STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035244	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prescott Valley Nursing & Rehabilitation	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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. **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 residents were provided copies of their personal and medical records upon written request within the required timeframe for one resident (#82). The deficient practice could result in resident rights being violated.Findings include:Resident #82 was admitted to the facility on [DATE], with diagnoses that included lack of coordination, difficulty walking, weakness, anemia, repeated falls, shortness of breath, hyperkalemia, hypertension, atherosclerotic heart disease, and adult failure to thrive.A review of a General Durable Power of Attorney (POA) document dated and signed on April 2, 2023, was uploaded into Resident #82's medical record and revealed that he elected to have his daughter act as his POA.A Medicare 5-Day Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. Review of an Arizona HIPAA (Health Insurance Portability and Accountability Act) Medical Release Form revealed that Resident #82 requested copies of his entire medical record, including consultations, developmental/behavioral, discharge summary, hospital records & reports, immunizations, history and physical, laboratory reports, prescriptions, treatments or tests, and X-ray reports. The form also revealed that the indicated reason for disclosure was for treatment and personal records, and that the resident authorized his daughter/POA to receive the records. The form revealed that it was completed on April 15, 2026, and that the resident signed the request. Review of a Medical Records Request Tracking Log revealed that on April 15, 2026, Resident #82 made a personal request for medical records. The log further revealed that the facility emailed to follow up on the record request on May 15, 2026, an invoice for the records on May 18, 2026, and the records were given to the requester on May 19, 2026. The log also revealed that Resident #82 was the requester, and that the records were released to the resident's daughter/POA.Review of an email dated May 14, 2026, at 1:39 p.m. was sent from Resident #82's daughter/POA to the facility's regional Business Office Consultant (Business Office Consultant/Staff #58) and revealed that her father requested medical records almost a month prior, and they had not received a response or the records. The email also revealed that Resident #82's daughter/POA handed the authorization form to the certified social worker (Social Services/Staff #4), and that she had been difficult to speak with. Review of an email dated May 14, 2026, at 1:52 p.m. revealed that the Business Office Consultant sent the email from Resident #82's daughter/POA to the admissions coordinator (Admissions/Staff #18), and said that he had received an email regarding the medical records request for Resident #82. Review of an email dated May 14, 2026, at 2:07 p.m. revealed that the Admissions Coordinator, Staff #18, sent the email to the Medical Records Director (Medical Records/Staff #70). Review of an email dated May 15, at 2:07 p.m. revealed that Medical Records, Staff #70, responded to Resident #82's daughter/POA and apologized for the delay in Resident #82's record request because the facility did not have someone in the medical records position for quite some time. The email also revealed that Medical Records told the daughter/POA that she would be happy to fulfill Resident #82's request, and asked if she would be invoicing the daughter/POA or Resident #82. Review of an email dated May 15, 2026, at 3:44 p.m. revealed that (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #82's daughter/POA requested more information from Medical Records, Staff #70, on the cost of paper versus electronic records, which method would be faster, and where she would need to pick up paper copies.Review of an email dated May 15, 2026, at 4:10 p.m. revealed that Medical Records, Staff #70, told Resident #82's daughter/POA the cost differences and that she was waiting on the release of Resident #82's records, so neither should take long or be difficult to do. Review of an email dated May 18, 2026, at 8:02 a.m. revealed that Resident #82's daughter/POA responded to Medical Records, Staff #70, and elected to have the medical record electronically, asked if the records would be available within the week, and asked about the estimated timeframe. Review of an email dated May 18, 2026, at 3:44 p.m. revealed that Medical Records, Staff #70, told Resident #82's daughter/POA that the records were available and ready for pick-up, requested to let her know when she was available, and thanked her for her patience through the process. Review of an email dated May 19, 2026, at 8:11 a.m. revealed that Resident #82's daughter/POA would pay the invoice and pick up the records that afternoon. An interview was conducted on June 10, 2026, at 2:08 p.m. with Resident #82's daughter/POA, who stated that her father made a medical records request on April 14, 2026, and that they did not receive a response to the request until May 15, 2026. Resident #82's daughter/POA stated that her father signed the authorization form and gave the form to Social Services, Staff #4, and that when they did not receive a response from the facility, she sent a follow-up email to a different employee from the facility because Social Services would not answer calls. Resident #82's daughter/POA stated that the records were not released until May 18, 2026. An interview was conducted on June 10, 2026, at 3:09 p.m. with Social Services, Staff #4, who stated that she did not handle medical records requests, but that she was helping out before the facility hired someone to work in medical records, so she was sending requests to the facility's regional medical records personnel as soon as she was able to, but that she had her own job to do, so it was only when she had time. The Social Services Director stated that she was