

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 08/19/2025
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 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. (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 0600</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** Number of residents sampled: 21Number of residents cited: 1The facility failed to ensure that one resident (#63) was free from abuseBased on clinical record review, staff interviews, facility documentation, policies and procedures, the facility failed to protect the rights of one resident (#63) to be free from abuse by another resident (#22). The deficient practice could result in further abuse of residents and appropriate action not taken. Findings include: -Resident #63 (alleged victim) was admitted to the facility on [DATE] with diagnoses of anxiety disorder, cognitive communication deficit, hypertension, and acute respiratory failure. A care plan pertaining to anti-anxiety medication related to anxiety disorder revised July 22, 2025 indicated that the resident was prescribed medication to treat anxiety symptoms as needed. Further review of the care plan did not indicate or document any issues or interventions related to resident-to-resident altercation/incidents. Review of the 5-day Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating that the resident was cognitively intact. Further review of the August 1, 2025 MDS assessment indicated that the resident was negative for psychosis indicators, behavioral symptoms, and wandering during the assessment period. A nursing note dated August 6, 2025 documented that resident reported that there was a strange man with a long beard, about 6 feet tall who stood at her door and stared at her. Additionally, the resident also reported that the resident across the hall tried to come into her room and that she told the other resident no. According to the note the other resident then shut the resident #63's door and began to make moaning noises outside of her room. Further review of the resident's record did not reveal any documentation regarding the resident #63's reported interaction with the other resident. There was no indication of any follow-up regarding the incident or that the issue was addressed. An interview was conducted with resident #63 on August 17, 2025 at 12:50 p.m. Resident #63 stated that a resident (#22) who had dementia used to be across the all from her. She said that resident #22 would sit outside her door and enter her room without asking. Resident #63 revealed that resident #22 entered her room shouting and slammed her door. According to resident #63, she reported the incident to a nurse but nothing was done. Additionally, resident #22's daughter came into her room uninvited, threatened, and yelled at her. Resident #22 stated that both incidents made her feel scared and felt assaulted. She said that she was afraid of resident #22's daughter due to her aggressiveness. Resident #22 noted that resident #22's son also frightened her since he stood by her door staring at her. She indicated that she feared he would come into her room. She conveyed that she was frantically thinking of what she would do if he did. Resident #63 said that she reported the incident to the staff but no action was taken. When her friends came to visit, resident #22 would not move from her doorway. She said that the incident with the resident #22's son took place approximately on August 6, 2025. Resident #63 indicated that the incident with resident #22's daughter took place on August 8 at around 6:30 p.m. Additionally, the incident in which resident #22 slammed resident #63's door occurred on August 8, 2025. Resident #63 stated that she reported the incident to Social Services (staff #56), the charge nurse assigned that night, and the RN (Registered Nurse/staff #82) on August 8, 2025. Resident #63 became visibly upset during the interview as she relayed the incidents. She said that resident #22 threw stuff, moaned, and groaned which frightened her. A progress note dated August 17, 2025 stated that she wanted staff to intervene when there are residents outside her room by her door. The note indicated that resident #63 was informed that staff are busy and if they are unable to intervene, the resident should activate her call light for assistance. An interview with a Certified Nursing Assistant (CNA/staff #50) was conducted on August 19, 2025 at 4:08 a.m. Staff #50 stated that resident #63 is an accurate historian who would voice out concerns. The CNA said that resident #63 is vocal about her needs. However, staff #50 denied any knowledge of any incidents involving resident #63. The CNA noted that resident #63 did mention approximately last week to inform the other residents to move away from her door since it was bothering her. Staff #50 said that it is important that residents are not subjected to abuse because the facility is their home. The residents have the right to be safe and protected. According to the CNA the impact of abuse on residents is that it becomes harder for them to adjust to their living situation and it can cause unnecessary stress. During an interview with a Registered Nurse (RN/staff #29) conducted on August 19 2025 at 8:10 a.m., staff #29 stated that when they are notified of an allegation or witness abuse, the staff have to stop the abuse and remove the resident from the situation. The RN said that protecting and mitigating abuse is important for the safety of the staff and residents. Staff #29 noted that the impact of</p>		

