STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035134	A. Building B. Wing	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rim Country Health & Retirement Community	807 West Longhorn Road Payson, AZ 85541

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 43863 Based on closed clinical record review, staff interviews, facility documentation and policy review, the facility failed to report an allegation of neglect for one resident (#1) within the required timeframe to the State Agency. The deficient practice could result in neglect/abuse allegations not being reported. Findings include: Resident #1 was admitted on [DATE] with diagnoses that included falls, chronic obstructive pulmonary disease with exacerbation, cognitive communication deficit, emphysema, and senile degeneration of brain. Review of an Advanced Directive dated [DATE] revealed a choice of resuscitation. Review of a Base Line Care Plan dated [DATE] revealed that the resident's advanced directives/code included cardiopulmonary, intravenous infusion, resuscitation, tube feeding and IV infusion. It revealed an initial admission goal as respite, to return home with family. A clinical record note dated [DATE] at 15:49 by Staff #44, included that all paperwork was reviewed with the Power of Attorney (POA), and the resident was full code. A clinical note dated [DATE] at 9:51 by Staff #100 included a Certified Nursing Assistant (CNA) was in to feed the resident and requested this nurse assess resident. Upon entering resident room resident sitting up and had a small amount of vomit with phlegm on her gown. Her lungs were congested throughout. Phone call placed to hospice and will be sending a nurse to see resident. Review of the clinical record revealed no nurse assessments or notes regarding the resident status between 9:51 AM and 12:13 PM. A clinical note dated [DATE] at 12:13 PM by a Registered Nurse (RN/staff #100) included the time of death at 10:26 AM, family notified by Hospice nurse, provider, and the Director of Nursing notified. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035134	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/03/2023
NAME OF PROVIDER OR SUPPLIER Rim Country Health & Retirement Community		STREET ADDRESS, CITY, STATE, ZIP CODE 807 West Longhorn Road Payson, AZ 85541	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record for [DATE] did not reveal any documented evidence that CPR had been provided, or that 911 had been called for immediate transport to the hospital, or the provider had been notified. Review of the clinical record revealed an alert note dated [DATE] at 3:42 by CNA (staff #101), that included at 8:15 I brought breakfast and noticed she was gurgling and spitting up phlegm, so I notified the nurse immediately, oxygen saturation at 88. Another alert note dated [DATE] at 3:46 by CNA (staff #101), included at 8:30 oxygen saturation was 77, nurse notified. Nurse said to keep an eye on her, I put on oxygen mask and oxygen saturation continues to decline. 9:30 saturation at 66, nurse notified, 10:06 notified nurse resident took last step. Review of the clinical record revealed no evidence that a CNA reported his concerns regarding neglect for one resident #1 on [DATE]. An interview was conducted with the facility administrator (staff # 43), on February 3, 2023 at 10:15 AM. She stated that the previous Director of Nursing (DON) had started an investigation regarding resident #1's death. She reviewed the DON's notes and stated that no formal investigation had been initiated, or submitted to the State Agency, but there were notes regarding her inquiry into the incident that included: -staff #100 stated that she found a document that stated the resident was DNR (do not resuscitate), but she did not know where she saw the form. -Two other nursing staff were talking about sending the resident out of the facility related to her code status. -A Nursing Assistant (CNA/staff #101) stated that the resident was gagging/struggling to breath, and he tried to get an RN to send her out, but the RN did not assess the resident. -Hospice Nurse on call stated that the RN had declined a visit by the hospice nurse. -[NAME] Nurse notified the facility regarding an investigation they were conducting regarding the residents death. - Review of a hospice fax cover sheet dated [DATE], revealed that they had no DNR on file. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on February 3, 2023 at 11:41 AM with a Registered Nurse (RN/staff #100) via telephone, who stated that she remembered the resident. She stated that she had been informed by the CNA that the resident had vomited, and she helped to clean up the resident and repositioned her. She also stated that she had checked on the resident and her breathing had slowed down and would not open her eyes. The nurse stated that she called hospice, but she was not certain if they arrived at the facility prior to the resident passing. She stated that in a form she had been given, it stated that the resident was DNR. However, she was not sure if she looked at the advanced directives form in the clinical record. She stated that if the advanced directive stated that the resident wanted CPR she would have started it at that time. She further stated that if the resident was full code, she should have notified the provider and awaited orders, and started CPR. The