STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035146	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Paradise Valley	4065 East Bell Road Phoenix, AZ 85032

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** 42319 Based on clinical record reviews, facility and hospital documentation, staff interviews and policy review, the facility failed to ensure that two residents (#17, 10) was free from verbal abuse. Findings include: -Resident #10 was admitted on [DATE] with diagnoses of Major Depressive Disorder, Adjustment Disorder with disturbance of conduct. Review of a care plan initiated 12/19/2023 included that this resident displays comments towards other residents and visitors at times as noted aggressive like behaviors. This care plan included 2 incidents: Family visiting and resident verbalized you need to control your kids and stated fat people are ugly, continued comments related to residents' appearances and body size. 12/19/2023 interaction with another resident and 3/27/24 confrontational language. This care plan included an intervention of observe interaction around others and intervene if noted concerns. However, an abusive incident was noted on 3/27/2024. A progress note dated 3/27/2024 included that at approximately 1530, nurse observed resident #17 shouting at resident #10 in T-Hall walk way area near the nurse's station. Nurse stood between the 2 residents to prevent any incidents from occurring. The note stated resident #17 was redirected to the nurse station, and calmed down and resident #10 was assisted by wheelchair to the other end of the hall. Another progress note dated 03/27/2024 included that Social Services (SS) and the Assistant Director of Nursing spoke with resident#10 regarding a verbal exchange that took place between her and resident #17. The note stated that resident#10 stated she did not like the way another resident was dressed and stated that Her fat was hanging out. It was disgusting. Resident #10 stated this upset resident #17. Resident #10 then called resident #17 fatso and resident #17 began yelling. The note further stated SS asked what resident #17 yelled at her and she said she was unable to hear exactly what was said. SS asked resident if she felt safe, she stated yes. SS reminded resident#10 that language can be hurtful and encouraged her to refrain from saying things to others that may be perceived as such. The note stated resident#10 verbalized understanding. (continued on next page)

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	-Resident #17 was admitted on [DATE] with diagnoses of schizoaffective disorder, bipolar disorder current episode manic severe with psychotic features and attention-deficit hyperactivity disorder. Review of a care plan initiated 5/19/2023, resident #17 has a behavior problem yelling, verbal aggression, throws items, plays in feces & accusatory related to delusions/psychosis and included that the resident has expressed thoughts of self-harm and thoughts of harming others. This care plan included an 3/27/2024 verbal aggression, and thoughts of harming self. This care plan included interventions of intervene as necessary to protect the rights and safety of others, approach/speak in a calm manner, divert attention, and to remove from situation and take to alternate location as needed. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] included that this resident experienced delusion, and had verbal behavioral symptoms directed at others and had other behavioral symptoms not directed at others. A progress note dated 3/27/2024 included that at approximately 1530, the nurse observed resident #10 shouting at resident #17 in T-Hall walk way area near the nurse's station. This note includes the nurse stood between the 2 residents to prevent any incidents from occurring. This note included that the resident was redirected to the nurse station, and calmed down and that the other resident #17 was assisted by wheelchair to the other end of the hall. Another progress note dated 3/27/2024 included that at approximately 1533, a nurse transported resident to the office and the writer asked the resident what they could help her with and she stated I'm going to kick her ass. This note included that when the writer asked resident who she was referring to and she named a resident #10. This note included that the writer asked her what transpired and she stated she called my friend fat and I don't appreciate that. (another resident) is not fat and I'm not going to let her talk about my friend like that, then the writer asked her did she mean what she had just said and this resident repeated again I'm going to kick her ass. This note included that the writer asked this resident if she have a plan on how she was going to accomplish that and she stated yes I'm going to strangle her in her sleep and then the writer asked the resident did she want to harm herself as well? and she stated yes and that she did not have a plan. This note included that a medical doctor was consulted and that the doctor said to send the resident out to the hospital for a psychiatric evaluation and that the residents were kept separated until that happened. An interview was conducted on 06/14/2024 at 1:31 P.M. with resident #10 who said that resident #17 is a very disturbed person and that she would go around half naked. This resident said she should cover herself. This resident said that resident #17 came after her multiple times, that she swung at her and called her bitch but they were in wheelchairs passing and she could not hit me. She said that the staff knew and that they restrained her from going after me. An interview was conducted on 6/14/2024 at 1:07 P.M. with a Certified Nursing Assistant (CNA/staff #32) who said that resident #17 was kind of aggressive but denied witnessing incidents between residents. She said that abuse could be verbal and that it should be reported to the nurse right away. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 6/14/24 at 12:46 P.M. with a Licensed Practical Nurse (LPN/staff #55) who said that abuse can be sexual, financial, neglect, seclusion, physical, verbal or mental. She said that if a resident is cussing or threatening another resident it's verbal abuse. She said that if she encountered that situation, that she would make sure that the two residents are never together. This nurse said that she would change floors or change destinations, have social services involved, and care plan that. She said that she would have to make the change occur so it would no longer happen. An interview was conducted on 6/14/24 at 1:45 P.M. with the Director of Nursing (DON/staff #27) who said that if a resident to resident occurs that immediately staff separate them and report right away to management. This DON included that resident #17 was here when she came back in august, and that she had quite a few behaviors, diagnoses, manipulative when they had to set boundaries. This DON said that they had to speak to her about activities, and that she would make statements to other residents, she was very involved in psych services and that they had to monitor her behavior because some days she was manic, some days not. This DON said that resident #17 would get the idea that someone did not like her and she would take things upon herself to resolve it. She said that her understanding of what happened in that instance, that resident #17 said that resident #10 had made a comment about her appearance. This DON stated that resident #10 was also verbally abusive and that incidents were going to happen but that they would take steps to prevent them. A policy reviewed 7/18/2023 revealed that it is the policy of this facility to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation.