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	06/09/2026

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 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, and policy review, the facility failed to protect one resident's (#76) rights to be free from resident-to-resident abuse by another resident (#14). The deficient practice could result in residents being physically and emotionally harmed. Findings include:-Regarding Resident #76Resident #76 was admitted to the facility on [DATE], with diagnoses that included a disorder of the thyroid, muscle weakness, mild cognitive impairment, hypertension, and amnesia.An annual Minimum Data Set (MDS) dated [DATE], revealed that the resident had a Brief Interview of Mental Status (BIMS) assessment score of 14, which indicated intact cognition. The MDS revealed that the resident had not exhibited behaviors directed towards others and that she had amnesia. A change of condition (COC) assessment dated [DATE], revealed that on May 15, 2026, the resident had a resident-to-resident altercation with her roommate/husband, who became confused and started yelling and swinging towards his wife. The COC assessment revealed that the certified nursing assistant (CNA) and the nurse entered the room at the time of occurrence and noted that the resident was yelling, and that the male resident was aggressive and agitated. The COC assessment also revealed that the residents were separated, frequent checks were initiated, and all parties were notified, and that the change of condition involved the resident's husband/roommate becoming agitated and aggressive with her due to confusion. A progress note dated May 15, 2026, at 7:28 p.m. revealed that the nurse was informed by staff that screaming came from the resident room, and that the resident was hit by her spouse, according to the nurse and Certified Nursing Assistant (CNA). The note revealed that the resident had no idea why he was hitting her, and the spouse was removed from the room with skin and pain assessments completed, and the responsible party, Director of Nursing (DON/Staff 28), and the administrator were notified. A progress note dated May 15, 2026, at 7:46 p.m. revealed that the residents were immediately separated and that Resident #76 reported to the nurse that she felt safe, and that Resident #14 was just confused. A progress note dated May 16, 2026, at 4:58 p.m. revealed that the provider was notified of the patient's wishes to share a room with her husband, and agreed that the patient and her husband could be in the same room.A progress note dated May 16, 2026, at 7:30 p.m. revealed that the daughter was asked about the room-sharing situation between Resident #14 and Resident #76, due to being kept separate after the occurrence on May 15, 2026, and the daughter stated that she wanted them back together if they wanted to be put back together, and to follow their wishes. A progress note dated May 16, 2026, at 7:45 p.m. revealed that the nurse asked the resident throughout the day if she was ok or hurting, and the resident told them she was okay and not hurting anywhere. The note revealed that the nurse asked if she remembered what happened the night before, and the resident stated that she remembered police being there. The note also revealed that the nurse asked the resident if she felt safe if her husband came back into the room with her, and the resident stated, It'll be ok because I know you are all here if something happens. A progress note dated May 17, 2026, at 8:31 a.m. revealed that the DON interviewed the resident and that the resident was alert and oriented times three. It was documented that she was happy that her husband was back in the room with her, and that both residents reported (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they slept well together the night before. A progress note dated May 17, 2026, at 2:47 p.m. revealed that the resident was asked if she wanted her husband to move back into the room with her, or if she would feel more comfortable separate, and the resident stated that she wanted him back in their room and that she was not afraid. The note also revealed that the writer had educated the resident on the possibility of a similar situation happening again, because it was unpredictable, and the resident stated that she understood and would still like him to come back. A care plan focus initiated on May 17, 2026, revealed that the resident was at risk and experienced an altercation with another resident, her husband, with whom she shared a room. The care plan focus had goals that the resident would not experience injury or aggression from her roommate, her husband, and had an intervention to frequently check the room. A care plan focus initiated on May 17, 2026, revealed that the resident had a history of trauma with a goal to create an emotionally and physically safe environment, and had interventions to encourage the resident to verbalize feelings of distress and help the resident deal with anxiety-producing experiences. A progress note dated May 22, 2026, at 10:34 p.m. revealed that the nurse heard screaming coming from the unit, and she found the female resident screaming. The note revealed that the nurse assessed the situation and saw a man grabbing the female's wrist as she was trying to pull away while holding a tissue box. The note further revealed that the nurse approached the couple calmly and gently to redirect the male resident until he released the female. The note also revealed that the CNA approached the male and distracted him while the nurse assessed the female for injuries, and the patient stated, he hit me and grabbed me. The note revealed that the male did not recognize his wife and stated that he did not have a daughter before making confused statements and being separated and removed from the room. The note also revealed that the DON and the daughter of the residents were notified, and that Resident #76 did not have pain or any injuries noted at that time, while Resident #14 was taken to the nurses' station for 1:1 care and given his as-needed medication. The note revealed that the male resident was temporarily moved to another room. A progress note dated May 26, 2026, at 11:41 a.m. revealed that the DON interviewed Resident #76, who reported that she was never hit, and that the nurse reported that the resident shared he was hitting at her but did not connect with her, and that no nursing staff witnessed any hitting, pushing, or other violence. A medical practitioner's progress note dated May 30, 2026, at 9:24 a.m. revealed that the resident had recently been separated from her husband because he was demented and had become increasingly abusive towards her, and that she was quite tearful that day. -Regarding Resident #14Resident #14 was admitted to the facility on [DATE], with diagnoses that included dementia, atherosclerotic heart disease, hypertension, muscle weakness, atherosclerosis, cognitive communication deficit, hypothyroidism, left shoulder pain, and chronic kidney disease.A care plan focus initiated on February 18, 2026, revealed a behavior of verbal threats and yelling noted when CNAs attempted to get the resident into the shower with a goal for the resident to not hit or injure any resident or staff member in the next 90 days. An annual Minimum Data Set (MDS) dated [DATE], revealed that the resident had a Brief Interview of Mental Status (BIMS) assessment score of 09, which indicated mild cognitive impairment. The MDS also revealed that the resident had not exhibited physical or verbal behaviors directed towards others, and that he had non-Alzheimer's dementia. A progress note dated May 15, 2026, at 7:23 p.m. revealed that the nurse heard screaming on the unit and followed the scream to a room where she noticed Resident #14 hitting at his wife. The note revealed that the nurse intervened and stopped the hitting, and the resident stated, Get that bastard out of here, and you get out of here too. The note revealed that the nurse stated, You were hitting her and the resident stated to get that bastard out of the room. The note further revealed that the nurse saw the night nurse in the hall and explained what had happened, and the DON and daughter were notified of the situation, with the DON reporting that she would notify the administrator. A review of the facility's investigation dated May 15, 2026, revealed that the facility reported that at 7:15 p.m., a CNA heard a female resident yelling