

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 06/24/2026
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, review of clinical record, and review of facility policy and procedure, the facility failed to ensure a comprehensive care plan was implemented for one of three sampled residents (#25) to ensure safe mobility during a functional transfer. The deficient practice could result in injury to a resident, or failure to honor a resident's preference.-Findings include:Resident #25 was admitted [DATE], with diagnoses of schizophrenia, anxiety, depression, emotional lability, chronic obstructive pulmonary disease, gangrene and necrosis of lung, and sarcopenia. A care plan focus initiated October 23, 2024, revealed Resident #25 had an activities of daily living (ADL) performance deficit due to weakness.Additionally, a care plan focus initiated September 26, 2025, revealed the resident had episodes of paranoia as evidence by making statements about other residents and staff that were unfounded.A revision to the resident's ADL care plan focus dated March 11, 2026, revealed two additional interventions for transfers: the resident required a mechanical hoier lift with two staff assistance, and the resident was totally dependent on two staff for transfers.A quarterly minimum data set (MDS) assessment dated [DATE], revealed Resident #25 had a Brief Interview for Mental Status (BIMS) assessment score of 12, indicating moderate cognitive impairment. Section E-Behavior revealed that Resident #25 had no hallucinations or delusions, and no behavioral symptoms. Section GG-Functional Abilities revealed the resident required substantial / maximal assistance to perform lying to sitting on the side of the bed. Additionally, the resident required dependent assistance for transfers to and from the bed to a chair or a wheelchair. The assessment revealed the resident did not walk, and that she used a wheelchair for mobility.An Incident Report dated June 22, 2026, revealed a certified nursing assistant (CNA) notified the nurse (Staff #31) that Resident #25 was upset and in pain after a bed to wheelchair transfer. The documentation revealed the nurse went to the resident's room and asked the resident what was wrong, and the resident stated she was transferred manually by a CNA onto her wheelchair, causing pain in her abdominal area and lower left leg during the transfer. The report revealed the nurse reported the incident to the nurse manager, the CNA was asked to leave the area, the wound nurse performed a skin assessment, and x-rays were ordered to the resident's lower back and left lower extremity.A Behavior Note dated June 22, 2026, revealed the nurse was called to the resident's room regarding a care concern on June 22, 2026, and an intervention was added for frequent psychosocial visits to ensure the resident feels safe in her environment.A physician's order dated June 22, 2026, indicated for stat (immediate) x-rays to the resident's left upper and lower leg, ankle, and back due to pain.A facility self-report submitted to the State Agency dated June 22, 2026, revealed that at 4:45 p.m., Resident #25 stated that the CNA put her roughly in the chair and grabbed her breast. The report revealed that another CNA was present during that time, and stated this did not occur. The documentation included that the accused CNA was removed from care areas and sent home pending investigation.A written staff interview/statement dated June 22, 2026, by a CNA (Staff #56) revealed Staff #56 went to check on Resident #25 to see if she needed changing, and the resident requested to get up in her wheelchair. The statement revealed that Staff #56 and the witness assisted the resident by changing her, and then Staff #56 proceeded to (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 4

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transfer the resident to her wheelchair from the bed. The documentation revealed that the resident stated she did not like the way that Staff #56 transferred her, and that Staff #56 had strangled her. Staff #56 immediately notified the nurse and supervisor of the situation. A written staff interview/statement dated June 22, 2026, by a CNA (Staff #20) revealed that Staff #20 and Staff #56 went to Resident #25's room to change the resident, who then demanded to get up in her wheelchair. The documentation revealed that Staff #20 and Staff #56 changed the resident, and then Staff #56 proceeded to transfer Resident #25. During the transfer, the resident became upset and verbalized care concerns, and then Staff #20 and Staff #56 went and reported the incident to the nurse immediately. Another written staff statement/interview dated June 22, 2026, by a licensed practical nurse (LPN / Staff #31) revealed that a CNA (Staff #56) came and informed Staff #31 that he had transferred Resident #25 manually, and the resident reported pain in the abdomen and left lower leg during the transfer. The documentation revealed the nurse asked Staff #56 why he did not use a hoist lift, and Staff #56 stated that the resident appeared in a rush and asked to be transferred quickly. The nurse went to the resident's room and Resident #25 advised the nurse that she was in pain after the manual transfer. The resident also stated that another CNA (Staff #20) was in the room at the time of the transfer. The nurse then asked Staff #20 what happened, and Staff #20 informed the nurse that Staff #56 had transferred the resident manually, causing pain in the abdomen and left lower leg, and that he had transferred the resident to the wheelchair by lifting under the resident's arms. The document revealed that Staff #20 also informed the nurse that Staff #56 had not touched the resident's neck or strangled her. The document also revealed that the nurse manager was informed of the incident and that the wound nurse performed a skin assessment of Resident #25. A weekly skin assessment dated [DATE], revealed a skin impairment on the resident's right outer ankle, 1.0 x 1.0 centimeters, and that the skin integrity was disrupted involving the epidermis only, and included a slight pink color, and that the surrounding skin was intact. A physician's order dated June 23, 2026, included change in condition monitoring due to care concerns, every shift for 3 days. A revision to the care plan focus for the resident's episodes of paranoia dated June 23, 2026, revealed a care concern on June 22, 2026, and an added intervention for frequent psychosocial visits to ensure the resident feels safe in her environment. An observation was conducted on June 24, 2026, at 9:08 a.m. of Resident #25 laying in her bed in her room. An Adult Protective Services (APS) investigator was in the room beside the resident and was conducting an interview with the resident. An interview was conducted on June 24, 2026, at 9:17 a.m. with the APS investigator, who stated that she interviewed the resident regarding the incident on June 22, 2026. The APS investigator stated that Resident #25 stated that a few days ago, she was in her bed and had asked a male staff member to help her get up in her wheelchair so that she could go downstairs. The APS investigator stated that the male staff did not give her any prompts, and picked her up with his hands under her armpit area, and flung her around like a rag doll to the wheelchair, and that he did not sit her straight in the wheelchair. The APS investigator stated that the resident said that then a female staff who was in the room corrected the male staff and told him to straighten Resident #25 in the wheelchair, and then the male staff straightened her in the wheelchair. The APS investigator stated that Resident #25 informed her that during the transfer, the male staff's hand had touched above her breast, and that Resident #25 stated that it was likely an accident, and that the male staff probably did not intend to touch above her breast. A telephonic interview was conducted on June 24, 2026, at 10:57 a.m. with a CNA (Staff #20) who stated that staff normally provide care in pairs, with two staff present, for Resident #25 due to her past behaviors of allegations against staff. The CNA stated that on June 22, 2026, Staff #56 and she went into Resident #25's room before dinner to change the resident. The CNA stated that they changed the resident, and the resident was demanding to get up out of bed into her wheelchair. The CNA stated that then Staff #56 moved Resident #25 from lying to sitting on the edge of the bed, and then performed a one-person transfer for Resident #25 to the wheelchair. The CNA stated that Resident #25 was saying that Staff #56 was squeezing her tightly and that she was uncomfortable, (continued on next page)		

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The CNA stated that the resident then started accusing him that he had strangled her and hurt her, and the CNA then left the room and reported the situation immediately to the nurse (Staff #31). The CNA stated that if he could do the situation over again, he would have used the hooyer lift to transfer the resident. A telephonic interview was conducted with an LPN (Staff #31) on June 24, 2026, at 11:23 a.m. The LPN stated that on June 22, 2026, a CNA (Staff #56) came to her and told her that Resident #25 was being changed, and wanted to get up into her wheelchair as soon as possible, and that Staff #56 had transferred the resident quickly to the wheelchair by picking her up under her arms. The nurse stated that she went to the resident's room and the resident was crying and stated the CNA had hurt her. The nurse stated that she asked the resident what happened, and the resident stated that Staff #56 had squeezed her and strangled her, and that her stomach and leg hurt. The nurse stated that she asked the other CNA (Staff #20) who was present in the room at the time what had happened, and the CNA stated that Staff #56 had transferred the resident, but had not strangled her. The nurse stated that the resident was a heavy patient, and a hooyer lift should have been used for the transfer. An interview was conducted with an LPN / staff development manager (Staff #85) on June 24, 2026, at 12:01 p.m. who stated nursing staff would follow the care plan to safely assist a resident with functional transfers. Staff #85 stated that she was familiar with Resident #25, and that the resident had high anxiety, hallucinations, and accusatory behaviors, and required care in pairs for staff to have a witness present. Staff #85 stated that Resident #25 required a hooyer lift to transfer to the wheelchair, and that it was not safe for a single staff to attempt to manually transfer the resident, and