STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035207	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springdale Village Healthcare	7255 East Broadway Road Mesa, AZ 85208

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** 49399 Based on clinical record review, resident and staff interviews, and policy review, the facility failed to protect the rights of one resident (#1) to be free from abuse by staff. The deficient practice could result in appropriate action not taken and further abuse of residents. Findings include: Resident #1 was readmitted on [DATE] with diagnoses of cerebrovascular disease (CVA), dementia and major depressive disorder. The care plan dated August 22, 2024 revealed that the resident was at risk for skin breakdown related to a decline in mobility/transfers/repositioning. Interventions included to administer ointments or medications as ordered as preventative measure and to assist resident to reposition while in bed or wheelchair as needed. The care plan on ADLs (activities of daily living) dated August 22, 2024 revealed that the resident was at risk for ADL self-care performance deficit related to weakness/debility. Interventions included staff participation was required with bathing, turning and repositioning, moving on and off unit, daily hygiene needs and toileting. A review of the facility staffing schedule document for September 27, 2024 revealed that the certified nurse assistant (CNA/staff #141) was on the schedule for the night shift. A health status progress note dated September 28, 2024 revealed that a certified nursing assistant (CNA) notified nursing staff of skin tear and bruising to resident #1 right forearm. Per the documentation, staff assessment revealed bruising and skin shearing to the lower right arm; and that, the administrator, charge nurse, and nurse practitioner were notified. The nursing note dated September 28, 2024 included a Braden Scale score of 12 indicating the resident was high risk for pressure ulcer. The Brief Interview for Mental Status (BIMS) Evaluation dated September 30, 2024 included a score of 99 indicating resident was unable to complete the interview. Per the documentation, the resident memory problems and ability to make decisions regarding tasks of daily life was severely impaired. (continued on next page)

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	Another BIMS evaluation dated October 1, 2024 included a score of 3 indicating the resident had severe cognitive impairment. The discharge summary dated October 2, 2024 included that resident was discharged to hospice. Reason for discharge was that goals were met. The facility's 5-day report dated October 3, 2024 revealed that during the morning rounds, the CNA identified that the resident had bruising on her right forearm consistent with being squeezed by a hand with scratches that would be consistent with fingernails. Per the documentation, the employee that cared for the resident could have been found to be more aggressive than necessary; and that, the allegation was verified by evidence collected during their investigation. In an interview with the administrator (staff #1) conducted on October 3, 2024 at 2:48 p.m. the administrator stated that resident #1 was admitted in the facility for respite and had gone home. The administrator stated that the resident #1 had a roommate (resident #2); and, the alleged certified nursing assistant (CNA/staff #141) worked from 6 p.m. to 6 a.m. at the time of the alleged incident. The administrator stated that the resident's roommate (resident #2) reported that resident #1 was swinging her arm and the CNA (staff #141) grabbed the arm of resident #1 and told resident #1 not to hit the CNA or the CNA will hit the resident back. The administrator stated that there were bruising like four fingers marking of right hand identified and found on the arm of resident #1. The administrator stated that they interviewed their staffs, notified the police, ombudsman, medical director, spoke to the resident's family, and notified the staffing agency for the CNA (staff #141). An interview was conducted via phone on October 3, 2024 at 3:31 p.m. with a CNA (staff #78) who stated that she received a report from the alleged CNA (staff #141) who told her that resident #1 and her roommate (resident #2) were good and had no problem. The CNA stated that had taken the resident's vital signs on the resident's left arm; and that, later she came back to provide resident #1 care and she removed the blanket covering on resident's right arm and when the resident raised her right arm, she saw marks on the resident's skin that she did not see on September 27, 2024. The CNA said that she saw three round markings in the front of the arm and one round marking in the back of the right forearm. The CNA stated that she then called the registered nurse (RN/staff #61) who asked resident #1 what happened. The CNA said that resident #1 reported that a black cat scratched her. However, the CNA said the nurse asked the resident's roommate what happened; and the roommate reported that resident #1 went to swing at the alleged CNA (staff #141) who then grabbed the resident's arm and told resident #1 do not hit or the CNA (staff #141) would hit the resident back. Further, the CNA stated that they received in-service training on abuse conducted by the administrator on September 28, 2024. A phone interview was conducted on October 3, 2024 at 3:45 p.m. with the RN (staff #61) who stated that at around 7:30 a.m. at the time of the incident, a CNA (staff #78) reported that the right arm of resident #1 had what looked like a hand print. The RN said that the resident's roommate (resident #2) reported that the alleged CNA (staff #141) came in to change resident #1 who was trying not to be changed; and that, the alleged CNA (staff #141) said that she will not have some old lady tell her that they were going to be changed. The RN said that resident #1 said it was a black cat; and, she reported the incident to the administrator at around 8:00 a.m. She said that the supervisor, administrator and police came; and there was a mandatory in-service on September 28, 2024. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A phone interview with the alleged CNA (staff #141) was attempted on October 3, 2024 at 4:21 p.m. but was unsuccessful. Staff #141 did not answer nor returned the call. An interview with the hospice nurse (staff #142) was conducted on October 3, 2024 at 4:55 p.m. The hospice nurse said that she visited resident #1 on September 27, 2024 the day resident was admitted to the facility and the resident did not have wounds or bruises. She stated that she heard that the incident happened on the weekend. Further, she stated that the resident was found to have bruising and skin tear on her right forearm, scabbed and open to air. A review of facility's policy titled, Abuse and Neglect Policy, revised October 2022 revealed residents have the right to be free from abuse, neglect, and it includes but is not limited to freedom from verbal, mental, neglect, or physical abuse.