STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035092	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bella Vita Health and Rehabilitation Center	5125 North 58th Avenue Glendale, AZ 85301

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 - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** 48814 Based on observations, staff and resident/resident representative interviews, clinical record and policy review the facility failed to ensure that two resident 's (#214 and #525) were free from abuse. The deficient practice may result in physical and/or psychosocial harm to the residents. Findings include: Resident #214 was admitted on [DATE] and discharged on [DATE] with diagnosis including unilateral primary osteoarthritis of left hip, other intervertebral disc disorders of lumbar region, pain in left hip, and muscle weakness. Review of the incident report dated January 15, 2024 revealed Resident #214 had a Brief Interview for Mental Status (BIMS) summary score of 14 indicating no cognitive impairment. The care-plan initiated on January 18, 2024 revealed that Resident #214 was at risk for impaired thought process related to new environment. The goal was that resident will maintain current level of cognitive function through the review date. Interventions included - monitor/observe resident for changes in mood/behavior patterns, fear of other residents and/or staff. Review of progress note dated January 18, 2024 showed that resident #214 was seated in her wheelchair in front of station 300 drinking her tea. Resident #214 was approached by another resident who yelled in her face. The unit secretary immediately came from behind the desk and removed resident #214 and called for assistance. Further around 4:10 pm, resident #214 informed the unit secretary that prior to her coming that the other resident had walked past her in front of the desk and took his right fist and struck her in the right shoulder and mid-back area as she was passing him in her wheelchair. Resident #214 didn't tell anyone of this alleged incident prior to telling the unit secretary. Resident #214 had a PRN skin evaluation completed and noted no marks or bruising to her right shoulder or mid-back area. Resident #214 denied pain or discomfort and feels safe in the facility. She declined notification to her family and explained that she would call her family. Provider, Ombudsman, Glendale Police, APS, and DHS were notified of the alleged incident. Resident #525 was admitted on [DATE] and discharged on [DATE] with diagnoses which included non-displaced zone II fracture of sacrum, acute pain due to trauma, muscle weakness and other stimulant abuse. (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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the incident report dated January 15, 2024 revealed Resident #214 had a Brief Interview for Mental Status (BIMS) summary score of 15 indicating no cognitive impairment. Review of progress note dated January 18, 2024 showed that resident #525 approached another resident and started yelling in her face. The unit secretary immediately separated both residents. Resident #525 continued to walk towards both the unit secretary and the other resident yelling and showed signs of aggression and then he walked outside to the patio. Around 4:10 pm, the other resident had informed the unit secretary that prior to her coming, resident #525 walked past her and took his right fist and struck her in her right shoulder and mid back area as she was passing him in her wheelchair. Both assistant directors of nursing went to speak with resident #525 and he continued to yell and requested to leave facility against medical advice (AMA). Resident #525 was removed by police and detained due to alleged incident and outstanding warrants. A facility reported incident and 5-day report was made on January 18, 2024. This report included Resident #214 notified unit secretary (staff #321) that resident #525 took his right fist and struck her in her shoulder and mid back area as she was passing him in her wheelchair. Resident #214 did not tell anyone prior to telling staff #321. An interview was conducted with several certified nursing assistants (CNAs) and licensed practical nurse (LPNs) who did not witness any aggressive behaviors between resident #214 and resident #525 in past. An interview was conducted licensed practical nurse (LPN/Staff #314) on October 30, 2024 at 8:54 a.m. who stated that the altercation had happened between resident #214 and #525. Staff #314 recalled that resident #525 had raised his fist and hit resident #214 but not sure how hard. Moreover, Staff #314 stated that assistance director of nursing and director of nursing approached resident #525 and separated him from the other residents. Full skin assessments were done on resident #214 and no injury were found. An interview was conducted with certified nursing assistant (CNA/Staff #203) on October 30, 2024 at 9:32 a. m. who stated that process after an altercation is reporting it to floor nurse, call for help, and separate residents immediately. If a resident hits another resident then we do skin