Nurse stated that the resident had a change in condition related to her oxygen status and respirations, and she should have been monitored the resident every 15 minutes, documented in the clinical record and notified the provider. She further stated that she did not remember if she did a complete assessment of the resident due to the change of condition, but if she did it would have been documented in progress notes. An interview with a CNA (Staff #101) was conducted on February 3, 2023 at 11:42 AM via telephone. He stated that he was familiar with the resident. He further stated that the resident was at the facility for a short respite stay, and was also on hospice. He stated that he was concerned about the resident's care and documented it in an alert note. He also stated that the resident was aspirating and struggling to breath and the nurse did not help her. He stated that the nurse said the resident was a DNR because she was on hospice, but he did not see her review the chart. The CNA stated that he did not observe the nurse performing any assessments of vitals during the residents decline, she only looked at the resident. He stated that after the resident passed he found that the resident record stated the resident was full code. He also stated that it was a horrible death. He stated that his major concern was that the resident was struggling to breath and had a decrease in oxygen saturations. He further stated that the Administrator did not interview him regarding his concerns of the resident's treatment. An interview was conducted on February 3, 2023 at 1:18 PM with the previous Director of Nursing (DON/RN/staff #102) via telephone, stated that she was not aware of the concerns regarding the resident's death until a policeman came to the facility. She further stated that she had not been notified by the CNA or the nursing regarding any concerns of Resident #1's care/treatment on [DATE]. She stated that she conducted an internal investigation that contained her notes, but that she did not submit a formal investigation to the State Agency. She stated that the police officer stated that he had filed a report. She further stated that there was no documentation that the police officer had reported the allegation of neglect to the State Agency, nor did she inquire with the State Agency. She further stated that it should have been a self-report. An interview was conducted with staff #42 on February 3, 2023 at 1:25 PM, who stated that she had received annual abuse and neglect training. She stated that the facility policy is to notify immediately to a supervisor regarding any concerns about care/treatment of a resident, not via alert notes. An interview was conducted on February 3, 2023 at 1:35 PM with a CNA (staff #31), who stated that when a resident is full code and the physician should be notified regarding a change of condition. She further stated that when a CNA is concerned about abuse or neglect due to a nurse not responding or assessing a resident, it should be reported immediately to another nurse, the DON or Administrator. She stated that alert documentation is not part of the abuse/neglect module training, that they are educated to notify a nurse, administrator or the DON. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on February 3, 2023 at 1:57 PM with the facility Administrator (staff #43), who stated that her expectation is that abuse/neglect are reported to the state agency within the required time frames. She stated that the expectation is that they verbally report any abuse/neglect to their supervisor, to report crime, suspicion of crime to any authority. She stated that she is familiar with Resident #1, but not what actually happened on that [DATE]. She stated that when she came back from maternity leave in February, that the police had contacted her regarding what happened with the resident. She further stated that the DON was handling the investigation with the police. She also stated that she sent records to the police, that the nurse that day was under the idea that the resident was DNR, but the resident should have been a full code. When she told the administrator this she asked if they should report the nurse to the state board, and to the state agency and the DON said that the police had already reported. She reviewed the previous DON notes of the investigation, was not the typical investigation process An interview was conducted on February 2, 2023 at 2:09 PM with the DON (staff #44), who stated that she reviewed the CNA's alert note and stated that her expectation was that another nurse was informed of his concerns regarding the resident's care. She further stated that the CNA did not report his concerns regarding neglect within the time frame. She also stated that the risk of not reporting concerns regarding abuse/neglect to a supervisor, and then to the state agency, could result in not reporting timely. Review of a facility policy titled, Resident Abuse and Neglect, revealed that Any incident or suspected incident of resident abuse or un-witnessed injury that cannot be explained will be reported promptly to the appropriate agencies and individuals, Director of Nursing and Administrator. Rim Country Health will not tolerate abuse. Neglect means failure to provide goods or services necessary to avoid physical harm, mental anguish or mental illness. The facility shall provide staff patterns on each shift that meet the resident's needs and knowledge to staff to the resident care needs. The facility will investigate all potential abuse incidents. The Administrator will be immediately alerted to every potential abuse incident. All alleged violations involving abuse or neglect shall be reported to the proper agencies within regulatory guidelines after the allegation is made. Results of each investigation will be forwarded to the appropriate agencies according to state law within 5 days on the online report.