STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **035225**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **07/24/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SUN CITY HEALTH AND REHABILITATION CENTER	**9940 WEST UNION HILLS DRIVE SUN CITY, AZ 85373**

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 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 record reviews, staff interviews, and review of policies and procedures, the facility failed to implement written policies and procedures to investigate an allegation of abuse for one resident (#2). The sample size was two residents. Findings include: Resident #2 was admitted on (MONTH) 10, 2019 and readmitted on (MONTH) 19, 2019 with [DIAGNOSES REDACTED]. A written care plan initiated on (MONTH) 11, 2019 included that the resident was at risk for falls, had cognitive loss, lack of safety awareness and needed assistance with transfers. The care plan included to offer the resident the toilet every 2 hours while awake, check on her every 2 hours while asleep for toileting needs, and to monitor and assist the resident with toileting needs. An MDS (Minimum Data Set) assessment dated (MONTH) 16, 2019 included a BIMS (Brief Interview for Mental Status) score of 8 which indicated that the resident had moderately impaired cognition. The assessment included that resident #2 required limited assistance from one person for personal hygiene and toileting, was continent of stool and did not have constipation.Review of a facility investigation report dated (MONTH) 5, 2019 included that resident #2 stated that on (MONTH) 17, 2019 resident #2 had gone into the bathroom, she was uncomfortable and unable to have a bowel movement. The report included that a CNA (Certified Nursing Assistant/staff #38) came to assist her and did not allow her to finish having a bowel movement. The report included that the CNA wiped her in such a rough manner that the stool went back inside which hurt and brought tears to her eyes. The facility investigation dated (MONTH) 5, 2019 included a statement from a resident (not resident #2) dated (MONTH) 1, 2019 that included that the resident did not have any problems with the care that the CNA provided. The investigation also included a statement dated (MONTH) 1, 2019 from a CNA (not staff #38) that included that residents (who were not identified in the statement) had complained to that CNA that staff #38 was difficult to understand, appeared like she was rushing and preferred not to receive care from her, and that the CNA had not witnessed staff #38 mistreat anyone. Further review of the facility investigation dated (MONTH) 5, 2019 did not reveal any documented evidence that the alleged staff perpetrator (staff #38) had been interviewed, or that any additional potential staff witnesses had been interviewed, or that any additional resident interviews had been conducted pursuant to the investigation. An interview was conducted on (MONTH) 24, 2019 at 1:00 p.m. with the Director of Nursing/staff #69. During the interview, the Director stated that when there is an allegation of abuse she conducted a full investigation and that the investigation includes interviewing the perpetrator, possible witnesses and additional staff and residents who may have been in the area. During an interview conducted on (MONTH) 24, 2019 at 3:10 p.m. with the Director of Nursing/#69 and the Administrator/staff #7, the Administrator stated that she had conducted most of the investigation and that she had interviewed additional residents, however she did not document the interviews, there was no additional documentation regarding the investigation and stated that's all there is. A policy and procedure titled Abuse Prohibition included a statement that the facility prohibits abuse, neglect, misappropriation of resident property and exploitation for all residents. The policy included that upon receiving information concerning a report of suspected or alleged abuse, mistreatment, or neglect the (administrator) or designee will initiate an investigation within 24 hours of an allegation of abuse that focuses on whether abuse or neglect occurred and to what extent. The policy and procedure included that the investigation will be thoroughly documented and to ensure that documentation of witnessed interviews is included.
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 record reviews, staff interviews, and review of policies and procedures, the facility failed to provide evidence that an allegation of abuse for one resident (#2) was thoroughly investigated. The sample size was two residents. Findings include: Resident #2 was admitted on (MONTH) 10, 2019 and readmitted on (MONTH) 19, 2019 with [DIAGNOSES REDACTED]. A written care plan initiated on (MONTH) 11, 2019 included that the resident was at risk for falls, had cognitive loss, lack of safety awareness and needed assistance with transfers. The care plan included to offer the resident the toilet every 2 hours while awake, check on her every 2 hours while asleep for toileting needs, and to monitor and assist the resident with toileting needs. An MDS (Minimum Data Set) assessment dated (MONTH) 16, 2019 included a BIMS (Brief Interview for Mental Status) score of 8 which indicated that the resident had moderately impaired cognition. The assessment included that resident #2 required limited assistance from one person for personal hygiene and toileting, was continent of stool and did not have constipation.Review of a facility investigation report dated (MONTH) 5, 2019 included that resident #2 stated that on (MONTH) 17, 2019 resident #2 had gone into the bathroom, she was uncomfortable and unable to have a bowel movement. The report included that a CNA (Certified Nursing Assistant/staff #38) came to assist her and did not allow her to finish having a bowel movement. The report included that the CNA wiped her in such a rough manner that the stool went back inside which hurt and brought tears to her eyes. The facility investigation dated (MONTH) 5, 2019 included a statement from a resident (not resident #2) dated (MONTH) 1, 2019 that included that the resident did not have any problems with the care that the CNA provided. The investigation also included a statement dated (MONTH) 1, 2019 from a CNA (not staff #38) that included that residents (who were not identified in the statement) had complained to that CNA that staff #38 was difficult to understand, appeared like she was rushing and preferred not to receive care from her, and that the CNA had not witnessed staff #38 mistreat anyone. Further review of the facility investigation dated (MONTH) 5, 2019 did not reveal any documented evidence that the alleged staff perpetrator (staff #38) had been interviewed, or that any additional potential staff witnesses had been interviewed, or that any additional resident interviews had been conducted pursuant to the investigation. An interview was conducted on (MONTH) 24, 2019 at 1:00 p.m. with the Director of Nursing/staff #69. During the interview, the Director stated that when there is an allegation of abuse she conducted a full investigation and that the investigation includes interviewing the perpetrator, possible witnesses and additional staff and residents who may have been in the area. During an interview conducted on (MONTH) 24, 2019 at 3:10 p.m. with the Director of Nursing/#69 and the Administrator/staff #7, the Administrator stated that she had conducted most of the investigation and that she had interviewed additional residents, however she did not document the interviews, there was no additional documentation regarding the investigation and stated that's all there is. A policy and procedure titled Abuse Prohibition included a statement that the facility prohibits abuse, neglect, misappropriation of resident property and exploitation for all residents. The policy included that upon receiving

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	035225	A. BUILDING ______ B. WING _____	**07/24/2019**

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