STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035003	A. Building B. Wing	08/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Terraces of Phoenix	7550 North 16th Street Phoenix, AZ 85020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47341 Based on clinical record review, resident/staff interviews, facility documentation and policy review and the State Agency (SA) complaint tracking system, the facility failed to protect the rights of two residents (#12 and #23) to be free from sexual abuse by another resident (#45). The deficient practice could result in the potential for harm and had placed residents at increased risk for further abuse, serious injury, harm and psychosocial harm. The census was 43. Findings include: -Resident #23 admitted on [DATE] with diagnoses of dementia and depression. The care plan dated May 16, 2023 revealed the resident had impaired cognitive function. The goal was that the quality of life will be nurtured and the resident will be exposed to pleasurable events each day. Intervention included to engage the resident's senses with pleasant smells. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that staff assessment that the resident had severe cognitive impairment. A health status note dated August 7, 2024 included that the resident's Power of Attorney (POA) was informed of an inappropriate behavior displayed by a male resident to the resident #23; and that, the male resident was witnessed to touch the resident's arm/back. An interview was conducted with the social service director (SSD) on August 9, 2024 at 1:30 p.m. The SSD that he was aware of the incident regarding resident #45 touching resident #23; and that, he was not part of the investigation. The SSD said that resident #23 was non-verbal and her eyes would track you when you are talking to her but cannot indicate a yes or no response. -Resident #12 admitted on [DATE] with diagnoses of hemiplegia and hemiparesis, major depressive disorder and anxiety. The quarterly MDS assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score 15 which indicated the resident had intact cognition. (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

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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 0600 Level of Harm - Actual harm Residents Affected - Few	The undated active care plan revealed that the resident was at risk for problematic behavior i.e. history of fabricating false accusations against staff that attempt to give directions on ADLs (activities of daily living), medications, diabetes control and management. The goal was that the resident will accept re-direction when making false accusations. Interventions included to identify stressful times of the day, schedule activities and tasks for other times, help the resident to cope using past successful coping mechanisms and praise/reward resident for demonstrating appropriate interactions with staff and others. The undated active care plan also included that the resident had actual or suspected history of personal trauma, was abused by a babysitter at the age of 3 and had associated behaviors of mis-trust for other caregivers. The goal was that the resident will maintain psychosocial well-being. Interventions included to offer reassurance of safety and trust and restore a sense of control by honoring the resident's choices. The nursing progress note dated July 26, 2024 included that the resident reported to the certified nursing assistant (CNA) that she had a bad day because something happened to her today that brought back past memories. Per the documentation, the resident had no unusual events reported other than officers here to visit for statement due to accusation regarding a staff member on another date and time. A late entry alert note dated August 1, 2024 included that the resident was seen by investigators before lunch; and that, the investigators went to speak to the Administrator. In an interview with resident #12 conducted on August 9, 2024 at 4:45 p.m., the resident stated that resident #45 would come up to her often up to twice daily and rub her knee and thigh; and that, the touch was very unwanted. The resident also stated that she had reported this to several nurses and certified nursing assistants (CNAs) who were often were present in the area when resident #45 touches her. The resident said that when this happens, the nurses and CNA who were present would laugh and think that it was funny, and would tell Resident #45 not to touch her. The resident stated that she can escape into her room which is her safe place because resident #45 does not enter her room. However, the resident stated that resident #45 would sit right outside her door and stare at her specifically when she changes clothing. An interview was conducted with the social service director (SSD) on August 9, 2024 at 1:30 p.m. The SSD that the administrator was the one investigating the incident on resident #45 patting another female resident on the shoulder. In an interview with a CNA (staff #6) conducted on August 9, 2024 at approximately 5:00 p.m., the CNA state that on Monday, August 5, 2024, she witnessed resident #45 rubbing the arm and back of resident #12 who had not in any way invited the touch. The CNA stated that she told resident #45 that he could not do that and then she went to report the incident to the RN (staff #5) -Resident #45 was admitted on [DATE] with diagnosis of dementia. The MDS assessment dated [DATE] included a BIMS score of 7 indicating the resident had severe cognitive impairment. (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 0600 Level of Harm - Actual harm Residents Affected - Few	The undated care plan revealed the resident had a behavior problem of inappropriate touching of a female resident related to dementia. The goal included that the resident will have no evidence of behavior problem of inappropriately touching. Interventions included 1:1 monitoring x 2 weeks, document his