

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035146	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/05/2026
NAME OF PROVIDER OR SUPPLIER Life Care Center of Paradise Valley		STREET ADDRESS, CITY, STATE, ZIP CODE 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** Based on clinical record review, staff interviews, facility documentation, and policies and procedures, the facility failed to protect the rights of one resident (#51) to be free from physical abuse from facility staff. The deficient practice could result in appropriate action not taken and further abuse of residents. Findings include: Resident #51 (alleged victim) was admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, adjustment disorder with mixed anxiety and depressed mood, hyperlipidemia, morbid (severe) obesity due to excess calories, neuralgia and neuritis, and abnormalities of gait and mobility. The annual Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident had a BIMS (Brief Interview for Mental Status) score of 15, indicating that the resident is cognitively intact. In a progress note dated June 2, 2026 At 5:46 pm the documentation revealed that at approximately 2:15 pm, LPN (Licensed Practical Nurse/ staff #82) was summoned by CNA (Certified Nursing Assistant/ staff #38) to assist with resident (#51) shower because the resident was exhibiting behaviors of yelling and throwing a hairbrush. Staff #82 had CNA, staff #38, leave the shower room and the LPN took over providing the shower. The resident reported care concerns. In a progress note dated June 3, 2026 At 8:37 pm the documentation revealed DON met with resident. She (resident) stated she is doing well and appeared to be in good spirits. She was smiling when the DON spoke with her. She stated she feels safe in the facility. A telephone interview was conducted with Staff #82 on June 4, 2026 at approximately 12:31 pm. Staff #82 revealed that there was a situation and the CNA (staff #38) asked for assistance with the resident (#51). She (the LPN) went into the shower room and the CNA had told her that the resident had thrown a brush at her. The CNA's clothes and hair were wet. The LPN stated that she stepped behind the privacy curtain with the resident. The resident was yelling and she (LPN) could not understand her. The LPN stated that she asked the resident to calm down a bit so she could be understood. Staff #82 reported that the resident stated that she had asked the CNA (staff #38) if she was just going to stand there and the CNA responded negatively at which time the resident stated to the LPN that she threw the hairbrush. The resident said she threw it in the opposite direction of the CNA. The resident had then reported to the LPN that she was hit by the CNA twice. Staff #82 then asked Certified Nursing Assistant (CNA/Staff #38/Alleged Perpetrator) to leave and that she (LPN) would take over. Staff #82, continued providing care, and looking the resident over. The LPN then called the unit supervisor and the DON with a request to see them in the shower room. Staff #82 noted that Resident #51 had a red area on her right shoulder. Staff #82 then described the red mark as looking like fingers from a slap. Staff #82 stated that abuse allegations should be reported immediately and the residents should be made safe and kept safe. We separate the resident from whoever, resident and staff, make sure they are safe and report it immediately. An interview was conducted with Resident #51 on June 4, 2026 at 1:46 pm. Resident #51 revealed that she was in the shower room trying to brush her hair before her shower and Staff #38 was watching her struggle. Resident #51 then reports that she asked Staff #38 if she was going to help, and Staff #38 said some smart-ass remark. Resident #51 then reported that she threw (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 035146
		If continuation sheet Page 1 of 3

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035146	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/05/2026
NAME OF PROVIDER OR SUPPLIER Life Care Center of Paradise Valley		STREET ADDRESS, CITY, STATE, ZIP CODE 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	the brush at the wall and told Staff #38 that she needs to get a job she likes. Resident #51 then stated that Staff #38 smacked me in the shoulder and smacked me in the back of the head. A telephone interview was conducted Staff #38 on June 4, 2026 at approximately 2:41 pm. Staff #38 revealed that she had gone into the shower room with Resident #51 and handed Resident #51 her hairbrush. Staff #38 then reported that Resident #51 had told her that the staff don't do anything and that they don't do anything to help her, to which Staff #38 said that she asked Resident #51 what was wrong with her. Staff # 38 stated that she told the resident and that if she didn't like it there, then she could go somewhere else. Staff #38 reported that Resident #51 then threw her brush on the floor and it broke. During an interview with the Director of Nursing (DON/staff #112) conducted on June 05, 2026 at 11:45am, she stated that Resident #51 had alleged she had been hit on the arm and that Staff #82 observed what was a red outline that was possibly a hand. Additionally, Staff #112 revealed that it was Staff #82 who told her about the red mark and that Resident #51 had told her that Staff #38 had struck her in the arm and in the back of the head. The DON identified that there was no documentation of the red mark in the resident's record. During an interview with the Administrator (Staff #160) on June 05, 2026 at 12:00 pm she stated that immediately on notification of the allegation, the staff(#38) was removed from care and then was removed from the building. Interviews were conducted to see if other residents are at risk and if staff had concerns. Psychosocial monitoring was conducted for Resident #51 as well as in-service training for staff. Follow-up with the resident is scheduled with the psychiatric provider inhouse. Review of the facility's follow up investigation report received June 08, 2026 revealed that an interview was conducted on June 02, 2026 at approximately 2:30pm with the LPN Staff #82. During the interview, Staff #82 revealed that she was at the nurse's station when Certified Nursing Assistant (CNA/Staff #38/Alleged Perpetrator) came out of the shower room and asked for assistance with a resident who was exhibiting increased behaviors in the shower room. She entered the shower room and saw that Resident #51 was sitting in a shower chair behind the privacy curtain and a broken hairbrush was on the floor. Staff #82 asked Resident #51 what was wrong, however, Staff #82 could hardly understand Resident #51 because she was upset and crying. Staff #82 provided therapeutic communication to calm Resident #51, who then reported to Staff #82 that Staff #38 hit her twice; on the right arm and on the back of her head. Staff #82 assessed Resident #51's arm and noticed a red area. She assessed the back of her head and did not observe any redness or injury. Additionally, Staff #82 revealed that Staff #38 had told her that Resident #51 had thrown a hairbrush at her. Further review of the facility's follow up investigation report revealed that an interview was conducted with Staff #38, in which Staff #38 revealed that Resident #51 had thrown the hairbrush on the floor. In the facility follow up investigation it identified that the CNA told LPN that the resident had thrown the hairbrush at the CNA and then this CNA (staff#38) repeated the details and told ADMIN and DON that the hairbrush was thrown on the floor. Further review of the facility's follow up investigation report revealed a timeline of events, which revealed that Staff #82 had assessed Resident #51's shoulder and head for injury and observed what looked like a red mark with fingers. Further review of the facility's follow up investigation report revealed that based on the a comprehensive review of the resident's medical record, the information gathered and analyzed during the investigation, staff and resident interviews, the facility found the allegation of abuse was verified based on the nurse observation of redness on the residents arm that appeared to be a silhouette of fingers. The facility identified the deficient practice after the incident on June 2, 2026. The facility completed an event check list and held an ad hoc QAPI meeting. The facility began a plan of correction that included an inservice directed at all staff to define abuse and reporting. The facility also initiated de-escalation training with return demonstration. Interviews with random staff members verified consistent knowledge. Review of the facility policy titled Abuse - Identification Types, reviewed date April 01, 2026, revealed that the resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation, and that this includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035146	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/05/2026
NAME OF PROVIDER OR SUPPLIER Life Care Center of Paradise Valley		STREET ADDRESS, CITY, STATE, ZIP CODE 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	required to treat the resident's medical symptoms. The policy also defined abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Further, the policy also states that 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.		