it would not matter how big or strong that staff member was. Staff #85 stated on June 22, 2026, staff called her to inform her of the incident with Resident #25, and that Staff #85 was informed that Staff #56 had transferred the resident manually, with his hands under her arms, to the wheelchair. Staff #85 stated that when she arrived to the resident's room, the resident stated that she had pain in her left leg, and that there was a very light red mark on her left leg that may have resulted from the transfer, however it was hard to say for certain. Staff #85 stated that if a staff were performing that type of manual transfer, a gait belt should be used to lift the resident, instead of lifting a resident under their arms. Additionally, Staff #85 stated that for Resident #25, Staff #56 should not have transferred her manually and should have used the hooyer lift, per the care plan. An interview was conducted with the interim Director of Nursing (DON / Staff #66) on June 24, 2026, at 2:33 p.m. who stated that the process for ensuring residents were safely assisted with mobility was that staff were trained extensively as part of onboarding, that nursing staff have monthly meetings, and that CNAs share pertinent information through verbal report each shift. The DON stated that information regarding safe transfer technique should be in the resident's care plan. Regarding Resident #25's incident, Staff #66 stated that she was not familiar with the details of the incident, but that she had learned the resident was on change of condition monitoring after the incident. The clinical record was reviewed, and the DON stated that Resident #25 had a care plan focus for ADLs and it included that for transfers, the resident was totally dependent with two staff, and required a mechanical hooyer lift. The DON stated that regarding the incident, a CNA notified the nurse that the resident was upset after she was transferred manually to her wheelchair, and that she could not tell exactly what occurred or if the care plan was followed because the investigation was still ongoing. The DON stated that there (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	could be risk to a resident if the care plan was not followed, and could result in an unsafe situation or the resident having a fall. An interview was conducted with the Administrator (Staff #4) on June 24, 2026, at 3:09 p.m. who stated that the process for ensuring residents are safe when staff are assisting with their mobility was for staff to follow the care plan or care profile, and that residents were assessed upon admission and routinely to determine what level of assistance was needed. Staff #4 stated that if the care plan was not followed for assisting a resident with a transfer, then the resident could get injured. Staff #4 stated the steps for assisting with a safe transfer included ensuring staff are following proper body mechanics, ensuring the resident had appropriate footwear, and for staff to explain the procedure and ensure the resident understands before proceeding with the transfer. Additionally, Staff #4 stated that staff should use a gait belt when lifting a resident for a transfer, unless there was a contraindication such as the resident having a fractured rib. Staff #4 stated if staff did not use a gait belt to lift a resident, then the resident could be at risk for injury. Regarding Resident #25, Staff #4 stated that the resident required a hoist lift to transfer. Staff #4 stated that she was first notified of the incident when Staff #85 had called her to inform her that Resident #25 stated that Staff #56 threw her in the chair, touched her breast, and strangled her. Staff #4 stated that Staff #56 was suspended pending the investigation of the incident, and that the resident was assessed for injury and did not have any. Staff #4 stated that through the course of the investigation, she learned that the resident's allegations regarding the CNA touching the resident's breast and strangling her were not substantiated; however, Staff #4 stated she did learn that Staff #56 had manually transferred the resident, and that it did not meet her expectation of following the care plan. After the incident, Staff #4 stated that one-on-one education was provided to Staff #56, as well as in-services for all the staff regarding safe hoist transfers and following the plan of care. Review of the facility policy titled Area of Focus: Care Planning- Baseline, Comprehensive, and Routine Updates, revised November 25, 2024, revealed the comprehensive care plan is developed after the MDS Assessment is completed to address the resident's goals and preferences, contain measurable objectives and timeframe, interventions to assist the resident meets their goals, additional follow-up and clarification, items needing additional assessment, testing, and review with the practitioner, items that may require additional monitoring but do not require other interventions, and the resident's preference and potential for future discharge and discharge plan. The policy additionally revealed that Federal Regulation S483.21(b) requires the facility to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and time frames to meet a resident's medical nursing, and mental and psychosocial needs that are identified in the comprehensive assessment (MDS).		