STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035154	A. Building B. Wing	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Agave Grove Post Acute	8641 North 67th Ave Glendale, AZ 85302

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interviews, review of records, and review of facility policy and procedure, the facility failed to report an allegation of abuse within the required timeframe to the state agency for one (#5) out of three sampled residents. The Universe was 118. The deficient practice could lead to ongoing abuse leading to harm of a resident.-Findings include:Resident #5 was admitted to the facility on [DATE], with diagnoses that included bipolar disorder, anxiety, depression, insomnia, and hypertension. An admission minimum data set (MDS) assessment dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition.A care plan initiated on April 28, 2026, revealed that Resident #5 had a behavior problem related to false and accusatory statements towards staff. The interventions included assist to develop more appropriate methods of coping, interacting and encourage to express feelings appropriately.A nursing progress note dated June 21, 2026, at 1:39 p.m., revealed that Resident #5 exhibited an altered level of conscious (LOC) and altered mental status. The note revealed that the resident appeared drowsy, slurring her words and was belligerent towards staff. The nursing progress note also revealed that the resident knocked the bedside table over, water spilled and she accused staff of throwing water at her. The note indicated that Resident #5 was having accusatory delusions, refusing care and called the police. The note included that the police reported that Resident #5 was exhibiting with behavior issues and they took her to the hospital for altered mental status and behavior issues. However, there was no evidence in the clinical record that the resident's complaint reported on June 21,2026 had been reported following the facility policy, to include the state agency. On June 24, 2026 at 10:00 a.m. the facility 5 day investigation reports for May 2026 - June 2026 were requested. However, the facility reported there were no facility self reports during May 2026 and June 2026. The facility provided no evidence that the incident that occurred on June 21, 2026 was reported to the state agency. An interview was conducted on June 24, 2026, at 1:56 p.m., with a licensed Practical Nurse (LPN, staff #47) who stated that there are different types of abuse, including physical, verbal, financial. The LPN stated that facility process, when there is an altercation between a resident and a staff member, is that the resident gets separated and assessed from head to toe. The LPN stated that the incident is then reported to the state agency (Arizona Department of Health Services, AZDHS), APS (Adult Protective Services), the Police Department immediately or within 24 hours (hrs.) and an investigation will start if it deemed abuse. The LPN stated that Resident #5 had behaviors towards staff including slurring, yelling, screaming and refusing care. The LPN stated that the incident happened on Sunday, June 21, 2026, when Staff #47 went inside the room of Resident #5, and the resident started knocking over things on the bed side table including the water pitcher, then started screaming, yelling and making false allegation that the LPN threw water on her. The LPN stated that Resident #5 then called Emergency Medical Services (EMS) and notified EMS staff that LPN (staff #47) threw water on her. The LPN further stated that EMS staff notified her that Resident #5 made an allegation of throwing water on her. The EMS staff also stated that the cognition status of Resident #5 was unstable and that they took her to the hospital. The LPN stated that there were no other staff (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035154	A. Building B. Wing	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Agave Grove Post Acute	8641 North 67th Ave Glendale, AZ 85302

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or resident present in the room during the incident. The LPN then stated that she then notified the charge nurse of the incident and the nurse notified the Director of Nursing (DON, staff #150). The LPN further stated that risk for staff and resident altercation, not investigated, would include that abuse would continue to happen and would not stop.An interview was conducted on June 24, 2026, at 2:33 p.m., with the Director of Nursing (DON, staff #150) who stated that abuse means infliction of harm towards resident, and there are all kinds of abuse including physical, verbal, mental, emotional, and financial. The DON stated that the facility process on suspected abuse would be to separate the resident, making sure resident is safe, notify State Agency within 2 hrs., suspend staff pending investigation, and then submitting the investigative report to State Agency within 5 business day. The DON stated that on June 21, 2026, Resident #5 was observed by LPN (staff #47) throwing water and other items from bedside table and accusing the LPN of throwing water on her face and chest and then calling EMS. The LPN then notified the registered nurse (RN, staff #124) of the incident, who then notified the DON. The DON stated that she would consider the incident as an allegation of abuse and should have reported the incident to the State Survey Agency with 2 hrs., as per the facility policy. The DON then stated that risk, if abuse was not reported to the State Agency and investigated then abuse would cause further harm to residents.An interview was conducted on June 24, 2026, at 3:04 p.m., with the Resident #5 who stated that the incident occurred either last Saturday or Sunday, and stated that LPN (staff #47) was screaming her name and told her to wake up but Resident #5 refused to wake up. The Resident #5 then stated that the LPN came back to her room again and forced medication into her mouth with liquid, and was screaming and throwing water on her face and chest. Resident #5 stated that she then called EMS and notified EMS and the Certified Nursing assistant (CNA, staff #64) regarding the incident.An attempt was made to call CNA (staff #64) on June 24, 2026, at 3:22 p.m. but there was no response. Review of the facility policy titled, Reporting Alleged Violations of Abuse, Exploitation or Mistreatment, the facility will ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately but not later than two hours after the allegation is made if the events that cause the allegation involves abuse or results in serious bodily injury and not later than twenty-four (24) hours if the events that cause the allegation does not involve abuse and does not result in serious bodily injury. The policy further revealed that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported to the Administrator of the Facility, the State Survey Agency, Adult Protective Services.