helping out for approximately 2 months, and that the medical records request turnaround timeframe was a week, but that she was told they had a month to process everything. An interview was conducted on June 10, 2026, at 3:19 p.m. with the Medical Records Director, Staff #70, who stated that her process when she received a medical records request was to print a copy of the request and put it in her file while she worked on it, and then she would pull all of the records that were requested. The Medical Records Director stated that, depending on the size of the request, it might take minutes, hours, or until the next day for the file to be made, and then she would send it to the facility's regional medical records resource to make sure it is okay to release. The Medical Records Director stated that she would hold on to the initial request and that she kept a tracking log that detailed the date of the request, the date the facility responded to the request, the date the records were ready, and the date that the requester received the requested records. The Medical Records Director stated that the required timeframe to fulfill a resident's medical records request was 10 days, but that when she started, it was taking her a week to fulfill them. The Medical Records Director also stated that no one was doing the medical records job for 2 months before she filled the position, and that there was one woman she apologized to specifically for the delay in fulfilling the records request. The Medical Records Director stated that the woman she apologized to was Resident #82's daughter, and further stated that she had the log, request form, and email thread about the request. The Medical Records Director stated that Resident #82 signed and requested the records himself on April 15, 2026, the daughter emailed the facility on May 6, 2026 asking for an update, then again emailed the regional resource on May 15, 2026, and that the records request was not fulfilled until May 19, 2026, which was roughly 1 month and 4 days after the request was made. An interview was conducted on June 10, 2026, at 4:12 p.m. with the Director of Nursing (DON/Staff #10), who stated that the process when they received a medical records request was to have the requestor fill out a form through the medical records department, and that she did not know the required timeframe for fulfilling the request but she thought that 30 days was reasonable.A follow-up interview was conducted on June 11, 2026, at 7:50 a.m. with the DON, Staff #10, who stated (continued on next page)

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F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that she wanted to change her answer regarding the timeframe for fulfilling a medical records request, and that once medical records were received, the facility would have 15 days to respond. The DON stated that the medical record request form for Resident #82 was completed on April 15, 2026, and that it was fulfilled on May 19, 2026, which was more than 15 days. A follow-up interview was conducted on June 11, 2026, at 10:00 a.m. with the Social Services, Staff #4, who stated that she received the filled-out request from Resident #82's daughter on April 15, 2026, and that it took over a month for the facility to fulfill the initial request. An interview was conducted on June 11, 2026, at 10:04 a.m. with the Administrator (Administrator/Staff #39), who stated that if a medical records request came from the resident, the facility was able to quickly process the request within 24 hours. The Administrator stated that the facility did not have a policy regarding medical records requests, but that, according to the regulation, they had 24 hours to fulfill a medical records request for a resident. The Administrator stated that there was an issue with Resident #82's medical records request because it was not channeled to the right person, and that the resident made the medical records request himself on April 15, 2026, while he was a resident at the facility. The Administrator stated that Resident #82's medical record request should have been fulfilled on April 16, 2026, but it was not completed until May 19, 2026, which was beyond the date. The Administrator stated that her expectation for fulfilling the medical records request would be within 24 hours, as per the regulation, and that the risk of failing to promptly do so would be a delay in services, or a violation of residents' rights in their access to medical records. A request was made on June 10, 2026, for a medical records request policy, and the Regional Nurse Consultant (Regional RN Consultant/Staff #21) stated that they did not have a specific policy, but they did have a records request guide or training document that the facility followed for record requests. A request was made on June 11, 2026, for medical records policies, and the Regional RN Consultant, Staff #21, stated that they did not have any other medical records policies other than the guide that was provided.Review of a Record Request guide, dated May 1, 2026, revealed that all personal requests for active residents must be completed within 24 hours of receipt. The guide revealed that it was essential that Medical Records process these requests immediately to prevent any delays in providing records.Review of the Code of Federal Regulations (CFR) S483.10(g)(2) revealed that The facility must provide the resident with access to personal and medical records pertaining to him or herself, upon an oral or written request, in the form and format requested by the individual, if it was readily producible in such form and format (including in an electronic form or format when such records are maintained electronically), or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, within 24 hours (excluding weekends and holidays). The CFR also revealed that the facility must allow the resident to obtain a copy of the records or any portions thereof (including in an electronic form or format when such records are maintained electronically) upon request and 2 working days' advance notice to the facility.