and ran into the room where Resident #14 struck Resident #76. The facility investigation revealed an investigation checklist with a resident-to-resident allegation date of May 15, 2026. The facility (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	investigation also revealed that the administrator, DON, Arizona Department of Health Services (AZDHS), Adult Protective Services (APS), Ombudsman, power of attorney, physician, and police were notified of the altercation on May 15, 2026. The facility investigation revealed that Resident #14 woke up at approximately 7:20 p.m. on May 15, 2026, from what he described as a nightmare, was very confused, began yelling and frantically hitting his wife, Resident #76, and was telling her to leave before staff responded immediately and intervened. The facility investigation further revealed that the residents were re-interviewed in the morning, and neither could recall the incident. The investigation also revealed that the Registered Nurse (RN/Staff #92) who was coming onto the night shift on the day of the incident was interviewed and stated that she had just gotten on to her shift when Resident #76 and Resident #14 were yelling, and that the day shift Licensed Practical Nurse (LPN/Staff #70) and CNA ran to the room and broke them up. A continued review of the facility's investigation revealed a written witness statement form dated May 15, 2026, at 7:08 p.m. by the CNA, Staff #35, who stated that she heard a very loud scream and stepped out of another resident's room to see what was happening. The written statement further revealed that the CNA entered Resident #76 and Resident #14's rooms and saw Resident #14 repeatedly slapping his wife and striking her in the face while she tried to dodge his blows. The written statement also revealed that the CNA returned to the room at 7:40 p.m. and asked Resident #76 if she wanted to remain in the same room as her husband, and she replied that she did not. The facility investigation also revealed a written witness statement form dated May 15, 2026, at 7:10 p.m. by the LPN, Staff #70, who stated that she heard screaming down the hall and saw Resident #14 hitting his wife before she intervened and told him to stop hitting his wife. The facility investigation also revealed a written witness statement form dated May 15, 2026, at 7:30 p.m. by the RN, Staff #92, who stated that staff informed her of the incident and that the day shift nurse and CNA reported seeing the male resident hitting the female resident, and that notifications and room arrangements had been made. A medical practitioner's progress note dated May 16, 2026, at 4:50 p.m. revealed that the resident was a [AGE] year-old man who was residing in the same room as his wife in the facility. The note further revealed that the resident became quite aggressive at about 6 p.m. the day before, and he had to be forcibly removed from the room. The note also revealed that the resident's wife also had dementia and did not remember anything that happened with regard to aggressive behaviors, and that she was willing to take Resident #14 back into the room. The note revealed that the resident had not had any aggressive behaviors while his wife had been a resident at the facility, and when he was there by himself, he would become agitated. The note also revealed that the assessment of the resident was that he had dementia with agitation and belligerent behavior, including physical striking of his wife. A social services progress note dated May 17, 2026, at 2:12 p.m. revealed that the resident was involved in an incident with his wife over the weekend, which was reported to the administrator, daughter, and local officials, and that the residents were separated after the incident, but the daughter thought it was safe to put them back in the room together. A COC assessment dated [DATE], revealed that the resident was noted by the nurse and aid to have gotten severely confused and become agitated and aggressive with his roommate/wife. The assessment also revealed that the resident experienced behavioral changes, including physical aggression, danger to self or others, and other behavioral symptoms. The assessment revealed that the dangerous behaviors included hitting, yelling, and swinging arms, and that his behavioral changes included increased confusion, which was causing agitation and aggression. A care plan focus initiated on May 17, 2026, revealed that the resident had severe confusion that increased and caused behaviors including verbal and physical aggression. A care plan focus initiated on May 17, 2026, revealed that the resident experienced severe confusion that caused behaviors of agitation and aggression, at times, with interventions that included, after the occurrence on May 15, 2026, a room move being completed for the safety of the resident's wife and frequent room checks. An alert progress note dated May 24, 2026, at 12:21 a.m. revealed that the resident was moved to another room at 7 p.m., related to a recent incident with his wife, and that the resident was (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in a single private room. An alert progress note dated May 25, 2026, at 12:45 a.m. revealed that the resident had incidents with his wife on May 15, 2026, and May 22, 2026, and that he was moved temporarily to a single private room for the safety of others, and that he was resting in bed with his as-needed medication given. A social services progress note dated May 27, 2026, at 8:21 a.m. revealed that a trauma assessment was done that day with the resident due to a situation over the weekend between him and his spouse, with whom he shared a room. The note revealed that he did not seem to remember the incident and that the resident and spouse were separated for safety. A telephonic interview was attempted on June 9, 2026, at 12:52 p.m., 1:32 p.m., and 3:06 p.m. with a RN, Staff #92, with no success.A telephonic interview was conducted on June 9, 2026, at 12:54 p.m. with an LPN, Staff #70, who stated that physical abuse was defined as physical contact with a resident, including grabbing an arm, holding someone down, hitting, or slapping. The LPN stated that she witnessed the first time there was a resident-to-resident altercation between Resident #76 and Resident #14 in which Resident #14 hit Resident #76's left cheek with his right hand. The LPN stated that there were no bruises or markings at that time, and that the altercation was witnessed by her, and did happen. The LPN stated that Resident #14 was yelling get that bastard out of here while he was hitting her, and that the LPN witnessed him making contact with her face at least twice while Resident #76 tried to block it. The LPN stated that the couple would have marital spats, and it was reported that there was another allegation of abuse that happened after the altercation she witnessed, but that she was not there for the second altercation. The LPN further stated that Resident #14 moved back into the room after the first altercation, but that they were separated again after the second altercation, and Resident #14 had since passed away. A telephonic interview was conducted on June 9, 2026, at 2:01 p.m. with the Nurse Practitioner (NP/Staff #87), who stated that an altercation occurred between Resident #76 and Resident #14 a couple of weeks ago. The NP stated that the incident occurred when the Resident #14 woke up suddenly, was disoriented, and struck Resident #76, but could not recall which part of her body was hit. The NP stated that he was told that it was a one-time incident and that Resident #76 did not recall the incident when the NP met with her. The NP stated that it was confirmed that Resident #14 made physical contact with Resident #76, and that he was not immediately notified of the incident. The NP stated that the facility did not give him very detailed or specific information about the incident aside from what he said previously. A telephonic interview was attempted on June 9, 2026, at 2:09 p.m. with the Physician (MD/Staff #5) with no success. An interview was conducted on June 9, 2026, at 2:28 p.m. with the DON, Staff #28, who stated that physical abuse was any form of intentional hitting or intentional aggression to cause harm. The DON stated that slapping a resident and aggressively grabbing a resident would both be considered reportable incidents, and that her expectation of staff in witnessing a resident-to-resident altercation would be to