

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035244	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2025
NAME OF PROVIDER OR SUPPLIER Prescott Valley Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3380 North Windsong Drive Prescott Valley, AZ 86314	
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of clinical record, and facility policy, the facility failed to ensure a resident was assessed timely and that a provider was notified timely of a change of condition for one resident (#3). The deficient practice resulted in the resident having a delay of care for treatment of a burn.-Findings include:Resident #3 was admitted to the facility May 31, 2025, with diagnoses of encephalopathy, attention and concentration deficit, cognitive communication deficit, frontal lobe and executive function deficit, weakness, and Alzheimer's disease.A brief interview for mental status (BIMS) assessment dated [DATE] revealed the resident had a score of 2, indicating severe cognitive impairment.A physician order, dated July 2, 2025, indicated for SSD (silver sulfadiazine) external cream 1% the right side abdomen twice a day.The clinical record was reviewed, and there was no evidence or documentation created/dated July 1, 2025, found in the clinical record regarding any incident on July 1, 2025, during breakfast time, that Resident #3 spilled coffee on herself or that the resident's skin was assessed by the nurse that date, or that the provider was notified that date. A Skin/Wound Note dated July 2, 2025 revealed the hall staff reported that Resident #3 sustained a burn of her right side of her abdomen yesterday with hot fluids; and that, the burn area was red and had a blister noted. It also included that the NP (nurse practitioner) was informed and silver sulfadiazine (SSD) cream was ordered to start twice a day until resolved.A Health Status Note dated July 2, 2025, included that the CNA (Staff #71) reported to the charge nurse yesterday that the resident had an incident with hot liquid yesterday morning; and that, the resident was wet on her shirt and hands. Per the documentation, the charge nurse directed to apply an ice pack; and that, the charge nurse would assess the patient. An ice pack was applied to the area at time of incident. The documentation also revealed that the morning of July 2, 2025, the same CNA (Staff #71) reported that the resident had a red area on her abdomen and the wound nurse was called to look at the area. According to the documentation, the area was assessed by the nurse and the NP and it showed evidence of a burn, and has a blister at the lower portion of the burn; and that, silver sulfadiazine cream was applied to the area.A Summary for Providers note dated July 2, 2025 revealed the change in skin color or condition. The documentation included that a burn was noted to abdomen post incident of spilling coffee with recommendations to apply SSD (silver sulfadiazine) cream twice a day and leave open to air.A Weekly Skin Check dated July 2, 2025, revealed a red area on the abdomen, on the front of the right iliac crest, with a blister on the bottom section.A provider encounter note dated July 2, 2025, revealed the resident was very uncomfortable and Tylenol (analgesic) was not treating her pain adequately; and that, the plan was to order for oxycodone (narcotic opioid). Per the documentation, the resident's new fracture was resetting her progress with therapy and she will need to start all over; and, the resident's cognition was requiring increased time with therapies. New diagnosis included burn involving 2% total body surface area. The plan was to get an order for Silvadene in place, and have the wound care nurse practitioner look at the resident.A late entry General Progress Note dated July 3, 2025 revealed that on July 1, 2025, at approximately 7:45 a.m., a CNA reported to the nurse who was walking to the medication cart that Resident #3 had spilled some coffee on her; and that, the resident's clothes were changed by the CNA and an icepack was applied to the resident's abdomen. Per the documentation, the nurse checked the area after the resident's clothes were changed and an ice pack applied; and that, there was slight redness noted to the abdomen after the resident was done with breakfast. There was no evidence that the provider was notified on July 1, 2025.Another late entry General Progress Note dated July 3, 2025, three days after the incident, included that on July 1, 2025 at approximately 10:00 a.m., the resident was checked very frequently for safety checks; and, the CNA had asked the nurse if it was okay to remove the icepack and this nurse stated that it was. The documentation included that the nurse checked the area and saw the same amount of redness to the resident's abdomen as earlier and after the icepack was removed; and that, there were no blister or open area noted and the resident did not complain of any pain and did not have any grimacing.A Weekly Skin Check dated July 7, 2025, revealed a red area on the resident's right abdomen with scabbed area from a blister that has popped.A phone interview was conducted on July 11, 2025, at 8:59 a.m. with a Registered Nurse (RN/staff #33), who stated was the floor nurse at the time of the incident when resident #3 spilled her coffee. The RN said that she was walking past the CNA (Staff #71) to her med cart at a little before 8:00 a.m. when she heard the CNA say that the resident spilled coffee on herself; and Staff #33 instructed for the CNA to stick an ice pack on it and I'll (Staff #33) come look at it The RN stated that she</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, review of clinical record, and facility policy, the facility failed to ensure adequate supervision consistent with the resident's needs was provided to one resident (#3) to prevent an accident of spilling a hot liquid beverage. The deficient practice resulted in the resident sustaining a burn.