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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. **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 residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one of three sampled residents (#82). The deficient practice could result in harm to the resident.Findings include:Resident #82 was admitted to the facility on [DATE], with diagnoses that included lack of coordination, difficulty walking, weakness, anemia, repeated falls, history of falling, shortness of breath, hyperkalemia, hypertension, atherosclerotic heart disease, and adult failure to thrive.An admission fall risk evaluation dated March 29, 2026, revealed that the resident had a history of 1-2 falls in the last 3 months, was chair-bound and required assistance with toileting, and had balance problems while standing, walking, and sitting. The evaluation also revealed that the resident had a fall risk score of 9.0 and that he was a moderate fall risk.A Medicare 5-Day Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS also revealed that the resident had active diagnoses of repeated falls and a history of falling. The MDS revealed that the resident had a fall in the month before admission, and that the resident had a fall in the 2-6 months before admission. A provider order dated April 7, 2026, included a Swimmer's AP (anteroposterior, from front to back) and Lateral X-ray (thoracic spine), one time only for pain.A care plan focus initiated on April 7, 2026, revealed that the resident had an ADL self-care performance deficit related to activity intolerance, fatigue, impaired balance, limited mobility, and pain. The care plan had interventions to have 1-2 people assist in ambulation and encourage him to use the call bell for assistance. The care plan interventions also included that the extent and type of assistance might fluctuate within the day or day to day, depending on the resident's level of strength, pain, or mood, and that he may require more or less staff assistance.A provider order dated April 7, 2026, included Methocarbamol Oral Tablet 500 MG, 1 tablet by mouth one time only for pain. A medication administration record (MAR) for April 2026 revealed that Methocarbamol Oral Tablet 500 MG, 1 tablet, was administered on April 8, 2026.A provider order dated April 8, 2026, included Acetaminophen Oral Tablet 325 MG, 2 tablets by mouth every 6 hours for pain.A medication administration record (MAR) for April 2026 revealed that Acetaminophen Oral Tablet 325 MG, 2 tablets every 6 hours, was administered until the resident was discharged on April 23, 2026, with only one dose not administered at 11:00 a.m. on April 8, 2026. A provider order dated April 8, 2026, included Methocarbamol Oral Tablet 500 MG, 1 tablet by mouth every 6 hours as needed for back pain/muscle spasms for 14 Days. A provider encounter progress note dated April 9, 2026, at 3:45 p.m. revealed that the resident had an assisted sit onto the floor, and that he did not have any obvious injuries initially. The note further revealed that the resident complained of back pain a couple of hours later, so the facility ordered X-rays. The note also revealed that the resident reported to the provider that his fall was secondary to making a wrong turn when he was ambulating to the shower room, and that he reported it was just an accident.Review of the findings for a spine X-ray dated April 10, 2026, revealed that the X-ray was taken due to pain and a history of cancer. The X-ray revealed that there was normal alignment of the thoracic spine with no fractures, and mild osteopenia (reduced bone mineral density) and spondylosis (spinal osteoarthritis characterized by joint degeneration and bone spurs) were demonstrated.A discharge MDS dated [DATE], revealed that the resident did not have any falls since admission or the prior assessment; however, the provider's encounter progress note revealed that there was 1 fall after the prior assessment. There was no evidence in Resident #82's clinical record of any risk management, change in condition, skin, pain, fall, or therapy assessments being conducted on or after April 7th, 2026, regarding the fall documented by the provider. There was no evidence of a care plan focus or interventions for falls or fall risk in Resident #82's clinical record.There was no evidence in the clinical record that a fall was documented by nursing staff on (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	April 7, 2026. An interview was conducted on June 10, 2026, at 2:08 p.m. with Resident #82's daughter, who stated that she partially witnessed a fall on April 7, 2026, because when she got to the facility, her dad was lying on the ground with a group of staff around him. The resident's daughter stated that she saw the medical records, and there was a documented assisted sit to floor while he was being ambulated to the shower room. The resident's daughter stated that she did not see the fall, but that she got there right after it happened. An interview was conducted on June 10, 2026, at 4:12 p.m. with the Director of Nursing (DON/Staff #10), who stated that a fall would be defined as a change in elevation, and could include a person falling from a chair to the floor, a bed to the floor, or an assisted