behavior every shift, report any sexual behavior to nurse and redirect as needed. A progress note dated July 24, 2024 and written by a registered nurse (RN/staff #5) revealed that the resident touched a female resident on the leg; and that, it was unwanted. Per the documentation, the resident was redirected. There was also no evidence found in the clinical record that interventions were put in place to prevent the reoccurrence of resident #45 inappropriately touching or sexual advances to other female residents . A health status note dated August 1, 2024 included that the resident was sexually explicit, was masturbating in his bed and was asking where's that girl? referring to the CNA. A health status note written by a registered nurse (RN/staff #5) dated August 7, 2024 revealed that the resident was observed multiple times groping the breasts of a female resident. Per the documentation, staff explained to the resident the wrongful behavior, was redirected and the resident showed no signs of understanding. Another health status note dated August 7, 2024 included that the resident was on alert charting related to inappropriate activities of wanting to touch other residents; and that, the resident was monitored hourly regarding his whereabouts. A behavior note dated August 7, 2024 included that the physician was notified regarding the resident's inappropriate behavior. Despite the documentation that a resident was observed multiple times groping the breasts of a female resident, the facility self-report received on August 7, 2024 revealed that the resident was seen touching another resident; and that, the facility was investigating specifically the location of resident touching. A written statement from the RN (staff #5) dated August 7, 2024 included that the RN was at his medication cart on August 6, 2024 at approximately 5:30 p.m., he saw resident #45 was trying to touch resident #23; and that, the RN was able to intervene and redirect resident #45 before resident #45 could touch resident #23. Per the documentation, the RN assumed that resident #45 was going to grope the breasts of resident #23 because the RN had seen resident #45 was reaching towards the breasts of resident #23. Further, the documentation included that resident #45 attempted 3 times and was seen approaching resident #23 with arms stretched towards the mid-section of the body of resident #23. The behavior note dated August 8, 2024 included that the resident was alert and oriented with some confusion; and, was self-propelling around the unit. Another behavior note dated August 8, 2024 revealed that the resident continued to be monitored for inappropriate behavior of wanting to touch/feel other residents. Per the documentation, the resident was able to respond [NAME] or no and was routinely self-propelling his wheelchair in the unit between hallways. (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 0600 Level of Harm - Actual harm Residents Affected - Few	A physician order dated August 8, 2024 included an order to monitor behavior of inappropriate touching to others every shift for a diagnosis of dementia. In a phone interview with the RN (staff #5) conducted on August 9, 2024 at 2:01 p.m., the RN stated that he had worked at the facility for 8 months; and, he does not think that staff could evaluate a resident with dementia regarding consensual sexual relationship with another resident. The RN stated that resident #45 had inappropriately touched residents #23 and #12; and that, he documented these incidents in the progress notes but did not report the incidents to anyone. In a later interview with the RN (staff #5) conducted on August 9, 2024 at 3:40 p.m., the RN stated that he did not witness the incident between resident #45 and resident #12. He stated that resident reported the allegation of abuse; and that, resident #45 touched resident #12 who reported that it was an unwanted touch. The RN said that he does not know if unwanted touching between residents was considered abuse; and, he did not report it to a supervisor because he was not sure what to do in the situation. An interview was conducted on August 9, 2024 at 4:45 p.m. with the Administrator who stated that her expectations was for staff to report abuse allegations immediately. She stated that an allegation of abuse was received, staff will ensure safety of the resident, separate the residents for the alleged perpetrator (staff or resident), monitor the affected residents for psychosocial effects or concerns, and document the incident. She stated that staff received in-service and computer training on how to identify abuse; and in these trainings, staff were provided specific examples of what abuse could look like, and when in doubt to report it to her. Regarding resident #45, the administrator stated that resident #45 had not been moved from the unit when the incident between resident #45 and resident #12 because resident #12 usually spend time close to the nurse's station; and, resident #45 was not trying to seek resident #12. A policy on Elder Abuse Prevention, Identification, Response, Reporting with revision date of October 10, 2023 included that team members are expected to prevent, identify, respond to, and report allegations of elder abuse according to the steps of this procedure. Identification of abuse from witnessed events, verbal resident report of abuse, and audit of resident records, among others methods of identification. In response to allegations or witness events, general steps include, take steps to protect the resident and prevent further potential abuse immediately, report the allege violation within required time frames, take appropriate corrective action, and revise the residents care or service plan. All allegations received by a team member are to be reported as soon as practicably to the appropriate leadership team member or designee. If an altercation occurs between resident, they should be separated by staff and placed in two different areas.