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43863 Based on record reviews, staff interviews and reviews of facility policies and procedures, the facility failed to ensure that one resident (#1) was provided basic life support including CPR (cardio-pulmonary resuscitation) in accordance the resident's advance directives. The deficient practice resulted in actual harm to the resident and has the potential to result in advance directives not being followed for additional residents. Findings include: Resident #1 was admitted on [DATE] with diagnoses that included falls, chronic obstructive pulmonary disease with exacerbation, cognitive communication deficit, emphysema, and senile degeneration of brain. Review of a form titled Rim Country Skilled Nursing and Rehabilitation Advanced Directive Information Acknowledgement dated [DATE], included a statement that the facility had provided her with a written copy of the facility's policy regarding advanced directives, had been given written materials regarding her right to accept or refuse medical treatment, and had been informed of her right to execute advanced directives. The form included a check mark next to the statement that she had executed an advanced directive. The form was signed by her guardian. Review of a form titled Rim Country Skilled Nursing and Rehabilitation Advanced Directive Statement dated [DATE], include multiple advance directive options, and was marked with an X for a section that read Yes, Cardiopulmonary Resuscitation (CPR). The form was signed by the resident's guardian, and witnessed by a staff member. A base line care plan dated [DATE], revealed that the resident's advanced directives/code included cardiopulmonary, intravenous infusion, resuscitation, tube feeding and IV infusion. It revealed an initial admission goal as respite, to return home with family. Review of the clinical record revealed no evidence of physician orders for Advanced Directive. A clinical noted dated [DATE] at 15:49 by Staff #44, included that all paperwork was reviewed with the Power of Attorney (POA), and the resident was full code. A clinical note dated [DATE] at 9:51 by Staff #100 included a Certified Nursing Assistant (CNA) was in to feed the resident and requested this nurse assess resident. Upon entering resident room resident sitting up and had a small amount of vomit with phlegm on her gown. Her lungs are congested throughout. Phone call placed to hospice and will be sending a nurse to see resident. Resident was not fed this morning as this was when resident was found to have phlegm on her gown. Review of the clinical record revealed no nurse assessments or notes regarding the resident status between 9:51 AM and 12:13 PM. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Actual harm Residents Affected - Few	A clinical note dated [DATE] at 12:13 PM by a Registered Nurse (RN/staff #100) included the time of death at 10:26 AM, family notified by Hospice nurse, provider, and the Director of Nursing notified. Review of the clinical record for [DATE] did not reveal any documented evidence that CPR had been provided, or that 911 had been called for immediate transport to the hospital, or the provider had been notified. Review of a hospice fax cover sheet dated [DATE], revealed that they had no DNR on file. An interview was conducted on February 3, 2023 at 11:41 AM with a Registered Nurse (RN/staff #100) via telephone, who stated that she remembered the resident. She stated that she had been informed by the CNA that the resident had vomited, and she helped to clean up the resident and repositioned her. She also stated that she had checked on the resident and her breathing had slowed down and would not open her eyes. The nurse stated that she called hospice, but she was not certain if they arrived at the facility prior to the resident passing. She stated that in a form she had been given, it stated that the resident was DNR. However, she was not sure if she looked at the advanced directives form in the clinical record. She stated that if the advanced directive stated that the resident wanted CPR she would have started it at that time. She further stated that if the resident was full code, she would have notified the provider and the administrator and awaited orders, and started CPR. An interview with a CNA (Staff # 101) was conducted on February 3, 2023 at 11:42 AM via telephone. He stated that he was familiar with the resident. He stated that the resident was aspirating and struggling to breath and the nurse did not help him. He stated that he placed oxygen on the resident, informed the nurse and the manager on duty. He further stated that the resident was at the facility for a short respite stay, and was also on hospice. He stated that the hospice nurse did not come into the facility on [DATE] to