separate them immediately, make sure the residents were safe, and then report to her or the administrator immediately. The DON stated that there was a witnessed altercation between Resident #76 and Resident #14 on May 15, 2026, and that she was notified of the incident around 7:30 p.m. by the RN, Staff #92. The DON stated that the nurse witnessed Resident #14 striking Resident #76, and there were no injuries or marks noted. The DON opened the resident's medical record and stated that after the May 15, 2026, incident, she was seeing a note regarding Staff #92, the RN, witnessing another incident where Resident #76 reported that Resident #14 hit her and grabbed her, and he did not recognize her. The DON stated that Staff #92 walked into the residents' room and saw Resident #14 grabbing and holding Resident #76's wrists, and that Staff #92 never reported to the DON the content of the progress note, or that he was agitated. The DON further stated that the note conveyed that there was aggression, the nurse did not report the aggression to her, and that it was her expectation that the note be reported to the DON because she would then be expected to report it to the administrator, who would have to report it to AZDHS, APS, the ombudsman, and police within 2 hours. The DON stated that they did not end up reporting or investigating the second altercation to any of the applicable state agencies, and that the date of the second incident was May 22, 2026. The (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON stated that the risk of not following their policy, reporting, or investigating would be the risk against resident safety, and that the handling of the incident on May 22nd was not her expectation. A telephonic interview was conducted on June 9, 2026, at 3:09 p.m. with the interim administrator (Administrator/Staff #9), who stated that physical abuse was defined as forceful contact or unwanted forceful contact, and resident-to-resident abuse was defined as a resident punching, slapping, kicking, pulling, or pushing another resident. The administrator stated that abuse would be a reportable event, and that the timeframe for reporting was 2 hours to the long-term care board, the department of health, the police, the ombudsman, the family, the medical director, and regional staff. The administrator stated that an allegation alone is reportable, and that it was not up to the staff member to decide if an incident was abuse; they would need to let administration know about the allegation. The administrator stated that there was an altercation between a husband and wife who were residents at the facility, and that the POA was requesting the residents to stay in the same room together. The administrator stated that both of the residents had low BIMS scores; they were both impaired, and the husband had a night terror that resulted in an altercation in the middle of May 2026. The administrator stated that he could not recall the result of the investigation. The administrator also stated that the residents did not have any altercations before that one, and the administrator believed there was an incident after the first altercation. The administrator stated that the second incident involved staff hearing a noise in the room, the wife said she was fine, and the husband was confused about where he was, but there was nothing that he was made aware of as far as physical contact. The administrator stated that the progress note in the resident's medical record was an allegation of abuse that would be considered reportable, and that they did not report or investigate the second incident. The administrator stated that it would have been his expectation for staff to report the incident because of the nursing note indicating forceful contact with the grabbing of the wrist. The administrator stated that staff did not follow their abuse policy, a full investigation should have been done, and they needed to report it to the applicable agencies.Review of a policy titled, Abuse Prevention and Prohibition Program, dated January 2026, revealed that each resident had the right to be free from abuse. The policy revealed that the facility had zero tolerance for abuse and that staff must not permit anyone to engage in verbal, mental, or physical abuse. The policy revealed that the facility was committed to protecting residents from abuse by anyone, including but not limited to staff, other residents, consultants, volunteers, staff from other agencies serving residents, family members, legal guardians, surrogates, sponsors, friends, and visitors. The policy further revealed that the administrator was responsible for coordinating and implementing the facility's abuse-prevention policies, procedures, training programs, and systems. The policy also revealed that supervisors should have immediately intervened, corrected, and reported identified situations where abuse was at risk of occurring. The policy further revealed that if the administrator received a report of an incident or suspected incident of resident abuse, the administrator or designee would investigate the alleged incident.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews, and policy review, the facility failed to ensure that the abuse policy was implemented following an incident of resident-to-resident abuse for two residents (#76 and #14). The deficient practice could result in residents being physically and emotionally harmed.-Regarding Resident #76Resident #76 was admitted to the facility on [DATE], with diagnoses that included a disorder of the thyroid, muscle weakness, mild cognitive impairment, hypertension, and amnesia.An annual Minimum Data Set (MDS) dated [DATE], revealed that the resident had a Brief Interview of Mental Status (BIMS) assessment score of 14, which indicated intact cognition. The MDS revealed that the resident had not exhibited behaviors directed towards others and that she had amnesia. A care plan focus initiated on May 17, 2026, revealed that the resident was at risk and experienced an altercation with another resident, her husband, with whom she shared a room. The care plan focus had goals that the resident would not experience injury or aggression from her roommate, her husband, and had an intervention to frequently check the room. A care plan focus initiated on May 17, 2026, revealed that the resident had a history of trauma with a goal to create an emotionally and physically safe environment, and had interventions to encourage the resident to verbalize feelings of distress and help the resident deal with anxiety-producing experiences. A progress note dated May 22, 2026, at 10:34 p.m. revealed that the nurse heard screaming coming from the unit, and she found the female resident screaming. The note revealed that the nurse assessed the situation and saw a man grabbing the female's wrist as she was trying to pull away while holding a tissue box. The note further revealed that the nurse approached the couple calmly and gently to redirect the male resident until he released the female. The note also revealed that the certified nursing assistant (CNA) approached the male and distracted him while the nurse assessed the female for injuries, and the patient stated, he hit me and grabbed me. The note revealed that the male did not recognize his wife and stated that he did not have a daughter before making confused statements and being separated and removed from the room. The note also revealed that the Director of Nursing (DON) and the daughter of the residents were notified, and that Resident #76 did not have pain or any injuries noted at that time, while Resident #14 was taken to the nurses' station for 1:1 care and given his as-needed medication. The note revealed that the male resident was temporarily moved to another room. A progress note dated May 26, 2026, at 11:41 a.m. revealed that the DON interviewed Resident #76, who reported that she was never hit, and that the nurse reported that the resident shared he was hitting at her but did not connect with her, and that no nursing staff witnessed any hitting, pushing, or otherwise violence. A medical practitioner's progress note dated May 30, 2026, at 9:24 a.m. revealed that the resident had recently been separated from her husband because he was demented and had become increasingly abusive towards her, and that she was quite tearful that day. -Regarding Resident #14Resident #14 was admitted to the facility on [DATE], with diagnoses that included