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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	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** 47341 Based on clinical record review, resident/staff interviews, facility documentation and policy review and the State Agency (SA) complaint tracking system, the facility failed to ensure allegations of sexual abuse for two residents (#23 and #12) by another resident (#45) was reported immediately to the administrator, State Agency (SA), Adult Protective Services (APS) and law enforcement. The deficient practice could result in the potential harm and had placed residents at increased risk for further abuse, serious injury, harm and psychosocial harm. As a result, the condition of Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) were identified. The census was 43. Findings include: On August 9, 2024 at 5:34 p.m., a condition of IJ was identified. The administrator was informed of the facility's failure to ensure residents were free from sexual abuse by a resident was found. The administrator presented the removal plan on August 9, 2024 at 8:23 p.m. The administrator was informed that the removal plan was not acceptable and failed to include any assessment completed for resident #12 and #23; until when will resident #45 be placed on 1:1 supervision; other interventions put in place to prevent inappropriate behaviors for resident #45; when the in-service training was started and expected to be completed for all staff; identify the staff that would complete the in-service training; and, actions the facility will take if a staff did not complete the required in-service/training. A revised removal plan was received on August 9, 2024 at 9:25 p.m. and was not accepted because it failed to include when the in-service training was started for all staff including staff that were on leave; how the facility will monitor resident #45 for inappropriate behaviors; until when will resident #45 be placed on 1:1 supervision; other interventions put in place to prevent inappropriate behaviors for resident #45; what actions will be taken for staff who documented the incident but did not report the allegation of abuse; and, how often and what kind of audits or monitoring will be done to identify any potential abuse. Another revised removal plan was presented by the administrator on August 9, 2024 at 10:31 p.m. the administrator was informed that the removal plan was not accepted and failed to include: what actions will be taken for staff who documented the incident but did not report the allegation of abuse; how the facility will monitor resident #45 for inappropriate behaviors; and, how often and what kind of audits or monitoring will be done to identify any potential abuse. On August 10, 2024 at 8:33 a.m., the administrator presented a revised removal plan that was accepted at 8:47 a.m. The accepted removal plan included: -Medical and Psychiatric Assessment completed for resident #12 and #23; -In-service training on abuse was started and expected to be completed for all staff including staff that were on leave; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Actions the facility will take if a staff did not complete the required in-service/training; -Actions taken for staff who documented the incident but did not report the allegation of abuse; -How the facility will monitor resident #45 for inappropriate behaviors, until when will resident #45 be placed on 1:1 supervision and other interventions put in place to prevent inappropriate behaviors for resident #45; and, -How often and what kind of audits or monitoring will be done to identify any potential abuse. On August 10, 2024 at 12:28 p.m., the condition of IJ was removed after multiple observations were conducted of the facility implementing their removal plan which included resident and staff interviews, personnel record review, in-service training of staff and review of documentation provided by the facility. -Resident #12 admitted on [DATE] with diagnoses of hemiplegia and hemiparesis, major depressive disorder and anxiety. The quarterly MDS assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score 15 which indicated the resident had intact cognition. The undated active care plan revealed that the resident was at risk for problematic behavior i.e. history of fabricating false accusations against staff that attempt to give directions on ADLs (activities of daily living), medications, diabetes control and management. The goal was that the resident will accept re-direction when making false accusations. Interventions included to identify stressful times of the day, schedule activities and tasks for other times, help the resident to cope using past successful coping mechanisms and praise/reward resident for demonstrating appropriate interactions with staff and others. The undated active care plan also included that the resident had actual or suspected history of personal trauma, was abused by a babysitter at the age of 3 and had associated behaviors of mis-trust for other caregivers. The goal was that the resident will maintain psychosocial well-being. Interventions included to offer reassurance of safety and trust and restore a sense of control by honoring the resident's choices. The nursing progress note dated July 26, 2024 included that the resident reported to the certified nursing assistant (CNA) that she had a bad day because something happened to her today that brought back past memories. Per the documentation, the resident had no unusual events reported other than officers here to visit for statement due to accusation regarding a staff member on another date and time. The documentation did not include whether the allegation was reported to the administrator, State Agency (SA), Adult Protective Services (APS) and law enforcement. A late entry alert note dated August 1, 2024 included that the resident was seen by investigators before lunch; and that, the investigators went to speak to the Administrator. There was no evidence found in the clinical record that this incident was reported to the administrator, State Agency (SA), Adult Protective Services (APS) and law enforcement until August 9, 2024. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the SA complaint tracking system included a facility self-report dated August 9, 2024. The self-report revealed that during their investigation of another incident, the facility found in the clinical record that on July 24, 2024 resident #45 touched the leg of resident #12. In an interview with resident #12 conducted on August 9, 2024 at 4:45 p.m., the resident stated that resident #45 would come up to her often up to twice daily and rub her knee and thigh; and that, the touch was very unwanted. The resident also stated that she had reported this to several nurses and certified nursing assistants (CNAs) who were often were present in the area when resident #45 touches her. The resident said that when this happens, the nurses and CNA who were present would laugh and think that it was funny, and would tell Resident #45 not to touch her. The resident stated that she can escape into her room which is her safe place because resident #45 does not enter her room. However, the resident stated that resident #45 would sit right outside her door and stare at her specifically when she changes clothing. In an interview with a CNA (staff #6) conducted on August 9, 2024 at approximately 5:00 p.m., the CNA state that on Monday, August 5, 2024, she witnessed resident #45 rubbing the arm and back of resident #12 who had not in any way invited the touch. The CNA stated that she told resident #45 that he could not do that and then she went to report the incident to the RN (staff #5) -Resident #23 admitted on [DATE] with diagnoses of dementia and depression. The care plan dated May 16, 2023 revealed the resident had impaired cognitive function. The goal was that the quality of life will be nurtured and the resident will be exposed to pleasurable events each day. Intervention included to engage the resident's senses with pleasant smells. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that staff assessment that the resident had severe cognitive impairment. A health status note dated August 7, 2024 included that the resident's Power of Attorney (POA) was informed of an inappropriate behavior displayed by a male resident to the resident #23; and that, the male resident was witnessed to touch the resident's arm/back. An interview was conducted with the social service director (SSD) on August 9, 2024 at 1:30 p.m. The SSD that he was aware of the incident regarding resident #45 touching resident #23; and that, he was not part of the investigation. The SSD said that resident #23 was non-verbal and her eyes would track you when you are talking to her but cannot indicate a yes or no response. -Resident #45 was admitted on [DATE] with diagnosis of dementia. The MDS assessment dated [DATE] included a BIMS score of 7 indicating the resident had severe cognitive impairment. The undated care plan revealed the resident had a behavior problem of inappropriate touching of a female resident related to dementia. The goal included that the resident will have no evidence of behavior problem of inappropriately touching. Interventions included 1:1 monitoring x 2 weeks, document his behavior every shift, report any sexual behavior to nurse and redirect as needed. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated July 24, 2024 and written by a registered nurse (RN/staff #5) revealed that the resident touched a female resident on the leg; and that, it was unwanted. Per the documentation, the resident was redirected. The documentation did no include whether the incident was reported to the the administrator, State Agency (SA), Adult Protective Services (APS) and law enforcement. There was no evidence found in the clinical record that this incident was reported to the administrator, State Agency (SA), Adult Protective Services (APS) and law enforcement. There was also no evidence found in the clinical record that interventions were put in place to prevent the reoccurrence of resident #45 inappropriately touching or sexual advances to other female residents. A health status note written by a registered nurse (RN/staff #5) dated August 7, 2024 revealed that the resident was observed multiple times groping the breasts of a female resident. Per the documentation, staff explained to the resident the wrongful behavior, was redirected and the resident showed no signs of understanding. Another health status note dated August 7, 2024 included that the resident was on alert charting related to inappropriate activities of wanting to touch other residents; and that, the resident was monitored hourly regarding his whereabouts. A behavior note dated August 7, 2024 included that the physician was notified regarding the resident's inappropriate behavior. Despite the documentation that a resident was observed multiple times groping the breasts of a female resident, the facility self-report received on August 7, 2024 revealed that the resident was seen touching another resident; and that, the facility was investigating specifically the location of resident touching. A written statement from the RN (staff #5) dated August 7, 2024 included that the RN was at his medication cart on August 6, 2024 at approximately 5:30 p.m., he saw resident #45 was trying to touch resident #23; and that, the RN was able to intervene and redirect resident #45 before resident #45 could touch resident #23. Per the documentation, the RN assumed that resident #45 was going to grope the breasts of resident #23 because the RN