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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. (continued on next page)

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<p>F 0607</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** Number of residents sampled: 21Number of residents cited: 1The facility failed to ensure that abuse policy was implementedBased on clinical record, staff interviews, review of facility documentation, policy and procedures and the State Agency (SA) database the facility failed to implement their policy regarding conducting thorough investigation of abuse allegation and protecting residents from further abuse for one resident (#63). The deficient practice could result in abuse continuing and not being prevented. Findings include: Resident #63 (alleged victim) was admitted to the facility on [DATE] with diagnoses of anxiety disorder, cognitive communication deficit, hypertension, and acute respiratory failure. A nursing note dated August 6, 2025 documented that resident reported that there was a strange man with a long beard, about 6 feet tall who stood at her door and stared at her. Additionally, the resident also reported that the resident across the hall tried to come into her room and that she told the other resident no. According to the note the other resident then shut the resident #63's door and began to make moaning noises outside of her room. Further review of the resident's record did not reveal any documentation regarding the resident #63's reported interaction with the other resident. There was no indication of any follow-up regarding the incident or that the issue was addressed. An interview was conducted with resident #63 on August 17, 2025 at 12:50 p. m. Resident #63 stated that a resident (#22) who had dementia used to be across the hall from her. She said that resident #22 would sit outside her door and enter her room without asking. Resident #63 revealed that resident #22 entered her room shouting and slammed her door. According to resident #63, she reported the incident to a nurse but nothing was done. Additionally, resident #22's daughter came into her room uninvited, threatened, and yelled at her. Resident #22 stated that both incidents made her feel scared and felt assaulted. She said that she was afraid of resident #22's daughter due to her aggressiveness. Resident #22 noted that resident #22's son also frightened her since he stood by her door staring at her. She indicated that she feared he would come into her room. She conveyed that she was frantically thinking of what she would do if he did. Resident #63 said that she reported the incident to the staff but no action was taken. When her friends came to visit, resident #22 would not move from her doorway. She said that the incident with the resident #22's son took place approximately on August 6, 2025. Resident #63 indicated that the incident with resident #22's daughter took place on August 8 at around 6:30 p.m. Additionally, the incident in which resident #22 slammed resident #63's door occurred on August 8, 2025. Resident #63 stated that she reported the incident to Social Services (staff #56), the charge nurse assigned that night, and the RN (Registered Nurse/staff #82) on August 8, 2025. Resident #63 became visibly upset during the interview as she relayed the incidents. She said that resident #22 threw stuff, moaned, and groaned which frightened her. Review of the SA database revealed that a self-report was submitted by the facility on August 17, 2025. The report indicated an allegation in which another resident would come into the alleged victim's room. However, it did not fully detail information on what occurred nor did it indicate who the alleged perpetrator was. Regarding resident #22 (alleged perpetrator) Resident #22 (alleged perpetrator) was admitted on [DATE] with diagnoses of dementia, delirium, depression, and anxiety disorder. A progress note dated August 8, 2025 documented that resident #22 was observed in neighbor's doorway just sitting there, and not saying anything. The note indicated that the resident was told that she should not be sitting there and when the staff member looked up, the resident was shutting the neighbor's door. According to the note, the neighbor came out very upset and stated that this had happened at least three previous times. The note stated that a social worker attempted to talk to the resident but she got very upset and refused to listen. The note indicated that the nurse convinced the resident to stay away from the neighbor's door and was pleasant for the rest of the shift. Review of the facility investigator's (Social Worker/staff #56) memo dated August 17, 2025 documented that according to resident #63, a resident from across the hall had wandered into her room and slammed the door. Additionally, the memo indicated that resident #63 shared that the other resident would sit outside her room to stare at her which frightened her. The memo noted that staff #56 informed resident #63 to notify staff when incidents occur so they can address it. The memo noted that resident was educated that she needed to press the call light and staff would intervene as they see it happen. Further review of the facility's investigator's memo dated August 17, 2025 revealed that no other residents or staff members were interviewed regarding the allegation. Additionally, the memo did not indicate any other fact-finding activity other than an interview with resident #63. An interview with a Certified Nursing Assistant (CNA/staff #50) was</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>(continued on next page)</p>