dementia, atherosclerotic heart disease, hypertension, muscle weakness, atherosclerosis, cognitive communication deficit, hypothyroidism, left shoulder pain, and chronic kidney disease.An annual Minimum Data Set (MDS) dated [DATE], revealed that the resident had a Brief Interview of Mental Status (BIMS) assessment score of 09, which indicated mild cognitive impairment. The MDS also revealed that the resident had not exhibited physical or verbal behaviors directed towards others, and that he had non-Alzheimer's dementia. A care plan focus initiated on February 18, 2026, revealed a behavior of verbal threats and yelling noted when CNAs attempted to get the resident into the shower with a goal for the resident to not hit or injure any resident or staff member in the next 90 days. A care plan focus initiated on May 17, 2026, revealed that the resident had severe confusion that increased and caused behaviors including verbal and physical aggression. A care plan focus initiated on May 17, 2026, revealed that the resident experienced severe confusion that caused behaviors at times of agitation and aggression, with interventions that included, after the occurrence on May 15, (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2026, a room move being completed for the safety of the resident's wife and frequent room checks. An alert progress note dated May 24, 2026, at 12:21 a.m. revealed that the resident was moved to another room at 7 p.m., related to a recent incident with his wife, and that the resident was in a single private room. An alert progress note dated May 25, 2026, at 12:45 a.m. revealed that the resident had incidents with his wife on May 15, 2026, and May 22, 2026, and that he was moved temporarily to a single private room for the safety of others, and that he was resting in bed with his as-needed medication given. A social services progress note dated May 27, 2026, at 8:21 a.m. revealed that a trauma assessment was done that day with the resident due to a situation over the weekend between him and his spouse, with whom he shared a room. The note revealed that he did not seem to remember the incident and that the resident and spouse were separated for safety. A request was made for an initial report and investigation for Resident #14 and Resident #76's altercation on May 22, 2026, and the DON signed and stated that they did not have an investigation for May 22. A telephonic interview was attempted on June 9, 2026, at 12:52 p.m., 1:32 p.m., and 3:06 p.m. with a RN, Staff #92, with no success.A telephonic interview was conducted on June 9, 2026, at 12:54 p.m. with an LPN, Staff #70, who stated that physical abuse was defined as physical contact with a resident, including grabbing an arm, holding someone down, hitting, or slapping. The LPN also stated that the timeframe for reporting and allegation of abuse was right away to the DON, administrator, or any supervisor she could get in touch with. The LPN stated that she witnessed the first time there was a resident-to-resident altercation between Resident #76 and Resident #14 in which Resident #14 hit Resident #76's left cheek with his right hand. The LPN stated that there were no bruises or markings at that time, and that the altercation was witnessed by her, and did happen. The LPN stated that Resident #14 was yelling get that bastard out of here while he was hitting her, and that the LPN witnessed him making contact with her face at least twice while Resident #76 tried to block it. The LPN stated that the couple would have marital spats, and it was reported that there was another allegation of abuse that happened after the altercation she witnessed, but that she was not there for the second altercation. The LPN further stated that Resident #14 moved back into the room after the first altercation, but that they were separated again after the second altercation, and Resident #14 had since passed away. A telephonic interview was conducted on June 9, 2026, at 2:01 p.m. with the Nurse Practitioner (NP/Staff #87), who stated that an altercation occurred between Resident #76 and Resident #14 a couple of weeks ago. The NP stated that the incident occurred when the Resident #14 woke up suddenly, was disoriented, and struck Resident #76, but could not recall which part of her body was hit. The NP stated that he was told that it was a one-time incident and that Resident #76 did not recall the incident when the NP met with her. The NP stated that it was confirmed that Resident #14 made physical contact with Resident #76, and that he was not immediately notified of the incident. The NP stated that the facility did not give him very detailed or specific information about the incident aside from what he said previously. A telephonic interview was attempted on June 9, 2026, at 2:09 p.m. with the Physician (MD/Staff #5) with no success. An interview was conducted on June 9, 2026, at 2:28 p.m. with the DON, Staff #28, who stated that physical abuse was any form of intentional hitting or intentional aggression to cause harm. The DON stated that slapping a resident and aggressively grabbing a resident would both be considered reportable incidents, and that her expectation of staff in witnessing a resident-to-resident altercation would be to separate them immediately, make sure the residents were safe, and then report to her or the administrator immediately, as per the facility policy. The DON stated that there was a witnessed altercation between Resident #76 and Resident #14 on May 15, 2026, and that she was notified of the incident around 7:30 p.m. by the RN, Staff #92. The DON stated that the nurse witnessed Resident #14 striking Resident #76, and there were no injuries or marks noted. The DON opened the resident's medical record and stated that after the May 15, 2026, incident, she saw a note regarding Staff #92, the RN, witnessing another incident where Resident #76 reported that Resident #14 hit her and grabbed her, and he did not recognize her. The DON stated that Staff #92 walked into the residents' room and saw (continued on next page)

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Prescott Village Nursing & Rehabilitation	1030 Scott Drive Prescott, AZ 86301

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #14 grabbing and holding Resident #76's wrists, and that Staff #92 never reported to the DON the content of the progress note, or that he was agitated. The DON further stated that the note conveyed that there was aggression, the nurse did not report the aggression to her, and that it was her expectation that the note be reported to the DON because she would then be expected to report it to the administrator, who would have to report it to AZDHS, APS, the ombudsman, and police within 2 hours, as per the facility policy. The DON stated that they did not end up reporting or investigating the second altercation to any of the applicable state agencies, and that the date of the second incident was May 22, 2026. The DON stated that the risk of not following their policy, reporting, or investigating would include resident safety, and that the handling of the incident on May 22nd was not her expectation and did not align with the facility's policy.A telephonic interview was conducted on June 9, 2026, at 3:09 p.m. with the interim administrator (Administrator/Staff #9), who stated that physical abuse was defined as forceful contact or unwanted forceful contact, and resident-to-resident abuse was defined as a resident punching, slapping, kicking, pulling, or pushing another resident. The administrator stated that abuse would be a reportable event, and that the timeframe for reporting was 2 hours to the long-term care board, the department of health, the police, the ombudsman, the family, the medical director, and regional staff, as per the facility policy. The administrator stated that an allegation alone was reportable, and that it was not up to the staff member to decide if an incident was abuse; they would need to let administration know about the allegation. The administrator stated that there was an altercation between a husband and wife who were residents at the facility, and that the POA was requesting the residents to stay in the same room together. The administrator stated that both of the residents had low BIMS scores; they were both impaired, and the husband had a night terror that resulted in an altercation in the middle of May 2026. The administrator stated that he could not recall the result of the