STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035092	A. Building B. Wing	07/02/2026

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	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** Based on staff and residents interviews, review of clinical record, and review of facility policy and procedure, the facility failed to protect a resident's (#2) right to be free from verbal abuse from a staff member for one of eleven sampled residents. The deficient practice could result in psychosocial harm to the resident.-Findings include:-Regarding Resident #2:Resident #2 was admitted to the facility on [DATE], with diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side, anxiety disorder, depression, type 2 diabetes mellitus, chronic kidney disease, and epilepsy.A quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #2 had a Brief Interview for Mental Status (BIMS) assessment score of 14, indicating intact cognition. Additionally, Section C-Cognitive patterns revealed Resident #2 had no inattention, disorganized thinking, or altered level of consciousness. Section E-Behavior revealed the resident had no hallucinations or delusions. Also, the assessment revealed the resident had exhibited physical and verbal behavioral symptoms toward others between 1 and 3 days.A care plan focus initiated October 8, 2025, revealed Resident #2 demonstrated verbal behaviors due to ineffective coping skills, with interventions that included to analyze key times, places, circumstances, triggers, and what de-escalates the behavior and to document, to assess and anticipate the resident's needs, to assess the resident's coping skills and support system, to document observed behavior and attempted interventions, to give as many choices as possible about care and activities, to provide positive feedback for good behaviors, and for psychiatric consult as indicated.A Psychiatric Note dated June 22, 2026, revealed the visit was a follow-up psychiatric evaluation and that the resident had a history of impulsivity, yelling, and aggression; however, the note included that the resident did not appear to be having increased behavioral disturbance since the last visit.The care plan was reviewed and revealed no evidence that Resident #2 had an actual fall on June 28, 2026, or that the resident had behaviors of intentionally placing himself on the floor.A Change in Condition Note dated June 28, 2026, at 3:57 a.m., revealed Resident #2 had no behaviors of verbal aggression that shift, and was compliant with medications and care.A Behavior Note dated June 28, 2026, at 8:11 a.m. revealed that Resident #2 refused personal care and assistance before breakfast. The note included that Resident #2 was yelling out when staff were passing trays, and that he was informed that staff would assist him. The note revealed that Resident #2 came out of his room with no pants on and was then redirected to his room. Additionally, the note revealed Resident #2 started cursing at staff, threatened to hit staff, and was making false accusations. The note included that the Assistant Director of Nursing (ADON), the provider, and the resident's family were notified.The clinical record was reviewed and revealed no evidence of Resident #2 having a fall or intentionally placing himself on the floor on June 28, 2026.A physician order dated June 29, 2026, included for change of condition monitoring for mood behavior pattern and fear of other patients and staff.A Change in Condition Note dated June 29, 2026, revealed that Resident #2 was on change of condition monitoring for mood behavior pattern and fear of other patients and staff, and that an episode of Resident #2 yelling was observed. The note included that the resident was not observed to be afraid of other patients and staff.- Regarding Resident (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	#35:Resident #35 (who was a resident on the same unit as Resident #2) admitted to the facility on [DATE], with diagnoses of incomplete paraplegia, bipolar disorder, schizophrenia, anxiety disorder, and type 2 diabetes mellitus.A quarterly MDS assessment dated [DATE], revealed Resident #35 had a BIMS assessment score of 15, indicating cognitively intact. The documentation included that Resident #35 had no inattention, disorganized thinking, altered level of consciousness, hallucinations, or delusions. Additionally, the assessment revealed the resident had no episodes of physical or verbal behavioral symptoms.-Regarding Resident #40:Resident #40 (who was a resident on the same unit as Resident #2) admitted to the facility on [DATE], with diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side, schizophrenia, type 2 diabetes mellitus, acquired absence of right leg below the knee, and epilepsy.A quarterly MDS assessment dated [DATE], revealed Resident #40 had a BIMS assessment score of 13, indicating intact cognition. Additionally, the documentation revealed that Resident #40 had no inattention, disorganized thinking, altered level of consciousness, hallucinations, or delusions, and no episodes of physical or verbal behavioral symptoms.-Regarding Resident #30:Resident #30 (who was also a resident on the same unit as Resident #2) admitted to the facility on [DATE], with diagnoses of parkinsonism, unspecified psychosis, schizophrenia, bipolar disorder, muscle weakness, and other abnormalities of gait and mobility.An admission MDS assessment dated [DATE], revealed Resident #30 had a BIMS assessment score of 14, indicating intact cognition. The assessment also revealed that Resident #30 had no inattention, disorganized thinking, altered level of consciousness, hallucinations, or delusions, and no episodes of physical or verbal behavioral symptoms.An interview was conducted on July 2, 2026, at 9:13 a.m., with a certified nursing assistant (CNA / Staff #74), who stated that there was one nurse on the unit whom she observed to be verbally aggressive with residents, and that Staff #74 did not want to state who that staff was.A telephonic interview was conducted with Resident #2's family member / emergency contact on July 2, 2026, at 9:28 a.m. who stated that Resident #2 had informed her that there was one nurse at the facility with whom Resident #2 did not get along with, and that she had heard Resident #2 and the nurse had verbal exchanges back and forth, and that Resident #2 got along with all the other staff members. The family member stated that she believed it was a personality clash between Resident #2 and the nurse. Additionally, the family member stated that Resident #2 was cognizant and aware, and would be able to remember and verbalize if an abusive situation occurred.A telephonic interview was conducted with a licensed practical nurse (LPN / Staff #66) on July 2, 2026, at 12:15 p.m., who stated that Resident #2 often had behaviors of yelling, cursing, and attempting to stand up and hit staff, and that staff would respond