had seen resident #45 was reaching towards the breasts of resident #23. Further, the documentation included that resident #45 attempted 3 times and was seen approaching resident #23 with arms stretched towards the mid-section of the body of resident #23. The undated facility report revealed that interviews with staff working on the PM shift on August 6, 2024 revealed no findings related to resident #45 touching other residents on the breast or private area. The report also included an interview with resident #12 who reported that she saw resident #45 touched resident #23 on the leg, arm and then rubbed her boob; and that a CNA was around when it happened. The report included an interview with a CNA named by resident #12. Per the documentation, the CNA reported that she saw resident #45 rubbing the arm and back of resident #23 liked resident #45 was comforting resident #23; and that, she told resident #45 that he can't do that. Further, the CNA denied seeing resident #45 touched the breast of resident #23. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continued review of the facility report revealed that the RN (staff #5) who documented the inappropriate behavior of resident #45 was interviewed; and that, the RN was not able to provide specific details about location, times and/or specific events related to the incident with resident #23. In a later interview with the RN (staff #5) conducted by the facility, the RN was at his medication cart on August 6, 2024 at approximately 5:30 p.m. and saw resident #45 was trying to touch resident #23. The documentation included that the RN was able to intervene and redirect resident #45 before resident #45 could touch resident #23. Per the documentation, the RN assumed that resident #45 was going to grope the breasts of resident #23 because the RN in other instances had seen resident #45 inch close, leaned over with arms stretched out in the direction of resident #23 but never made physical contact. Further, the documentation included that resident #45 attempted 3 times and was seen approaching resident #23 with arms stretched towards the mid-section of the body of resident #23. Further review of the facility report revealed that the facility was unable to substantiate that abuse occurred and the RN (staff #5) made an addendum to his progress notes clarifying what he witnessed, the nurse's statement from the following shift corroborated that resident #45 did not touch resident #23 and the CNAs statement did not validate that she witnessed the allegation like resident #12 had reported. It also included that the police did not take the case as sexual abuse and were not pressing charges on resident #45. A physician order dated August 8, 2024 included an order to monitor behavior of inappropriate touching to others every shift for a diagnosis of dementia. In a phone interview with the RN (staff #5) conducted on August 9, 2024 at 2:01 p.m., the RN stated that he had worked at the facility for 8 months; and, he does not think that staff could evaluate a resident with dementia regarding consensual sexual relationship with another resident. The RN stated that resident #45 had inappropriately touched residents #23 and #12; and that, he documented these incidents in the progress notes but did not report the incidents to anyone. In a later interview with the RN (staff #5) conducted on August 9, 2024 at 3:40 p.m., the RN stated that he did not witness the incident between resident #45 and resident #12. He stated that resident #12 reported the allegation of abuse; and that, resident #45 touched resident #12 who reported that it was an unwanted touch. The RN said that he does not know if unwanted touching between residents was considered abuse; and, he did not report it to a supervisor because he was not sure what to do in the situation. An interview was conducted on August 9, 2024 at 4:45 p.m. with the Administrator who stated that her expectations was for staff to report abuse allegations immediately. She stated that an allegation of abuse was received, staff will ensure safety of the resident, separate the residents for the alleged perpetrator (staff or resident), monitor the affected residents for psychosocial effects or concerns, and document the incident. She stated that staff received in-service and computer training on how to identify abuse; and in these trainings, staff were provided specific examples of what abuse could look like, and when in doubt to report it to her. Regarding resident #45, the administrator stated that resident #45 had not been moved from the unit when the incident between resident #45 and resident #12 because resident #12 usually spend time close to the nurse's station; and, resident #45 was not trying to seek resident #12. (continued on next page)

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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	A policy on Elder Abuse Prevention, Identification, Response, Reporting with revision date of October 10, 2023 included that team members are expected to prevent, identify, respond to, and report allegations of elder abuse according to the steps of this procedure. Identification of abuse from witnessed events, verbal resident report of abuse, and audit of resident records, among others methods of identification. In response to allegations or witness events, general steps include, take steps to protect the resident and prevent further potential abuse immediately, report the allege violation within required time frames, take appropriate corrective action, and revise the residents care or service plan. All allegations received by a team member are to be reported as soon as practicably to the appropriate leadership team member or designee. If an altercation occurs between resident, they should be separated by staff and placed in two different areas.