investigation. The administrator also stated that the residents did not have any altercations before that one, and the administrator believed there was an incident after the first altercation. The administrator stated that the second incident involved staff hearing a noise in the room, the wife said she was fine, and the husband was confused about where he was, but there was no physical contact that he was made aware of. The administrator stated that the progress note in the resident's medical record was an allegation of abuse that would be considered reportable, and that they did not report or investigate the second incident. The administrator stated that it would have been his expectation for staff to report the incident because of the nursing note indicating forceful contact with the grabbing of the wrist. The administrator stated that staff did not follow their abuse policy, a full investigation should have been done, and they needed to report it to the applicable agencies. The administrator stated that the risk of not reporting allegations of abuse was the potential of not protecting the resident through facility intervention. The administrator also stated that the risk of not investigating an allegation of abuse would be that they would not be able to put interventions in place appropriately, and if they are not aware of an allegation, it would be tough for them to follow their process and policy.Review of a policy titled, Abuse Prevention and Prohibition Program, dated January 2026, revealed that each resident had the right to be free from abuse. The policy revealed that the facility had zero tolerance for abuse and that staff must not permit anyone to engage in verbal, mental, or physical abuse. The policy revealed that the facility was committed to protecting residents from abuse by anyone, including but not limited to staff, other residents, consultants, volunteers, staff from other agencies serving residents, family members, legal guardians, surrogates, sponsors, friends, and visitors. The policy further revealed that the administrator was responsible for coordinating and implementing the facility's abuse-prevention policies, procedures, training programs, and systems. The policy also revealed that supervisors should have immediately intervened, corrected, and reported identified situations where abuse was at risk of occurring. The policy further revealed that if the administrator received a report of an incident or suspected incident of resident abuse, the administrator or designee would investigate the alleged incident. The policy revealed that the facility would report allegations of abuse immediately, but no later than 2 hours (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	after forming the suspicion, if the alleged violation involved abuse or resulted in serious bodily injury to the state survey agency, adult protective services, law enforcement, and the Ombudsman. The policy also revealed that the administrator would provide the state survey agency, law enforcement, and the Ombudsman with a copy of the investigative report within 5 days of the incident. The policy further revealed that the resident's attending physician and responsible party, if applicable, would also be notified of the allegation and outcome of the investigation.Review of the investigation section of the policy titled, Abuse Prevention and Prohibition Program, revealed that the facility would promptly and thoroughly investigate reports of resident abuse. The policy further revealed that the investigator would take some or all of the following steps: Review all relevant documentation, review the resident's medical record to determine events preceding the alleged incident, interview the person(s) making the incident report, interview any witnesses to the alleged incident, interview the resident (as medically appropriate), interview the resident's Attending Physician as needed to determine the resident's level of cognitive function and medical condition, interview facility staff members who have had contact with the resident during the period of the alleged incident, interview the resident's roommate, family members, and visitors, interview other residents, review all events leading up to the alleged incident, communicate with the administrator daily regarding the progress of the investigation, and prepare an investigation report documenting findings of the investigation. The policy also revealed that witness reports must be given in writing and should be signed and dated. The policy revealed that resident-to-resident altercations must be reported if the altercation was caused by a willful action. The policy also revealed that the presence of a mental disorder or cognitive impairment would not automatically preclude a resident from engaging in deliberate, non-accidental behavior.

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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 clinical record review, staff interviews, and policy review, the facility failed to ensure that an incident of resident-to-resident abuse was reported within the required timeframe for two residents (#76 and #14). The deficient practice could result in residents being physically and emotionally harmed.-Regarding Resident #76Resident #76 was admitted to the facility on [DATE], with diagnoses that included a disorder of the thyroid, muscle weakness, mild cognitive impairment, hypertension, and amnesia.An annual Minimum Data Set (MDS) dated [DATE], revealed that the resident had a Brief Interview of Mental Status (BIMS) assessment score of 14, which indicated intact cognition. The MDS revealed that the resident had not exhibited behaviors directed towards others and that she had amnesia. A care plan focus initiated on May 17, 2026, revealed that the resident was at risk and experienced an altercation with another resident, her husband, with whom she shared a room. The care plan focus had goals that the resident would not experience injury or aggression from her roommate, her husband, and had an intervention to frequently check the room. A care plan focus initiated on May 17, 2026, revealed that the resident had a history of trauma with a goal to create an emotionally and physically safe environment, and had interventions to encourage the resident to verbalize feelings of distress and help the resident deal with anxiety-producing experiences. A progress note dated May 22, 2026, at 10:34 p.m. revealed that the nurse heard screaming coming from the unit, and she found the female resident screaming. The note revealed that the nurse assessed the situation and saw a man grabbing the female's wrist as she was trying to pull away while holding a tissue box. The note further revealed that the nurse approached the couple calmly and gently to redirect the male resident until he released the female. The note also revealed that the certified nursing assistant (CNA) approached the male and distracted him while the nurse assessed the female for injuries, and the patient stated, he hit me and grabbed me. The note revealed that the male did not recognize his wife and stated that he did not have a daughter, before making confused statements and being separated and removed from the room. The note also revealed that the Director of Nursing (DON) and the daughter of the residents were notified, and that Resident #76 did not have pain or any injuries noted at that time, while Resident #14 was taken to the nurses' station for 1:1 care and given his as-needed medication. The note revealed that the male resident was temporarily moved to another room. A progress note dated May 26, 2026, at 11:41 a.m. revealed that the DON interviewed Resident #76, who reported that she was never hit, and that the nurse reported that the resident shared he was hitting at her but did not connect with her, and that no nursing staff witnessed any hitting, pushing, or otherwise violence. A medical practitioner's progress note dated May 30, 2026, at 9:24 a.m. revealed that the resident had recently been separated from her husband because he was demented and had become increasingly abusive towards her, and that she was quite tearful that day. -Regarding Resident #14Resident #14 was admitted to the facility on [DATE], with diagnoses that included dementia, atherosclerotic heart disease, hypertension, muscle weakness, atherosclerosis, cognitive communication deficit, hypothyroidism, left shoulder pain, and chronic kidney disease.An annual Minimum