| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 035192 | A. BUILDING _____ B. WING _____ | 05/01/2019 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| WEYRICH HCC OF WESTMINSTER VLG | 12000 NORTH 90TH STREET SCOTTSDALE, AZ 85260 |

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) |
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| F 0600<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on clinical record reviews, facility documentation, staff interviews, an observation, and policy review, the facility failed to ensure that 2 residents (#12 and #26) out of 4 sampled residents were free from abuse by other residents (#4 and #232 respectively). The facility census was 30. The deficient practice could result in the potential for further resident to resident abuse.<br>Findings include:<br>-Resident #12 was admitted to the facility on (MONTH) 24, (YEAR), with [DIAGNOSES REDACTED].<br>A progress note dated (MONTH) 28, 2019, noted that resident #12 got slapped on her right hand by another female resident. The residents were separated. When asked what happened, resident #12 said, I don't know. A skin assessment was completed and a 0.5 centimeter (cm) scratch was observed on resident #12's right hand. No other injuries were sustained. Resident #12's mood was stable, she was not afraid, and she continued propelling herself in her wheelchair per her baseline.<br>Review of the (MONTH) 2, 2019 Annual Minimum Data Set (MDS) assessment revealed the resident had a Brief Interview for Mental Status (BIMS) score of 3, indicating the resident had severe cognitive impairment. The resident was noted to have other behaviors (such as hitting or scratching self, pacing, rummaging, verbal/vocal symptoms like screaming, and disruptive sounds) daily.<br>Review of a dementia care plan revealed the resident demonstrated wandering, pacing and roaming in and out of peers' rooms. The interventions for this care plan included:<br>-If the resident begins to enter a peer's personal space, redirect and move to another area.<br>-Assess for potential elopement departure risk<br>-Make rounds/room checks per facility protocol to minimize chance of elopement.<br>-Provide simple clear direction to help the resident know what is expected. Phrase using positive language.<br>-Engage the resident in walking/movement/keeping busy/exercise programs. Go for a walk around the facility when the resident appears restless.<br>-Resident #4 was admitted to the facility on (MONTH) 19, 2014 with [DIAGNOSES REDACTED].<br>Review of the (MONTH) 9, 2019 quarterly MDS assessment revealed resident #4 had a BIMS of 3, which indicated the resident had severe cognitive impairment. The MDS indicated that the resident did not display any behaviors during the time of the assessment.<br>Review of a behavioral care plan revealed the resident displayed behavioral symptoms related to dementia. The behavioral symptoms exhibited were physical abuse and aggression. Interventions for this care plan included the following:<br>-Redirect the resident away from peers that may provoke aggressive behaviors.<br>-Intervene when any inappropriate behavior is observed.<br>-Communicate that the resident is responsible for exercising control over impulses and behavior.<br>A nursing note dated (MONTH) 28, 2019 revealed that the nurse was informed by a Certified Nursing Assistant (CNA) who witnessed that resident #4 slapped another female resident on the right hand and yelled, Don't touch me, when the other resident touched resident #4's back of chair and shoulder. The CNA separated the residents. When asked what happened, the resident said what do you mean? and I'm fine, all this people.<br>A facility investigation revealed an alleged resident to resident altercation took place on (MONTH) 28, 2019 at 1:35 p.m. The facility investigation indicated resident #12 was in her wheelchair behind resident #4 who was sitting in a chair in the common area. While behind resident #4, resident #12 went to grab the back of resident #4's chair and she touched resident #4's shoulder in the process. Resident #4 turned around in her chair and slapped resident #12 on the right hand. Resident #12 received a 0.5 centimeter (cm) scratch/skin tear on her right hand between her thumb and forefinger. Both residents have a [DIAGNOSES REDACTED].#4 prefers to have personal space and staff are mindful when others get near that space and will redirect the resident. The reported also noted that resident #12 will pace and wander throughout the facility and is unaware of other residents' personal space. Staff have frequent visual checks on resident #12 as she will unknowingly enter another residents personal space and does not understand verbal cues or redirection and staff will assist her to another destination. However, there was no evidence that resident #12 was redirected prior to getting into resident #4's personal space resulting in the altercation.<br>The facility's investigation documented resident #12 and #4 were immediately separated. Resident #4 was assigned to a one on one (1:1) for the remainder of the evening. Resident #12 was treated by the nurse for the skin tear on her right hand. The care plans were reviewed for both residents. Law enforcement met with both residents but did not file a report due to the cognitive impairments of the residents. The officer noted that neither of the residents remembered the situation and neither exhibited any emotional or physical distress after the incident. The facility concluded that resident to resident abuse was unable to be substantiated.<br>On (MONTH) 30, 2019 at 2:58 p.m. an interview was conducted with a CNA (staff #9). Staff #9 stated that resident #12 has a history of grabbing other resident's wheelchairs to pull herself forward. In this situation, resident #4 was sitting in a chair in the common area of the facility. Staff #9 stated resident #12 grabbed the chair resident #4 was sitting in and while doing so she grazed resident #4's shoulder. Staff #9 stated resident #4 swiped at resident #12's hand which caused a skin tear. Staff #9 stated that this was a reaction to having someone touching her shoulder.<br>An interview was conducted with a CNA (staff #74) on (MONTH) 1, 2019 at 9:34 a.m. Staff #74 stated that resident #12 has a history of trying to grab other resident's wheelchairs. She stated resident #12 will attempt to grab a resident's wheelchair and will try to pull herself toward the resident. Staff #74 stated she witnessed resident #12 reaching to grab resident #4's wheelchair and in doing so she brushed resident's #4's shoulder. Resident #4 then swiped at resident #12 hitting her right hand causing a skin tear. She stated both residents were separated. Staff #74 stated that resident #4 swiping at resident #12's hand was a reaction be being touched on the shoulder.<br>On (MONTH) 1, 2019 at 11:14 a.m., an interview was conducted with the administrator (staff #31). He stated his role in abuse prevention is to make sure the residents are safe and to ensure staff are empowered to provide the best possible care. He stated in regards to abuse, the leadership team will discuss different interventions and will try new things. He also stated staff attempt to connect with the resident's family if possible to find out what the resident likes and doesn't like as well as determine other interventions if the resident presents with behaviors. Staff #31 stated interventions in the past have included using light noise machines, making sure the environment is clean and tidy, checking up on residents more frequently, walking and rounding by staff, including charge nurses. He stated [MEDICAL CONDITION] medications would be |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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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<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 1)<br>considered a possibility if non-pharmacological attempts are not successful.<br>-Resident #26 was admitted to the facility on (MONTH) 28, 2013 with [DIAGNOSES REDACTED].<br>A nursing progress note dated (MONTH) 25, (YEAR) stated that at 7:15 a.m., a Certified Nursing Assistant (CNA) witnessed resident #26 get slapped on the back by another resident in the TV room. The note stated both residents were immediately separated to opposite sides of the room by staff, vitals were collected, and a head-to-toe assessment was conducted. The note said resident #26's skin was intact. The physician and family were notified of the incident.<br>A social service assessment/review dated (MONTH) 27, (YEAR) indicated the resident's verbal communication was sometimes understood and the resident was able to understand others sometimes. The assessment further stated the resident exhibited difficulty focusing, was easily distracted, and engaged in rambling/irrelevant conversation with unpredictable changing of subject.<br>An annual Minimum Data Set (MDS) assessment dated (MONTH) 27, (YEAR) revealed the resident scored a 99 on the Brief Interview for Mental Status (BIMS) indicating she had severe cognitive impairment and was unable to complete the interview. The assessment revealed the resident had behaviors not directed towards others (hitting or scratching self, pacing, or rummaging) on a daily basis.<br>A behavioral care plan updated on (MONTH) 28, 2019 noted that the resident was diagnosed with [REDACTED]. The goals for this behavior were for the resident to comply with staff redirection, behave in a safe and respectful manner, and to be redirected from verbal behaviors through interactions with others and during meals. Interventions for this care plan included:<br>-Conduct an evaluation of the behavioral symptoms to determine what strengths or abilities and needs are communicated via the behavior<br>-To use interventions that address the abilities and needs reflected in the specific symptom<br>-If the resident becomes preoccupied by hallucinations and/or delusional thoughts, do not attempt to talk her out of the delusions. Remind her that she is in a safe environment.<br>On (MONTH) 30, 2019 at 12:57 p.m., resident #26 was observed sitting in the day room with several other residents. The television was on. Resident #26 was speaking quietly to herself. She counted to 100 three times, then continued speaking to herself about going home.<br>-Resident #232 was admitted to the facility on (MONTH) 24, 2014 with [DIAGNOSES REDACTED].<br>Review of the nursing notes revealed that on (MONTH) 6 and (MONTH) 26, (YEAR), resident #232 struck another female resident. The identity of the other resident was not revealed. On (MONTH) 26, resident #232 hit the other resident after the other resident was seen interacting with a male resident.<br>A nursing progress note dated (MONTH) 27, (YEAR) reported that the resident had been restless, anxious, and combative with staff during the shift. The note stated the resident was observed yelling out in Hungarian and wandering around. An additional note on the same date stated the resident has been exhibiting an increase in irritability with staff and residents in the past few weeks. The note said the resident was being evaluated for causal factors.