assess the resident due to her change of condition. He stated that the nurse said the resident was a DNR because she was on hospice, but he did not see her review the chart. He stated that after the resident passed he found that the resident record stated the resident was full code. He also stated that it was a horrible death. He stated that he did not observe the nurse performing any assessments or vitals during the change of condition, she only looked at the resident. He stated that his major concern was that the resident was struggling to breath and had a decrease in oxygen saturations. An interview was conducted on February 3, 2023 at 1:18 PM with the previous Director of Nursing (DON/RN/staff #102) via telephone, stated that she was not aware of the concerns regarding the resident's death until a policeman came to the facility. She further stated that she had not been notified by the CNA or the nursing regarding any concerns of Resident #1's care/treatment on [DATE]. An interview was conducted on February 3, 2023 at 9:34 AM with a Licensed Practical Nurse (LPN/staff #103), who stated that for a change of condition, or decline with a hospice patient that had a full code advanced directive, leadership should be notified regarding the resident's status. An interview was conducted on February 2, 2023 at 9:45 AM with a CNA (staff #31). She stated that when a resident is declining (change of condition), and a full code, CPR would be administered immediately until paramedics arrive. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted on February 3, 2023 at 9:53 AM with an LPN (staff #42), who stated that the facility policy related to advance directives, includes reviewing the form with the resident or POA on admission. She stated that if the resident is full code there should be physician order in the clinical record. The LPN also stated that according to standard nursing practice, when a hospice resident is declining/change of condition, hospice and the provider should be notified, and it should be documented in the medical record. She stated that she would expect to see a full set of vitals, and nursing assessments/monitoring until hospice arrived, and document it should be documented in the clinical record. She reviewed Resident #1's clinical record and stated that the resident was having respiratory issues and was full code, so she should have been sent out to the emergency room . She reviewed the advanced directive in the clinical record, dated [DATE], and stated that the resident was full code. Further interview was conducted on February 2, 2023 at 1:35 PM with a CNA (staff #31), who stated that when a resident is full code the physician should be notified regarding a change of condition. She further stated that when a resident is declining and the nurse is not responding the CNA should notify another nurse or the DON and report the concerns. An interview was conducted on February 3, 2023 at 1:57 Pm with the facility Administrator (staff #43), who stated that the nurse caring for the resident on February 17, 2021 was under the idea that the resident was DNR. She reviewed the clinical record and stated that the resident was full code. An interview was conducted on February 2, 2023 at 2:09 PM with the DON (staff #), who stated that she had reviewed Resident #1's clinical record and stated that she would have expected that the hospice nurse would have been contacted a second time, if she did not come quickly to assess the resident. She stated that her expectation is to honor the residents advanced directives. She further stated that she expected that resident #1 would have received CPR, and should have been moved to a higher level of care. The DON also stated the risk of not following the advance directives could result in possible premature death. Review of the facility policy titled, Advanced Directives, revealed that all staff will comply with the resident directives.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43863 Based on record reviews, staff interviews and reviews of facility policies and procedures, the facility failed to ensure that one resident (#1) received treatment and care in accordance with professional standards of practice regarding implementation of basic life support including CPR (cardio-pulmonary resuscitation) in accordance the resident's advance directives. The deficient practice resulted in actual harm to the resident by their physical needs not being met in resident advance directives not being followed. Findings include: Resident #1 was admitted on [DATE] with diagnoses that included falls, chronic obstructive pulmonary disease with exacerbation, cognitive communication deficit, emphysema, and senile degeneration of brain. Review of a form titled Rim Country Skilled Nursing and Rehabilitation Advanced Directive Statement dated [DATE], include multiple advance directive options, and was marked with an X for a section that read Yes, Cardiopulmonary Resuscitation (CPR). The form was signed by the resident's guardian, and witnessed by a staff member. A base line care plan dated [DATE], revealed that the resident's advanced directives/code included cardiopulmonary, intravenous infusion, resuscitation, tube feeding and IV infusion. It revealed an initial admission goal as respite, to return home with family. A clinical noted dated [DATE] at 15:49 by Staff #44, included that all paperwork was reviewed with the Power of Attorney (POA), and the resident was full code. A clinical note dated [DATE] at 9:51 by Staff #100 included a Certified Nursing Assistant (CNA) was in to feed the resident and requested this nurse assess resident. Upon entering resident room resident sitting up and had a small amount of vomit with phlegm on her gown. Her lungs are congested throughout. Phone call placed to hospice and will be sending a nurse to see resident. Resident was not fed this morning as this was when resident was found to have phlegm on her gown. Review of the clinical record revealed no evidence of change of condition assessments or notes regarding the resident's status between 9:51 AM and 12:13 PM on [DATE]. A clinical note dated [DATE] at 12:13 PM by a Registered Nurse (RN/staff #100) included the time of death at 10:26 AM, family notified by Hospice nurse, provider, and the Director of Nursing notified. Review of the clinical record for [DATE] did not reveal any documented evidence that CPR had been provided, or that 911 had been called for immediate transport to the hospital, or the provider had been notified. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the clinical record revealed an alert note dated [DATE] at 3:42 by CNA (staff #101), that included at 8:15 I brought breakfast and noticed she was gurgling and spitting up phlegm, so I notified the nurse immediately, oxygen saturation at 88. Another alert note dated [DATE] at 3:46 by CNA (staff #101), included at 8:30 oxygen saturation was 77, nurse notified. Nurse said to keep an eye on her, I put on oxygen mask and oxygen saturation continues to decline. 9:30 saturation at 66, nurse notified, 10:06 notified nurse resident took last step. An interview was conducted with the facility administrator (staff # 43), on February 3, 2023 at 10:15 AM. She stated that the previous Director of Nursing (DON) had started an investigation regarding resident #1's death. She reviewed the DON's notes and stated that no formal investigation had been initiated, or submitted to the State Agency, but there were notes regarding her inquiry into the incident that included: -staff #100 stated that she found a document that stated the resident was DNR (do not resuscitate), but she did not know where she saw the form. -Two other nursing staff were talking about sending the resident out of the facility related to her code status. -A Nursing Assistant (CNA/staff #101) stated that the resident was gagging/struggling to breath, and he tried to get an RN to send her out, but the RN did not assess the resident. -Hospice Nurse on call stated that the RN had declined a visit by the hospice nurse. -[NAME] Nurse notified the facility regarding an investigation they were conducting regarding the resident's death. - Review of a hospice fax cover sheet dated [DATE], revealed that they had no DNR on file. An interview was conducted on February 3, 2023 at 9:34 AM with a Licensed Practical Nurse (LPN/staff #103), who stated that for a change of condition, or decline with a hospice patient that had a full code advanced directive, leadership should be notified regarding the resident's status. He further stated that nursing should conduct assessments regarding the resident's status. An interview was conducted on February 3, 2023 at 9:45 AM with a CNA (staff #31). She stated that when a resident is declining (change of condition), and a full code, CPR would be administered immediately until paramedics arrive. She also stated that nursing should assess and monitor all residents that have had a change of condition. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted on February 3, 2023 at 9:53 AM with an LPN (staff #42), who stated that the facility policy related to advance directives, includes reviewing the form with the resident or POA on admission. She stated that if the resident is full code there should be physician order in the clinical record. The LPN also stated that according to standard nursing practice, when a hospice resident is declining/change of condition, hospice and the provider should be notified, and it should be documented in the medical record. She stated that she would expect to see a full set of vitals, and nursing assessments/monitoring until hospice arrived, and document it should be documented in the clinical record. She reviewed Resident #1's clinical record and stated that the resident was having respiratory issues and was full code, so she would have expected documentation of vitals, assessments, and the resident should have been sent out to the emergency room . She reviewed the advanced directive in the clinical record, dated [DATE], and stated that the resident was full code. An interview was conducted on February 3, 2023 at 11:41 AM with a Registered Nurse (RN/staff #100) via telephone, who stated that she remembered the resident. She also stated that the resident did have a change of condition, and that she did not notify the provider. She further stated that with a change of condition the resident's oxygen status, respirations and pain should be assessed/monitored every 15 minutes, and documented in the clinical record. The RN stated that if she had assessed the resident it would have been documented in the progress notes, but she did not remember if she did complete assessments related to the resident's