Data Set (MDS) dated [DATE], revealed that the resident had a Brief Interview of Mental Status (BIMS) assessment score of 09, which indicated mild cognitive impairment. The MDS also revealed that the resident had not exhibited physical or verbal behaviors directed towards others, and that he had non-Alzheimer's dementia. A care plan focus initiated on February 18, 2026, revealed a behavior of verbal threats and yelling noted when CNAs attempted to get the resident into the shower with a goal for the resident to not hit or injure any resident or staff member in the next 90 days. A care plan focus initiated on May 17, 2026, revealed that the resident had severe confusion that increased and caused behaviors including verbal and physical aggression. A care plan focus initiated on May 17, 2026, revealed that the resident experienced severe confusion that caused behaviors at (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	times of agitation and aggression, with interventions that included, after the occurrence on May 15, 2026, a room move being completed for the safety of the resident's wife and frequent room checks. An alert progress note dated May 24, 2026, at 12:21 a.m. revealed that the resident was moved to another room at 7 p.m., related to a recent incident with his wife, and that the resident was in a single private room. An alert progress note dated May 25, 2026, at 12:45 a.m. revealed that the resident had incidents with his wife on May 15, 2026, and May 22, 2026, and that he was moved temporarily to a single private room for the safety of others, and that he was resting in bed with his as-needed medication given. A social services progress note dated May 27, 2026, at 8:21 a.m. revealed that a trauma assessment was done that day with the resident due to a situation over the weekend between him and his spouse, with whom he shared a room. The note revealed that he did not seem to remember the incident and that the resident and spouse were separated for safety. A request was made for an initial report and investigation for Resident #14 and Resident #76's altercation on May 22, 2026, and the DON, Staff #28. signed and stated that they did not have an investigation for May 22. Review of State Agency Complaint Database did not reveal that the resident to resident altercation from May 22, 2026 was reported to the state agency within the required timeframe.A telephonic interview was attempted on June 9, 2026, at 12:52 p.m., 1:32 p.m., and 3:06 p.m. with a RN, Staff #92, with no success.A telephonic interview was conducted on June 9, 2026, at 12:54 p.m. with an LPN, Staff #70, who stated that physical abuse was defined as physical contact with a resident, including grabbing an arm, holding someone down, hitting, or slapping. The LPN also stated that the timeframe for reporting an allegation of abuse was right away to the DON, administrator, or any supervisor she could get in touch with. The LPN stated that she witnessed the first time there was a resident-to-resident altercation between Resident #76 and Resident #14 in which Resident #14 hit Resident #76's left cheek with his right hand. The LPN stated that the couple would have marital spats, and it was reported that there was another allegation of abuse that happened after the altercation she witnessed, but that she was not there for the second altercation. The LPN further stated that Resident #14 moved back into the room after the first altercation, but that they were separated again after the second altercation, and Resident #14 had since passed away. A telephonic interview was conducted on June 9, 2026, at 2:01 p.m. with the Nurse Practitioner (NP/Staff #87), who stated that an altercation occurred between Resident #76 and Resident #14 a couple of weeks prior to the interview. The NP stated that the incident occurred when the Resident #14 woke up suddenly, was disoriented, and struck Resident #76, but could not recall which part of her body was hit. The NP stated that he was told that it was a one-time incident and that Resident #76 did not recall the incident when the NP met with her. The NP stated that it was confirmed that Resident #14 made physical contact with Resident #76, and that he was not immediately notified of the incident. The NP stated that the facility did not give him very detailed or specific information about the incident or any other incident between the residents aside from what he said previously. A telephonic interview was attempted on June 9, 2026, at 2:09 p.m. with the Physician (MD/Staff #5) with no success. An interview was conducted on June 9, 2026, at 2:28 p.m. with the DON, Staff #28, who stated that physical abuse was any form of intentional hitting or intentional aggression to cause harm. The DON stated that slapping a resident and aggressively grabbing a resident would both be considered reportable incidents, and that her expectation of staff in witnessing a resident-to-resident altercation would be to separate them immediately, make sure the residents were safe, and then report to her or the administrator immediately. The DON stated that there was a witnessed altercation between Resident #76 and Resident #14 on May 15, 2026, and that she was notified of the incident around 7:30 p.m. by the RN, Staff #92. The DON stated that the nurse witnessed Resident #14 striking Resident #76, and there were no injuries or marks noted. The DON opened the resident's medical record and stated that after the May 15, 2026, incident, she saw a note regarding Staff #92, the RN, witnessing another incident where Resident #76 reported that Resident #14 hit her and grabbed her, and he did not recognize her. The DON stated that Staff #92 walked into the residents' room and saw Resident (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#14 grabbing and holding Resident #76's wrists, and that Staff #92 never reported to the DON the content of the progress note, or that he was agitated. The DON further stated that the note conveyed that there was aggression, the nurse did not report the aggression to her, and that it was her expectation that the note be reported to the DON because she would then be expected to report it to the administrator, who would have to report it to AZDHS, APS, the ombudsman, and police within 2 hours. The DON stated that they did not end up reporting or investigating the second altercation to any of the applicable state agencies, and that the date of the second incident was May 22, 2026. The DON stated that the risk of not following their policy, reporting, or investigating would include resident safety, and that the handling of the incident on May 22nd was not her expectation. A telephonic interview was conducted on June 9, 2026, at 3:09 p.m. with the interim administrator (Administrator/Staff #9), who stated that physical abuse was defined as forceful contact or unwanted forceful contact, and resident-to-resident abuse was defined as a resident punching, slapping, kicking, pulling, or pushing another resident. The administrator stated that abuse would be a reportable event, and that the timeframe for reporting was 2 hours to the long-term care board, the department of health, the police, the ombudsman, the family, the medical director, and regional staff. The administrator stated that an allegation alone is reportable, and that it was not up to the staff member to decide if an incident was abuse; they would need to let administration know about the allegation. The administrator stated that there was an altercation between a husband and wife who were residents at the facility, and that the POA was requesting the residents to stay in the same room together. The administrator stated that both of the residents had low BIMS scores; they were both impaired, and the husband had a night terror that resulted in an altercation in the middle of May 2026. The administrator stated that he could not recall the result of the investigation. The administrator also stated that the residents did not have any altercations before that one, and the administrator believed there was an incident after the first altercation. The administrator stated that the second incident involved staff hearing a noise in the room, the wife said she was fine, and the husband was confused about where he was, but there was no physical contact that he was made aware of. The administrator stated that the progress note in the resident's medical record was an allegation of abuse that would be considered reportable, and