-Findings include:Resident #3 was admitted to the facility May 31, 2025, with diagnoses of encephalopathy, attention and concentration deficit, cognitive communication deficit, frontal lobe and executive function deficit, weakness, and Alzheimer's disease.A brief interview for mental status (BIMS) assessment dated [DATE] revealed the resident had a score of 2, indicating severe cognitive impairment.The General Progress note dated May 31, 2025, revealed Resident #3 arrived via transport in a wheelchair, was a 2-person transfer into bed, and required 2-person assistance to change. Per the documentation, the resident was unable to verbalize needs or acknowledge the use of the call light, was combative with brief changes and medication distribution, and needed continuous rounds.The Hot Liquids Safety Evaluation dated May 31, 2025, revealed that Resident #3 did not have moderately to severely impaired cognition, despite documentation of cognitive impairment and combativeness. The evaluation also revealed that that the resident was not easily agitated, had no frequent impulsive acts/short tempered, had no weakness or paresis in the resident's upper extremities, and, had a mood that did not vary over the course of the day. Interventions selected from the Hot Liquids Safety Evaluation were for resident to use the dominant hand for drinking, for the temperature of drinks not to exceed 140 degrees, and for the resident to drink hot liquids while sitting at table only. However, there was no evidence found that the care plan was updated to include the interventions for the resident to use the dominant hand for drinking, for the temperature of drinks not to exceed 140 degrees, and for the resident to drink hot liquids while sitting at table only.A Mood/Behavior Note dated June 1, 2025, revealed the Certified Nursing Assistant (CNA) reported that when Resident #3 was checked in the morning, the resident was anxious and panicky. Per the documentation, Resident #3 had a diagnosis of Alzheimer's mixed with vascular dementia; and that, the encounter was of a serious nature. It also included that the resident told the CNA, I (referring to Resident #3) want to watch you (referring to the CNA) bleed. Further, the documentation included that the Director of Nursing (DON) and nurse practitioner (NP) were made aware of the behavior and statement made by Resident #3.The Skilled Evaluation note dated June 1, 2025 included that Resident #3 was oriented to person, was confused, had short term memory impairment, and had impaired decision-making ability.A General Progress Note dated June 1, 2025, revealed the resident was experiencing mood/behaviors in the evening when medications were given, and had pushed her medications away. Per the documentation, Resident #3 got agitated, raised her voice, had garbled speech, was impulsive, had tried to get up on her own, did not comprehend how to use the call light and had a disregard for her own safety. The documentation also included that the resident had done these the last two nights since admission; and that, the resident eventually took her medications after she was slowly instructed and explained to. Further, the documentation included that consistent rounding on Resident #3 was crucial to avoid a potential fall.An Occupational Therapy (OT) Evaluation dated June 2, 2025, revealed Resident #3 was right-hand dominant, had cognitive impairments, and required supervision or touching assistance when eating.The OT treatment encounter notes dated June 2 and June 3, 2025, included the resident required partial/moderate assistance with eating.The OT treatment encounter note dated June 4, 2025, revealed resident required set-up or clean-up assistance with eating.The OT treatment encounter note dated June 5, 2025, included resident #3 required supervision or touching assistance with eating.A provider encounter note dated June 6, 2025, revealed Resident #3 had significant dementia, so reminders were difficult, and that, she had poor impulse control and no safety awareness, so future falls were likely.The OT treatment encounter note dated June 9, 2025, included the resident required supervision or touching assistance with eating.A Change of Condition note dated June 10, 2025, revealed the resident was having difficulty taking her evening medications and was holding them in her mouth. The documentation included that the resident had difficulty understanding how to drink through a straw; and that, the straw was removed and the resident required total assistance to drink from the cup. Further, the documentation included that this seemed to only happen in the evenings during med pass.A Skilled Evaluation note dated June 12, 2025, revealed Resident #3 had an increase in confusion and behaviors today more than baseline due to cognition. The documentation included the resident was anxious and aggressive, had physical and verbal aggression with</p>		