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<p>F 0609</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** Number of residents sampled: 21Number of residents cited: 1The facility failed to ensure that an allegation of abuse was reportedBased on closed record review, staff interviews, review of facility documentation, policy and procedures, the facility failed to conduct and submit an investigation report for an allegation of abuse for one resident (#3). The deficient practice could result in abuse allegations not being investigated and reported. Findings include: Resident #63 (alleged victim) was admitted to the facility on [DATE] with diagnoses of anxiety disorder, cognitive communication deficit, hypertension, and acute respiratory failure. A nursing note dated August 6, 2025 documented that resident reported that there was a strange man with a long beard, about 6 feet tall who stood at her door and stared at her. Additionally, the resident also reported that the resident across the hall tried to come into her room and that she told the other resident no. According to the note the other resident then shut the resident #63's door and began to make moaning noises outside of her room. Further review of the resident's record did not reveal any documentation regarding the resident #63's reported interaction with the other resident. There was no indication of any follow-up regarding the incident or that the issue was addressed. Review of the 5-day Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating that the resident was cognitively intact. An interview was conducted with resident #63 on August 17, 2025 at 12:50 p.m. Resident #63 stated that a resident (#22) who had dementia used to be across the hall from her. She said that resident #22 would sit outside her door and enter her room without asking. Resident #63 revealed that resident #22 entered her room shouting and slammed her door. According to resident #63, she reported the incident to a nurse but nothing was done. Additionally, resident #22's daughter came into her room uninvited, threatened, and yelled at her. Resident #22 stated that both incidents made her feel scared and felt assaulted. She said that she was afraid of resident #22's daughter due to her aggressiveness. Resident #22 noted that resident #22's son also frightened her since he stood by her door staring at her. She indicated that she feared he would come into her room. She conveyed that she was frantically thinking of what she would do if he did. Resident #63 said that she reported the incident to the staff but no action was taken. When her friends came to visit, resident #22 would not move from her doorway. She said that the incident with the resident #22's son took place approximately on August 6, 2025. Resident #63 indicated that the incident with resident #22's daughter took place on August 8 at around 6:30 p.m. Additionally, the incident in which resident #22 slammed resident #63's door occurred on August 8, 2025. Resident #63 stated that she reported the incident to Social Services (staff #56), the charge nurse assigned that night, and the RN (Registered Nurse/staff #82) on August 8, 2025. Resident #63 became visibly upset during the interview as she relayed the incidents. She said that resident #22 threw stuff, moaned, and groaned which frightened her. An interview with a Certified Nursing Assistant (CNA/staff #50) was conducted on August 19, 2025 at 4:08 a.m. The CNA noted that resident #63 did mention approximately last week to inform the other residents to move away from her door since it was bothering her. During an interview with a Registered Nurse (RN/staff #29) conducted on August 19 2025 at 8:10 a.m., staff #29 stated that when they are notified of an allegation or witness abuse, the staff have to stop the abuse and remove the resident from the situation. The RN said that reporting abuse is important for the safety of the staff and residents. Staff #29 noted that the impact of abuse is that it affects safety and residents feel like the cannot trust the staff. Additionally, abuse can affect the residents psychologically. The RN stated that resident #63 told her that she had issues with someone coming into her room. The RN said that she informed staff #56 (Social Worker). According to staff #29, the Social Worker (staff #56) spoke with resident #63 immediately. Following the discussion between staff #56 and resident #63, staff #29 was told that resident #22 had to be watched. The RN said that someone had seen resident #22 coming out of resident #63's room. Staff #29 stated that if resident #63 had expressed to a staff that an incident scared and intimidated her then yes, it would be qualified as abuse. According to staff #29, she heard that resident #22 had gone into another resident's room and that resident was unhappy. Staff #29 said that the incident happened approximately 2-weeks ago. The RN noted that reporting and investigating allegations of abuse is important so that residents trust and know that their rights are not being abused and that they have the right to not feel threatened. An interview with a Social Worker (staff #56) was conducted on August 19, 2025 at 9:44 a.m. Staff #56 stated that it is important that the facility prevents residents from being abuse. The Social Worker said that the impact of residents being subjected to abuse is that the residents might get hurt and</p>		