<br>A nursing progress note dated (MONTH) 29, (YEAR) revealed the resident hit a female peer (the resident was not identified) in her right upper arm. The note stated resident #232 was observed propelling herself in her wheelchair towards the female peer and striking her. The note said this happened as the female peer was heard making repetitive statements and talking to herself loudly. The note reported that both residents were separated and redirected.<br>A social service assessment/review dated (MONTH) 4, (YEAR) revealed that the resident was experiencing behavioral symptoms directed towards others such as hitting, and behavioral symptoms not directed at others such as pacing. The note said the resident had a peer that she disapproved of, and that she had had physical altercations with. The note stated that the resident was easily irritable; but that she had befriended a male peer and that they would sit and watch television together.<br>A behavioral care plan dated (MONTH) 8, (YEAR) revealed behavioral symptoms related to dementia and difficulty communicating needs. The goals for the resident included to comply with staff redirection and behave in a safe respectful manner, to accept care provided by staff after reproach daily, and that when having episodes of hitting or loud verbal expressions will respond to redirection and reproach from staff. Interventions for these behaviors included:<br>-To intervene when inappropriate behavior is observed<br>-Encourage participation in activities of interest<br>-Give psychoactive medication as ordered<br>-Observe and monitor behaviors including but not limited to: refusing care, hitting, pushing, and loud verbal expression<br>-Supervise when near peers whom she dislikes, and remove from situations that provoke behaviors.<br>A nursing progress note dated (MONTH) 25, (YEAR) stated that a CNA had witnessed resident #232 slap another female resident on the back. The note stated the two residents were immediately separated to opposite sides of the TV room. Resident #232 was sitting in her wheelchair frustrated and shaking her head. The note stated that the resident was assigned a CNA to be a one on one (1:1) with the resident.<br>The quarterly MDS assessment dated (MONTH) 3, (YEAR) revealed the resident scored a 3 on the BIMS assessment indicating she was severely cognitively impaired. The assessment indicated the resident exhibited verbal symptoms directed toward others (threatening others, screaming at others, or cursing at others) and physical symptoms directed towards others (hitting, kicking, pushing, or scratching) during 1 to 3 days out of the 7 day lookback period and experienced other behavioral symptoms not directed toward others (hitting or scratching self, pacing, or rummaging) daily.<br>The social services assessment/review dated (MONTH) 20, (YEAR) revealed the resident had been discharged to another facility on (MONTH) 19, (YEAR).<br>Review of a facility investigation dated (MONTH) 29, (YEAR) revealed that on (MONTH) 25, (YEAR) at 7:15 a.m., resident #232 was observed wheeling herself behind resident #26. She then slapped resident #26 on her back. No injury was noted. Resident #232 was removed from the area and provided 1:1 supervision during waking hours. The report indicated that increased monitoring of the resident was to be done, her antidepressant medication would be increased, and she would be referred to a psychiatrist.<br>On (MONTH) 1, 2019 at 8:41 a.m., an interview was conducted with the CNA (staff #74) who witnessed the incident on (MONTH) 25, (YEAR). She stated that resident #26 talks a lot and that it irritated resident #232. Staff #74 thought resident #232 smacked resident #26 as a way to tell her to be quiet. She stated that the staff had tried to keep the two residents separated utilizing distraction and separate activities. However, she said resident #232 could wheel herself around in her wheelchair and that was what happened the morning resident #26 was struck. After the incident, she said she separated the two residents, made sure resident #26 was ok, and then notified the nurse. She reported she didn't remember any new interventions being added to either resident's care plan.<br>An interview was conducted with a CNA (staff #9) on (MONTH) 1, 2019 at 8:50 a.m. She said if one resident hit another one she would separate them immediately, make sure they were both safe, and then tell the charge nurse. She said she remembered that resident #26 really irritated resident #232 with her constant talking and that she remembered resident #26 being hit by her on more than one occasion.<br>On (MONTH) 1, 2019 at 9:43 a.m., an interview was conducted with a Licensed Practical Nurse (LPN/staff #63). She stated that the facility's policy on resident-to-resident abuse would direct her to ensure that the residents had been separated, assess them for any injuries, and report to the facility administrator/Director of Nursing, physician, and the resident's families. She said staff tried to keep resident #26 and resident #232 separated, but it wasn't always possible.<br>The facility policy on abuse, dated (MONTH) 27, (YEAR), stated the facility leadership will assess the needs of residents to be able to identify concerns in order to prevent potential abuse. The purpose of the policy was to ensure that residents remained free from abuse, neglect, misappropriation of resident property, and exploitation. This included, but was not limited to, freedom from corporal punishment of any type, by anyone. The policy further stated the facility does not condone resident abuse by anyone including other residents. |