STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035205	A. BUILDING _____ B. WING _____	**09/27/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SUNCREST HEALTHCARE CENTER	**2211 EAST SOUTHERN AVENUE PHOENIX, AZ 85040**

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 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on clinical record reviews, interviews, review of facility documentation and policy and procedures, the facility failed to conduct thorough investigations into allegations of sexual abuse for two residents (#8 and #12) of three residents sampled. The deficient practice has the potential for further abuse resulting in harm to residents. Findings include: -Resident #8 was readmitted to the facility on (MONTH) 10, (YEAR) with [DIAGNOSES REDACTED]. Review of the annual Minimum Data Set (MDS) assessment dated (MONTH) 23, 2019 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident was moderately cognitively impaired. A nursing note dated (MONTH) 22, 2019 at 9:46 PM included the nurse (staff #8), while standing outside the resident's room, heard resident #8 scream why are you molesting me? The note included that the nurse entered the room and saw a Certified Nursing Assistant (CNA/staff #52 #52) with the resident's genitals in his hands, and when the nurse entered the room the CNA held his hands up in the air and stated that he was changing the resident's brief. The note described the CNA as a male who was not wearing gloves and had no supplies such as wipes, washcloths, or briefs to perform a brief change. The note included the CNA was asked to leave the room and that the supervisor, the resident's physician, the Director of Nursing (DON), and the police were notified. Review of the facility's investigative report revealed that on (MONTH) 22, 2019 at around 9:45 p.m. a nurse heard the resident scream out and when she went into the room, she saw staff #52 holding the resident's genitals. The CNA let go of the resident's genitals and put his hands up in the air. The CNA was asked what he was doing and he did not answer and walked out of the room. The nurse went into the resident's room and asked the resident what the CNA was doing and he said that the CNA did, inappropriate things to his penis. The CNA told the nurse that you had to know the resident first before you could believe what he is saying. The CNA did not deny nor confirm the allegation. He stated he was cleaning the resident, but it was noted that he was not wearing gloves and did not have any wipes or a washcloth. The report did not indicate if the allegation was substantiated or not, but staff #52's employment at the facility was terminated. The investigative report did not include evidence that resident #8, other residents, staff #52, or other staff had been interviewed regarding the incident. In an interview with the DON on (MONTH) 27, 2019 at 1:39 PM, he stated that when completing an investigation regarding abuse, he would interview the person accused, the resident, and any staff who were in the vicinity of the resident when the allegation occurred. He stated that he could not interview staff #52 because when he arrived to the facility, the police were already there. He said that he did interview some of the residents, but had not gotten all of this written down yet. He said he planned to interview more staff. -Resident #12 was readmitted to the facility on (MONTH) 11, 2019 with [DIAGNOSES REDACTED]. Review of a quarterly MDS dated (MONTH) 26, 2019 revealed that the resident scored an 8 on the Brief Interview for Mental Status (BIMS) indicating that he was cognitively impaired. A DON progress note dated (MONTH) 27, 2019 revealed that resident #12 had recently learned that a male CNA (staff #52) was a homosexual and that he did not want this person taking care of him. He denied any inappropriate behavior, but said that it makes him uncomfortable. The note included that the administrator and the DON decided to remove the CNA from providing care to this resident. The facility was unable to provide any evidence that any incidents between staff #52 and resident #12 were investigated. In an interview with a CNA (staff #15) conducted on (MONTH) 26, 2019 at 3:30 PM, the CNA stated that she knew of an incident between staff #52 being inappropriate with resident #12. She said that the incident occurred around (MONTH) 20, 2019 and involved staff #52 changing resident #12's brief. In an interview with resident #12 conducted on (MONTH) 27, 2019 at 9:30 AM, he stated that staff #52 would undress him and put him in bed and then just look at him. He stated that no one saw staff #52 doing this. Resident #12 stated he would yell at staff #52 and told him not to stare at him or he would yell and fight with him and tell him he was going to hell for touching him. The resident stated he had reported staff #52 to the administrator and DON and was told that staff #52 would not be assigned to care for him. He stated he had heard other people talking about staff #52 and they told him that staff #52 was homosexual. The resident also stated that this had been happening since he was admitted to the facility and that it most recently happened around (MONTH) 20, 2019. Resident #12 stated staff #52 ruined his life and he didn't think that he would ever get over it. In a telephone interview with a Licensed Practical Nurse (LPN/staff #8) she stated that around (MONTH) 21, 2019, resident #12 came to her and said he needed a change in his CNA assignment because staff #52 had been sexually inappropriate with him. In an interview with the DON conducted on (MONTH) 27, 2019 at 1:39 PM, he stated that he was not aware of resident #12's allegations, but knew that the resident had come to his office and told him that he did not want any homosexual males touching him. He said that he honored this request but had not put anything in writing about this incident. A review of the facility's Abuse and Neglect Policy revised (MONTH) (YEAR), revealed it is the policy of the facility to investigate any reports of alleged abuse. The policy included that the investigation would be conducted by the DON or a designated representative and will include interviews with individuals who may have knowledge of the incident. The policy also included to utilize the Resident Neglect/Abuse Checklist form when completing the investigation. The Resident Neglect/Abuse Checklist dated (MONTH) 3, 2005, revealed that when investigating an alleged abuse/neglect incident, the investigator is to review all interviewable residents regarding whether they are treated appropriately and will document what each resident says including the time, date, and the name of the interviewer. The checklist directs the investigator to interview all staff who worked during the timeframe of the incident.

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.