that they did not report or investigate the second incident. The administrator stated that it would have been his expectation for staff to report the incident because of the nursing note indicating forceful contact with the grabbing of the wrist. The administrator stated that staff did not follow their abuse policy, a full investigation should have been done, and they needed to report it to the applicable agencies within 2 hours. The administrator stated that the risk of not reporting allegations of abuse was the potential of not protecting the resident through facility intervention.Review of a policy titled, Abuse Prevention and Prohibition Program, dated January 2026, revealed that each resident had the right to be free from abuse. The policy revealed that the facility had zero tolerance for abuse and that staff must not permit anyone to engage in verbal, mental, or physical abuse. The policy revealed that the facility was committed to protecting residents from abuse by anyone, including but not limited to staff, other residents, consultants, volunteers, staff from other agencies serving residents, family members, legal guardians, surrogates, sponsors, friends, and visitors. The policy further revealed that the administrator was responsible for coordinating and implementing the facility's abuse-prevention policies, procedures, training programs, and systems. The policy also revealed that supervisors should have immediately intervened, corrected, and reported identified situations where abuse was at risk of occurring. The policy further revealed that if the administrator received a report of an incident or suspected incident of resident abuse, the administrator or designee would investigate the alleged incident. The policy revealed that the facility would report allegations of abuse immediately, but no later than 2 hours after forming the suspicion, if the alleged violation involved abuse or resulted in serious bodily injury to the state survey agency, adult protective services, law enforcement, and the Ombudsman. The policy also revealed that the administrator would provide the state survey agency, law enforcement, (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and the Ombudsman with a copy of the investigative report within 5 days of the incident. The policy further revealed that the resident's attending physician and responsible party, if applicable, would also be notified of the allegation and outcome of the investigation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review, the facility failed to ensure that an incident of resident-to-resident abuse involving two residents (#76 and #14) was investigated. The deficient practice could result in residents being physically and emotionally harmed.-Regarding Resident #76Resident #76 was admitted to the facility on [DATE], with diagnoses that included a disorder of the thyroid, muscle weakness, mild cognitive impairment, hypertension, and amnesia.An annual Minimum Data Set (MDS) dated [DATE], revealed that the resident had a Brief Interview of Mental Status (BIMS) assessment score of 14, which indicated intact cognition. The MDS revealed that the resident had not exhibited behaviors directed towards others and that she had amnesia. A care plan focus initiated on May 17, 2026, revealed that the resident was at risk and experienced an altercation with another resident, her husband, with whom she shared a room. The care plan focus had goals that the resident would not experience injury or aggression from her roommate, her husband, and had an intervention to frequently check the room. A care plan focus initiated on May 17, 2026, revealed that the resident had a history of trauma with a goal to create an emotionally and physically safe environment, and had interventions to encourage the resident to verbalize feelings of distress and help the resident deal with anxiety-producing experiences. A progress note dated May 22, 2026, at 10:34 p.m. revealed that the nurse heard screaming coming from the unit, and she found the female resident screaming. The note revealed that the nurse assessed the situation and saw a man grabbing the female's wrist as she was trying to pull away while holding a tissue box. The note further revealed that the nurse approached the couple calmly and gently to redirect the male resident until he released the female. The note also revealed that the certified nursing assistant (CNA) approached the male and distracted him while the nurse assessed the female for injuries, and the patient stated, he hit me and grabbed me. The note revealed that the male did not recognize his wife and stated that he did not have a daughter before making confused statements and being separated and removed from the room. The note also revealed that the Director of Nursing (DON) and the daughter of the residents were notified, and that Resident #76 did not have pain or any injuries noted at that time, while Resident #14 was taken to the nurses' station for 1:1 care and given his as-needed medication. The note revealed that the male resident was temporarily moved to another room. A progress note dated May 26, 2026, at 11:41 a.m. revealed that the DON interviewed Resident #76, who reported that she was never hit, and that the nurse reported that the resident shared he was hitting at her but did not connect with her, and that no nursing staff witnessed any hitting, pushing, or otherwise violence. A medical practitioner's progress note dated May 30, 2026, at 9:24 a.m. revealed that the resident had recently been separated from her husband because he was demented and had become increasingly abusive towards her, and that she was quite tearful that day. -Regarding Resident #14Resident #14 was admitted to the facility on [DATE], with diagnoses that included dementia, atherosclerotic heart disease, hypertension, muscle weakness, atherosclerosis, cognitive communication deficit, hypothyroidism, left shoulder pain, and chronic kidney disease.An annual Minimum Data Set (MDS) dated [DATE], revealed that the resident had a Brief Interview of Mental Status (BIMS) assessment score of 09, which indicated mild cognitive impairment. The MDS also revealed that the resident had not exhibited physical or verbal behaviors directed towards others, and that he had non-Alzheimer's dementia. A care plan focus initiated on February 18, 2026, revealed a behavior of verbal threats and yelling noted when CNAs attempted to get the resident into the shower with a goal for the resident to not hit or injure any resident or staff member in the next 90 days. A care plan focus initiated on May 17, 2026, revealed that the resident had severe confusion that increased and caused behaviors including verbal and physical aggression. A care plan focus initiated on May 17, 2026, revealed that the resident experienced severe confusion that caused behaviors at times of agitation and aggression, with interventions that included, after the occurrence on May 15, 2026, a room move being (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed for the safety of the resident's wife and frequent room checks. An alert progress note dated May 24, 2026, at 12:21 a.m. revealed that the resident was moved to another room at 7 p.m., related to a recent incident with his wife, and that the resident was in a single private room. An alert progress note dated May 25, 2026, at 12:45 a.m. revealed that the resident had incidents with his wife on May 15, 2026, and May 22, 2026, and that he was moved temporarily to a single private room for the safety of others, and that he was resting in bed with his as-needed medication given. A social services progress note dated May 27, 2026, at 8:21 a.m. revealed that a trauma assessment was done that day with the resident due to a situation over the weekend between him and his spouse, with whom he shared a room. The note revealed that he did not seem to remember the incident and that the resident and spouse were separated for safety. A request was made for an initial report and investigation for Resident #14 and Resident #76's altercation on May 22, 2026, and the DON signed and stated that they did not have an investigation for May 22. A telephonic interview was attempted on June 9, 2026, at 12:52 p.m., 1:32 p.m., and 3:06 p.m. with a RN, Staff #92, with no success.A telephonic interview was conducted on June 9, 2026, at 12:54 p.m. with an LPN, Staff #70, who stated that physical abuse was defined as physical contact with a