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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035158	A. Building B. Wing	03/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prescott Village Nursing & Rehabilitation	1030 Scott Drive Prescott, AZ 86301

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record review, interviews, and review of the facility's policies and procedures, the facility failed to ensure a physician's order was in place prior to one resident's (#60) discharge. The sample size was three and the universe was 50. The deficient practice could result in a resident having an unsafe discharge.Findings include:Resident #60 was admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting the right dominant side, dysphagia, acute kidney failure, and major depressive disorder.The admission Minimum Data Set (MDS), dated [DATE], revealed Resident #60 did not complete a Brief Interview for Mental Status (BIMS) assessment. Instead, staff assessed his cognitive skills for daily decision making as moderately impaired.The discharge MDS, dated [DATE], revealed that staff assessed his cognitive skills for daily decision making as severely impaired.The progress notes revealed an entry, dated November 24, 2025 at 3:54 P.M., indicating Resident #60 was discharged home with a family member.The physician's orders for Resident #60 did not reveal an order for the resident to be discharged from the facility.Resident #60's care plan did not reveal discharge goals or objectives.An undated Discharge Planning Review form indicated the resident was discharged home due to insurance. It was also noted that Resident #60 was not going to have a caregiver after discharge and no home services were in place.On March 5, 2026 at 2:41 P.M. A physician's order for the resident's discharge with home health services was submitted by the facility. Further review of the order indicates it was a verbal order with an order date of November 24, 2025 and was confirmed by the Assistant Director of Nursing (ADON/Staff #1). The printed date on the order was March 5, 2026.A secondary review of the physician's order list did not reveal a discharge order in the order tab Resident #60's EHR (Electronic Health Record).An interview was conducted on March 5, 2026 at 2:45 P.M. with Staff #1. Staff #1 shared that when a resident is discharging from the facility, they need a discharge summary, physician's orders indicating the resident is able to discharge from the facility, and a recapitulation of the resident's stay. Staff #1 further shared that the discharge orders can be found with the regular orders in the electronic health record (EHR). Staff #1 recalled remembering resident #60 and shared that she was issued a Notice of Medicare Non-Coverage (NOMNC) and the family had appealed. He also shared that even if a resident was given a NOMNC, they would still require a physician's order for a discharge and the orders would be in place prior to a discharge. When asked if a Physician's orders for discharge was in place prior to Resident #60 being discharged , he shared that he was asked by the Interim Director of Nursing (Staff #101) to put in the discharge orders today. He further shared that he was not sure of the Physician had given them an actual order for the discharge but recalled that the Physician was aware of the discharge as it was discussed during a Quality Assurance and Performance Improvement (QAPI) meeting. Staff #1 explain that the risk of discharging a resident without a Physician's order would be the resident being discharged when the Physician has a concern, related to the resident, that the facility is not aware of.An interview was conducted on March 5, 2026 at 3:00 P.M. with Staff #101. She explained that residents who discharge from the facility need to have a physician's order prior to discharge. Staff #101 shared (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that Resident #60 was discharged on November 24, 2025 and that the Physician's order was received the day of the discharge. However, she also confirmed that the discharge order was put into the EHR today.An interview was conducted on March 6, 2026 at 8:57 A.M. with Licensed Practical Nurse (LPN/Staff #11). He shared that everything related to a resident needs a physician's order and this included the discharge of a resident. He explained that they cannot do anything without a physician's order. Related to Resident #60, Staff #11 looked at the EHR and shared there was an order for the resident's discharge with home health services on November 24, 2025; however, he also explained that the order was created yesterday by the ADON (Staff #1). Staff #11 shared that the order tab section of the EHR would be the only place in the system where you could find the physician's orders. He also shared that when it comes to discharging residents, they are usually informed of the upcoming discharges by social services and he assumes that there would be an order for it since it is required. He added that he should be looking to see if there is an order before a resident is discharged from the facility.Review of the facility's policy and procedure, titled Transfer and Discharge revealed it was last revised in June 2020. The policy and procedure explained that residents are transferred or discharged upon a physician's order. It further explained that the resident's clinical record will have documentation from the physician indicating that the transfer/discharge is because it is either necessary for the resident's welfare or the resident's health has improved and no longer required services at the facility.