assessment for any marks, injury, bruise or open areas. An interview was conducted with administration/executive director (Staff # 72) on October 30, 2024 at 9:48 a. m. who stated that any altercation or abuse that happens is reported to adult protected service (APS), state, police, family, power of attorney (POA) and ombudsmen within 2 hours. He further stated that we substantiate if it happens or people witness that it happens then we separate them first, make sure they are safe, not injured. Regarding resident #214 and #525, he stated that he saw in camera recorder that residents were in hall 300, resident #214 said something to resident #525, he gone away and then he came back and pushed resident #214 with palm on right shoulder and both of them were on wheelchair. Review of facility policy regarding Abuse: Prevention of and Prohibition Against revised on August, 2024 revealed that the facility will act to protect and prevent abuse and neglect from occurring within the facility by establishing a safe environment.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51159 Based on interview, record review, and facility policy review, the facility failed to notify the Ombudsman of transfer/discharge for one resident (#163). Failure to notify Ombudsman of transfers/discharges may result in residents being discharged against their will. Findings include: Resident # 163 was admitted on [DATE] with a diagnoses including acute kidney failure, Gastro-Esophageal reflex, and multiple fractures of the ribs. A Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderately impaired cognition. Admission transfer/discharge reports dated July 2024 revealed no evidence that resident (#163) had been listed as discharged . A Care plan dated July 29, 2024 revealed a focus that the resident is to return or be discharged to an alternative placement. A progress note dated July 30, 2024 revealed that the resident was transferred to a rehabilitation facility via stretcher. A physician's order dated July 30, 204 revealed an order to discharge to a rehabilitation facility. An email sent to the Ombudsman on August 7, 2024 by the Medical Records Supervisor (Staff # 208) revealed no evidence that the resident was discharged in July 2024. Review of the facility Record Hospital Transfer and Admission / Discharge revealed no evidence of Resident (#163) discharge. An interview was conducted on October 30, 2024 at 11:53 AM with Social Services Supervisor (Staff # 230), who stated that the resident had requested to be transferred to another facility. She also stated that the Ombudsman should be notified when residents transfer / discharge from the facility on a monthly basis. She reviewed the email she sent to the Ombudsman with the residents that discharged /transferred during July 2024, and stated that resident #163 was not on the list. An interview was conducted on October 30,2024 at 12:33 PM with the Medical Records Supervisor (Staff #208), who stated that the discharge paperwork would be sent to her, and scanned into the clinical records. She also stated that she would send a list of discharged or transferred residents to the Ombudsman once a month. She reviewed the clinical Record and stated there was no evidence that the Ombudsman had been notified of the resident's discharge. She further stated that Resident (#163) was not on that list of discharged / transferred residents for July 2024 that she sent to the Ombudsman. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	An interview was conducted on October 30,2024 at 2:26PM with the Assistant Director of Nursing (ADON/ Staff # 34) who reviewed the July Hospital Transfers and Admission Discharge report and stated that Resident (#163) was not included on the list of transfers or discharges. An interview was conducted on October 31, 2024 at 8:56 AM with the Case Manger (Staff #301), who stated that it is mandatory to notify the Ombudsman when residents are discharged from the facility . She further stated the risk could be that the Ombudsman would not be aware that a resident was discharged . An interview was conducted on October 31, 2024 at 11:34 AM with the Director of Nursing (DON/ Staff # 42) who stated that the Ombudsman would be notified of when a resident transfers or discharges from the facility. She also stated that the Ombudsman was not notified of the resident's discharge in July. A facility Policy titled, Admission, Transfer and Discharge, revealed that when the facility transfers/discharges a resident, the facility will ensure that the transfer / discharge is documented in the Resident medical record and appropriate information is communicated to the receiving health care institution is provided. Review of facility policy titled, Change of Condition Reporting, reviewed on June, 2023 indicated, for acute medical change that the resident representative will be notified that there has been a change in the resident's condition and what steps are being taken. Review of State Operations Manual (Rev. 211; Issued: 02-03-23; Effective: 10-21-22; Implementation: 10-24-22) revealed, S483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.