resident, including grabbing an arm, holding someone down, hitting, or slapping. The LPN stated that she witnessed the first time there was a resident-to-resident altercation between Resident #76 and Resident #14 in which Resident #14 hit Resident #76's left cheek with his right hand. The LPN stated that there were no bruises or markings at that time, and that the altercation was witnessed by her, and did happen. The LPN stated that Resident #14 was yelling get that bastard out of here while he was hitting her, and that the LPN witnessed him making contact with her face at least twice while Resident #76 tried to block it. The LPN stated that the couple would have marital spats, and it was reported that there was another allegation of abuse that happened after the altercation she witnessed, but that she was not there for the second altercation. The LPN further stated that Resident #14 moved back into the room after the first altercation, but that they were separated again after the second altercation, and Resident #14 had since passed away. A telephonic interview was conducted on June 9, 2026, at 2:01 p.m. with the Nurse Practitioner (NP/Staff #87), who stated that an altercation occurred between Resident #76 and Resident #14 a couple of weeks ago. The NP stated that the incident occurred when the Resident #14 woke up suddenly, was disoriented, and struck Resident #76, but could not recall which part of her body was hit. The NP stated that he was told that it was a one-time incident and that Resident #76 did not recall the incident when the NP met with her. The NP stated that it was confirmed that Resident #14 made physical contact with Resident #76, and that he was not immediately notified of the incident. The NP stated that the facility did not give him very detailed or specific information about the incident aside from what he said previously. A telephonic interview was attempted on June 9, 2026, at 2:09 p.m. with the Physician (MD/Staff #5) with no success. An interview was conducted on June 9, 2026, at 2:28 p.m. with the DON, Staff #28, who stated that physical abuse was any form of intentional hitting or intentional aggression to cause harm. The DON stated that slapping a resident and aggressively grabbing a resident would both be considered reportable incidents, and that her expectation of staff in witnessing a resident-to-resident altercation would be to separate them immediately, make sure the residents were safe, and then report to her or the administrator immediately. The DON stated that there was a witnessed altercation between Resident #76 and Resident #14 on May 15, 2026, and that she was notified of the incident around 7:30 p.m. by the RN, Staff #92. The DON stated that the nurse witnessed Resident #14 striking Resident #76, and there were no injuries or marks noted. The DON opened the resident's medical record and stated that after the May 15, 2026, incident, she saw a note regarding Staff #92, the RN, witnessing another incident where Resident #76 reported that Resident #14 hit her and grabbed her, and he did not recognize her. The DON stated that Staff #92 walked into the residents' room and saw Resident #14 grabbing and holding Resident #76's wrists, and that Staff #92 never reported to the DON the content of the progress note, or that he was agitated. The DON further stated that the note conveyed (continued on next page)

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	06/09/2026

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that there was aggression, the nurse did not report the aggression to her, and that it was her expectation that the note be reported to the DON because she would then be expected to report it to the administrator, who would have to report it to AZDHS, APS, the ombudsman, and police within 2 hours. The DON stated that they did not end up reporting or investigating the second altercation to any of the applicable state agencies, and that the date of the second incident was May 22, 2026. The DON stated that the risk of not following their policy, reporting, or investigating would include resident safety, and that the handling of the incident on May 22, 2026, did not meet her expectations. A telephonic interview was conducted on June 9, 2026, at 3:09 p.m. with the interim administrator (Administrator/Staff #9), who stated that physical abuse was defined as forceful contact or unwanted forceful contact, and resident-to-resident abuse was defined as a resident punching, slapping, kicking, pulling, or pushing another resident. The administrator stated that abuse would be a reportable event, and that the timeframe for reporting was 2 hours to the long-term care board, the department of health, the police, the ombudsman, the family, the medical director, and regional staff. The administrator stated that an allegation alone is reportable, and that it was not up to the staff member to decide if an incident was abuse; they would need to let administration know about the allegation. The administrator stated that a facility investigation required statements and conducting an interview with the individuals involved, including staff members who were working, residents in the surrounding area, and the medical director. The administrator further stated that the investigation should be documented in a file and submitted as a 5-day report for all reportables. The administrator stated that there was an altercation between a husband and wife who were residents at the facility, and that the POA was requesting the residents to stay in the same room together. The administrator stated that both of the residents had low BIMS scores; they were both impaired, and the husband had a night terror that resulted in an altercation in the middle of May 2026. The administrator stated that he could not recall the result of the investigation. The administrator also stated that the residents did not have any altercations before that one, and the administrator believed there was an incident after the first altercation. The administrator stated that the second incident involved staff hearing a noise in the room, the wife said she was fine, and the husband was confused about where he was, but there was no physical contact that he was made aware of. The administrator stated that the progress note in the resident's medical record was an allegation of abuse that would be considered reportable, and that they did not report or investigate the second incident. The administrator stated that it would have been his expectation for staff to report the incident because of the nursing note indicating forceful contact with the grabbing of the wrist. The administrator stated that staff did not follow their abuse policy, a full investigation should have been done, and they needed to report it to the applicable agencies. The administrator stated that the risk of not investigating an allegation of abuse would be that they would not be able to put interventions in place appropriately, and if they are not aware of an allegation, it would be tough for them to follow their process. Review of a policy titled, Abuse Prevention and Prohibition Program, dated January 2026, revealed that each resident had the right to be free from abuse. The policy revealed that the facility had zero tolerance for abuse and that staff must not permit anyone to engage in verbal, mental, or physical abuse. The policy revealed that the facility was committed to protecting residents from abuse by anyone, including but not limited to staff, other residents, consultants, volunteers, staff from other agencies serving residents, family members, legal guardians, surrogates, sponsors, friends, and visitors. The policy further revealed that the administrator was responsible for coordinating and implementing the facility's abuse-prevention policies, procedures, training programs, and systems. The policy also revealed that supervisors should have immediately intervened, corrected, and reported identified situations where abuse was at risk of occurring. The policy further revealed that if the administrator received a report of an incident or suspected incident of resident abuse, the administrator or designee would investigate the alleged incident. Review of the investigation section of the policy titled, Abuse Prevention and Prohibition Program, revealed that the facility would promptly and thoroughly investigate reports of resident (continued on next page)

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