by attempting to redirect the resident. Staff #66 stated that around breakfast time on June 28, 2026, that Resident #2 had come out of his room with his brief halfway on, and was yelling and cursing, and Staff #66 stated that she redirected the resident back to his room. At one point during the interview, Staff #66 referred to Resident #2 as a grown a** man. Additionally, Staff #66 stated that she did not go into the resident's room and was never alone with Resident #2 anytime during her shift June 28, 2026.An interview was conducted with Resident #2 on July 2, 2026, at 1:09 p.m., who stated that sometime between several days ago to less than a week ago, Staff #66 was his nurse, and that she had bullied him, and yelled and cursed at him. Resident #2 stated that Staff #66 had gotten him alone in his room, and she threw him down on the floor, and that he did not believe there were any witnesses that saw the nurse throw him on the floor. Resident #2 stated that he did not have any issues with any other staff member. Resident #2 stated the mistreatment he had received from Staff #66 had left him feeling scared.An interview was conducted with Resident #35 on July 2, 2026, at 1:15 p.m., who stated that every staff member treats him really well, except Staff #66. Resident #35 stated that he had been cursed at before by Staff #66, who had told him to shut the f**k up. Resident #35 stated that several days ago, he had witnessed Staff #66 verbally assault Resident #2, and then drag Resident #2 to his room by his wheelchair, and that Resident #35 did not see anything after that.A telephonic interview was conducted with a CNA (Staff #8) on July 2, 2026, at 1:31 p.m., who stated (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that on June 28, 2026, at breakfast time, Staff #8 had observed Resident #2 come out of his room, and then the nurse (Staff #66) was yelling and cursing at Resident #2, and specifically said I don't play that sh*t ni**er, and pushed Resident #2 in his wheelchair very aggressively back into his room. The CNA stated she did not see what happened next inside the Resident #2's room, but then the nurse (Staff #66), who had been in the room alone with the resident, then left the resident's room. Staff #8 stated that directly after that, Staff #8 entered Resident #2's room, and observed Resident #2 sitting on the floor crying, and then Staff #8 helped him get up off of the floor. Staff #8 stated that she did not believe that Resident #2 had placed himself on the floor.A telephonic interview was conducted with a CNA (Staff #29) on July 2, 2026, at 1:48 p.m. who stated that during breakfast time on June 28, 2026, Resident #2 had come out of his room and his pants were down, and the nurse (Staff #66) had told him to go back into his room. Staff #29 stated that she observed the nurse go over to the resident, and then Staff #29 stated she did not pay attention to what happened next because she was busy passing coffee. Staff #29 stated that then she overheard Resident #2 scream get your hands off of me. Staff #29 stated that right after that, she walked past Resident #2's room, and saw that Staff #66 had left the resident's room and Resident #2 was sitting on the floor in his room. Staff #29 stated that Resident #2 was not able to get himself off of the floor, and that another CNA entered the resident's room and helped the resident get off of the floor.An interview was conducted with Resident #40 on July 2, 2026, at 2:13 p.m. who stated that on June 28, 2026, he had observed Resident #2 come out of his room to ask for cigarettes and to smoke, and that there was a verbal exchange between Resident #2 and Staff #66. Resident #40 stated he heard Resident #2 call Staff #66 a bi**h and that Staff #66 said something disrespectful back to Resident #2 and then took the resident back into his room. Resident #40 stated he did not want to repeat what the nurse had said, but that it was disrespectful and not something you would say to a family member. An interview was conducted on July 2, 2026, at 2:34 p.m. with Resident #30, who stated that approximately 4-5 days ago, he had witnessed Staff #66 say something rude to Resident #2, but could not recall exactly what was said.An interview was conducted on July 2, 2026, at 3:05 p.m. with the ADON (Assistant Director of Nursing/ Staff #41), who stated that there were different types of abuse, such as verbal or physical, and that if an allegation of abuse were to occur, that staff were expected to follow the chain of command and report the incident right away to their supervisor. The ADON stated that facility staff were expected to never use foul language toward residents, and if that did occur, then staff would report it right away as an allegation of verbal abuse. The ADON stated that a risk to a resident if staff were to use foul language or verbally abuse a resident would be that the resident could become sad or get their feelings hurt. The ADON stated that on June 28, 2026, she was working on a medication cart in another unit, and that the nurse (Staff #66) had come to her unit and informed her that Resident #2 was acting up and was agitated. The ADON stated she went to Resident #2's unit and attempted to calm the resident. The ADON stated that she went with Resident #2 outside on the patio to sit with him while he smoked a cigarette and that helped to calm the resident.An interview was conducted with the Director of Nursing (DON / Staff #90) on July 2, 2026, at 3:35 p.m., who stated that the facility staff identify and report any allegation of abuse immediately. The DON stated that it is not her job to determine if abuse occurred, and that all allegations are reported to the abuse coordinator / administrator immediately, and that an investigation takes place, and that after the investigation, that it is a collaborative team effort to determine if abuse occurred or not. The DON stated that a risk to a resident if a staff member abused a resident would be a potential injury to the resident. The DON stated that on June 29, 2026, an Adult Protective Services (APS) investigator entered the facility and informed facility staff that there was an allegation of physical and verbal abuse from a staff member toward Resident #2, and the staff member had been identified as Staff #66. The DON stated that she had suspended Staff #66, and the completion of the investigation was pending. Review of the facility policy titled Abuse: Prevention of and Prohibition Against, revised April 2026, revealed that it is the policy of the facility that each resident has the right to be free from abuse, neglect, misappropriation (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of resident property, exploitation and mistreatment. Additionally, the policy revealed that abuse is willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. This includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology.