff and peers related to poor impulse control, with a goal that the resident would demonstrate effective coping skills through the review date. Interventions included to anticipate the resident's needs and to keep the resident a significant distance from peers that were known to cause him to become upset. Review of a quarterly MDS assessment dated (MONTH) 28, 2019, revealed a BIMS score of 12, which indicated the resident had moderate cognitive impairment. The MDS also included the resident required supervision with transfers, bed mobility, walking on the unit and eating. A behavioral care plan updated (MONTH) 13, 2019, included the resident had behaviors of aggression towards peers and staff, and the resident would exhibit minimal behavior change or change in affect, prior to acting out. Behavioral triggers included vague responses to questions and not understanding unit guidelines. De-escalation techniques included eliminating environmental stressors and/or triggers to agitation, and maintaining a homelike, low stimulation environment in his room. Interventions included the resident may only respond positively to unit structure or guidelines if he was able to understand the reason for the guideline and tolerate any delay in getting his needs met, provide clear, concrete answers to questions and use positive phrasing to prevent the resident from interpreting responses as overly restrictive. Review of a facility's incident report revealed that resident #16 hit another resident (not resident #358) on the head on (MONTH) 22, 2019 at approximately 6:35 p.m. The report included that resident #16 was placed on one to one supervision, while in the day room and fifteen minute safety checks while in his room. The report did not indicate the duration of the one to one supervision or the fifteen minute safety checks. Review of the facility's daily staff assignment sheets revealed they did not include that a staff member was assigned for one to one supervision on (MONTH) 22 starting at 10:00 p.m. to 6:00 a.m. on (MONTH) 23. One staff member was assigned to provide one to one supervision on the unit for the 6:00 a.m. to 2:30 p.m. shift on (MONTH) 23, and another staff member was assigned for one to one supervision on the 2:00 p.m. to 10:30 p.m. shift. However, the assignment sheets did not include the name of the resident associated with the one to one supervision, nor did they include specific details regarding the level of supervision to be provided, such as one to one supervision or visual supervision. Review of the nurse aide behavioral monitoring for the 10:00 p.m. to 6:00 a.m. shift on (MONTH) 22, 2019, revealed that resident #16 slept throughout the night and was only up to use the bathroom. Review of the documentation for fifteen minute safety checks for resident #16 revealed safety checks were done every fifteen minutes on (MONTH) 22, 2019, except for the period between 2:00 p.m. through 5:15 p.m. There was also a page of safety checks following the page dated (MONTH) 22, 2019, which documented that safety checks were done every 15 minutes for an entire day, however the page was not dated. A nursing progress note dated (MONTH) 23, 2019, revealed that at approximately 5:30 p.m., resident #16 attempted to sit in a chair by another resident (not resident #358) in the day room/dining room. Staff attempted to redirect resident #16 away from the other resident, but resident #16 walked over to his table, picked it up, threw it, then picked up his chair and threw it. The chair grazed the arm of resident #358. Resident #16 then went into his room and slammed the door. Review of the facility's investigation report revealed that on (MONTH) 23, 2019 at approximately 5:30 p.m., resident #16 was walking across the day room to take a seat by the window and was redirected by staff back to his seat near the hallway. As he returned back to his seat, he picked up his tray table and threw it. Then he picked up his chair and threw it. Then he went into his room and slammed the door. The chair grazed the arm of resident #358. Both residents and the staff members on the unit were interviewed. Resident #358 said he was hit by the chair but it did not hurt. Resident #16 was placed on one to one supervision in the day room and a medication review and labs were ordered. The report included a witness statement from a Certified Nursing Assistant (CNA/staff #128), which included that staff #128 was in the dining room picking up dinner trays with other staff members when the resident threw the table and chair. Review of the facility's daily staff assignment sheet dated (MONTH) 23, 2019, revealed that staff #128 was assigned on the unit to provide the one to one at the time of the incident. An interview was conducted with the Director of Nursing (DON/staff #187) on (MONTH) 6, 2019 at 1:42 p.m. She stated that during an investigation of resident to resident abuse, one of the interventions to consider would be increased supervision, particularly for the alleged aggressor. She said if a resident on one to one supervision became physically aggressive, she would expect interventions such as calling the crisis line and trying medication and behavior stabilization. She said she would also consider moving the resident to a different unit. She said moving the resident to a different unit or calling the crisis line was not considered for resident #16 after he exhibited physical aggression while receiving one to one

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 _____	11/07/2019

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 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) supervision was because the resident's behavior was an outburst related to a trigger that was identified immediately and not directed toward another resident. She said resident #16 had been known to cycle through behaviors, and there had been no other incidents from this incident to the present time where resident #16 had been the aggressor. She said for the undated fifteen minute safety check page, the page had been located between pages dated (MONTH) 22 and 24, 2019, and the documentation had been done in order of date. An interview was conducted with staff #128 on (MONTH) 6, 2019 at 2:38 p.m. She stated she remembered the incident regarding resident #16 throwing a chair in the dining room. She said resident #16 was not happy about something, then he knocked down his table and picked up his chair and threw it, sort of hitting a resident in front of him. She said after that the nurse and other staff intervened and escorted the resident back to his room. Another interview was conducted with staff #187 on (MONTH) 7, 2019 at 8:53 a.m. She said based on the daily staff assignment sheet and the CNA documentation of care provided on (MONTH) 23, 2019, staff #128 had been assigned as the one to one for resident #16 during the time of the incident. A follow up interview was conducted with staff #128 on (MONTH) 7, 2019 at 9:28 a.m. She stated she did not remember if resident #16 had one to one supervision at the time. She said she may have been assigned to provide one to one supervision, but she did not recall specifically. She said she remembered that as soon as she walked away from the resident, that is when he began to throw things. She said she remembered this because she recalled thinking it was fortunate that she had moved away, because if not she would have been struck. A follow up interview was conducted with staff #187 on (MONTH) 7, 2019 at 9:44 a.m. She stated her expectation for a staff member providing one to one supervision should include keeping the resident within eyesight at all times and to provide all needed care for the resident. She said the staff member providing one to one supervision should have no other assignments on the unit. She said if the resident was in the dining room, the one to one staff could help with cleaning up meal trays, as long as the resident was still within sight. She said it was not an expectation that the staff member should clean up trays, but it was just natural to want to help other staff. After reviewing the facility's policy for resident supervision, she stated her overall expectation for a one to one staff member would be to keep the resident within eyesight and to monitor the resident's mood and behaviors. However, review of the facility's policy for resident supervision and monitoring revealed different levels of supervision which included one to one supervision, visual supervision, periodic checks and general supervision. The policy stated the following: -One to one supervision included assigned staff would stay within close proximity, no more that two arm's length, of the resident at all times. The assigned staff member would have no other assigned duties. One to one supervision required a physician's orders [REDACTED].>-Visual supervision included the resident would be in visual contact of the assigned staff member at all times. The staff member assigned to maintain visual contact may be assigned to other duties, including visual supervision of other residents.
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** Based on observations, staff interviews and policy review, the facility failed to ensure that medications were discarded when expired. Findings include: In an interview with a licensed practical nurse (LPN/staff #183) conducted on (MONTH) 7, 2019 at 8:45 a.m., she stated that she checks for expired items in her cart every time she administers medication/treatments to a resident. She stated the Director of Nursing (DON) and central supply staff also conduct weekly checks for expired items in the medication rooms and carts. She said that all expired items are discarded. During a medication room observation on the Sunset unit conducted on (MONTH) 7, 2019 at 9:26 a.m. with the Director of Staff Development (registered nurse/staff #57), there were 19 individually packed [MEDICATION NAME] creams with an expiration date of (MONTH) 2019, and there were 12 individual [MEDICATION NAME] packs with an expiration date of (MONTH) 2019, which were located in the top drawer of a treatment cart, which was inside the medication room. During the observation, an interview was conducted with staff #57, who stated that the treatment cart is used by the wound nurse who is responsible for checking the cart for expired items. However, staff #57 did not know how frequent this is done. Staff #57 also stated that the DON checks the medication rooms and carts at least weekly for expired items. An interview with a registered nurse (staff #24) was conducted on (MONTH) 7, 2019 at 9:46 a.m. She stated the floor nurses check the medication carts for expired items sporadically. She said that staff #57 and the pharmacist check the medication rooms and carts for expired items at least once a month. She said expired items are brought to the DON or the Director of Staff Development for destruction. During an interview with the wound nurse (staff #188) conducted on (MONTH) 7, 2019 at 10:04 a.m., staff #188 stated that she has her own treatment cart. She said she does not check the treatment carts in the medication rooms for expired items, because she does not use them. She further stated the nurses and the unit managers check the treatment carts in the medication room for expired items, but did not know how frequent it is done. In an interview with the DON (staff #187) conducted on (MONTH) 7, 2019 at 10:27 a.m., she stated that staff #57 and the unit managers check the medication rooms for expired items on a weekly basis, and she conducts random checks of the medication rooms and carts to ensure that expired items are discarded. Review of the policy on Medication Storage revealed that medications and biologicals are stored safely, securely and properly, following manufacturer's recommendations or those of the supplier. Per the policy, outdated, contaminated or deteriorated medications and those in containers that are cracked, soiled or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal and reordered from pharmacy, if current order exists.