change of condition. She stated that she had checked on the resident and her breathing had slowed down and would not open her eyes. She also stated that she was not sure if she looked at the advanced directives form in the clinical record. She stated that if the advanced directive stated that the resident wanted CPR she would have started it at that time. An interview with a CNA (Staff # 101) was conducted on February 3, 2023 at 11:42 AM via telephone. He stated that he was familiar with the resident. He stated that he was concerned about the resident's care and documented it in an alert note. He stated that the resident was aspirating and struggling to breath and the nurse did not help him. He stated that he placed oxygen on the resident, informed the nurse and the manager on duty. He further stated that the resident was at the facility for a short respite stay, and was also on hospice. He stated that the hospice nurse did not come into the facility on [DATE] to assess the resident due to her change of condition. He stated that the nurse said the resident was a DNR because she was on hospice, but he did not see her review the chart. He stated that after the resident passed he found that the resident record that stated the resident was full code. He also stated that it was a horrible death. He stated that he did not observe the nurse performing any assessments or vitals during the change of condition, she only looked at the resident. He stated that his major concern was that the resident was struggling to breath and had a decrease in oxygen saturations. An interview was conducted on February 3, 2023 at 1:18 PM with the previous Director of Nursing (DON/RN/staff #102) via telephone, stated that she was not aware of the concerns regarding the resident's death until a policeman came to the facility. She further stated that she had not been notified by the CNA or the nursing regarding any concerns of Resident #1's care/treatment on [DATE]. Further interview was conducted on February 3, 2023 at 1:25 PM with LPN (staff #42), who stated that when a resident has a change of condition nursing assessments should be documented in the clinical record. She further stated that if assessments were not completed it would be considered neglect. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035134	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/03/2023
NAME OF PROVIDER OR SUPPLIER Rim Country Health & Retirement Community		STREET ADDRESS, CITY, STATE, ZIP CODE 807 West Longhorn Road Payson, AZ 85541	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Further interview was conducted on February 2, 2023 at 1:35 PM with a CNA (staff #31), who stated that when a resident is full code the physician should be notified regarding a change of condition. She further stated that when a resident is declining and the nurse is not responding the CNA should notify another nurse or the DON and report the concerns. The CNA stated that when a resident is declining and the nurse id not responding another nurse or manager should be notified immediately. An interview was conducted on February 3, 2023 at 1:57 PM with the facility Administrator (staff #43), who stated that the nurse caring for the resident on February 17, 2021 was under the idea that the resident was DNR. She reviewed the clinical record and stated that the resident was full code. An interview was conducted on February 2, 2023 at 2:09 PM with the DON (staff #44), who stated that she had reviewed Resident #1's clinical record and stated that she would have expected that the hospice nurse would have been contacted a second time, if she did not come quickly to assess the resident. She stated that her expectation regarding changes of condition, would be to assess the resident's vitals, status and document in the medical record. She stated that she did not see nursing documentation in Resident #1's medical record regarding the change of condition related to a decline. She also stated that she would have expected that the provider would have been notified regarding the decline, if the nurse did not want hospice attending the resident. She reviewed the CNA Alert Notes, and stated that she expected the CNA to notify another nurse regarding his concerns, and if the nurse did not respond to contact a manager on duty. She stated that the risk of resident harm and potential death could result from negligent nursing, regarding the nurse not assessing frequently after a change of condition and decline in well-being. Review of the facility policy titled, Quality of Care and Services, revealed that each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical well-being. Professional standards of quality means services that are provided according to accepted standards of clinical practice. Staff shall notify physicians as appropriate and show evidence of discussions regarding acute medical problems. Residents with acute conditions who require intensive monitoring and hospital level treatments will be promptly transferred to a higher level of care according to physician orders. There shall be evidence of assessment and care planning sufficient to meet the needs of newly admitted residents. Direct caregiver staff should have an understanding of the expected outcomes of the care they provide and understand the relationship of these expected outcomes to the care provided.