sit onto the floor. The DON stated that her expectation if someone were to experience an assisted sit onto the floor would be to aid them to the floor as carefully as possible, contact the nurse, and the nurse would be expected to do an evaluation and take vitals to ensure the resident was safe. The DON also stated that staff would be expected to get the resident back into a chair or their bed, neuro checks initiated, and there were 6 assessments that staff were expected to complete for every fall that occurred, including fall risk, pain, skin check, therapy, risk management, and change in condition. The DON stated that she would review the assessments with staff, and they would reevaluate, update the care plan, including intervention, and the date that the fall happened so that it was recognized, and the family, DON, and physician needed to be notified. The DON stated that she recalled Resident #82, and that he did have falls while he was here at the facility. The DON stated that she could recall that Resident #82 had a fall around the corner of the shower room, that she did not recall the day, and that a certified nursing assistant (CNA) was walking him. The DON further stated that the CNA was permitted to ambulate the resident because he had been ambulating with physical therapy, and that the CNA helped him to the floor. The DON stated that therapy witnessed the fall but could not recall who was there, and that the family was not there when the fall occurred, but they arrived right after. The DON opened Resident #82's clinical record and stated that he had diagnoses of difficulty walking and a history of falls, and that the fall was not documented in the care plan. The DON stated that she could not find any assessments or progress notes regarding the fall, but that she recalled the fall occurred. A follow-up interview was conducted on June 11, 2026, at 7:50 a.m. with DON, Staff #10, who stated that she looked into the clinical record and found that Resident #82 did have a fall that occurred on April 7, 2026. The DON stated that she spoke with the NP after the last interview, and the NP confirmed that the fall occurred. The DON stated that they did not do a care plan revision, any assessments, or progress notes for the fall, and that it was not documented outside of the NP note. The DON stated that it was her expectation that, after a fall, nursing staff would complete the risk management, change in condition, skin, pain, fall, and therapy assessments. The DON further stated that it was her expectation that the care plan be updated after a fall to include education, interventions, and the date and time of the fall that occurred. The DON stated that everyone needed to be notified of the fall, including family, the DON, and the physician, and interventions such as fall mats needed to be implemented. The DON further stated that there was no documentation that the resident's daughter/Power of Attorney (POA) had been notified, and that the instructions for what staff were expected to do were posted at each nurse's station. The DON stated that she spoke with the NP to discuss education and systemic changes regarding falls and the post-fall process. An interview was conducted on June 11, 2026, at 8:49 a.m. with a CNA, Staff #80, who stated that she had a resident who experienced a fall in April of 2026 when she got him up to go to the shower, and that she slowly brought him down to the ground after his knees gave out. The CNA stated that he was permitted to use a walker with therapy, so she ambulated him to the shower room. The CNA stated that she recalled it was Resident #82 who experienced the fall, and that he was so tall that it was difficult for her to catch him. The CNA stated that she grabbed the Licensed Practical Nurse (LPN/Staff #65), who came over to help him get into a wheelchair, and they took his vitals. The CNA stated that she did not know if the LPN assessed the resident, but that the LPN reported the fall to the DON while the CNA took his vitals. The CNA stated that the resident's daughter showed up (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	when the resident was on the ground and was mad that the CNA could not catch him. The CNA stated that the daughter did not witness the fall, but that she was there after when they were trying to assist the resident into the chair. The CNA stated that the resident was not using a walker after the fall and that therapy staff were the only ones to ambulate the resident after the fall. The CNA stated that she recalled the resident had a fall mat after the fall. An interview was attempted on June 11, 2026, at 8:58 a.m. with the LPN, Staff #65, with no success.An interview was conducted on June 11, 2026, at 8:59 a.m. with the Nurse Practitioner (NP/Staff #43), who stated that when there was a fall at the facility, there was charting that the facility staff needed to complete. The NP stated that when a fall would occur, the DON and NP were notified, and she would request to see vital signs and neuro checks. The NP further stated that she would usually look through nursing progress notes to catch falls documented in the record. The NP stated that she vaguely recalled Resident #82, and that according to her notes, he did have a fall at the facility on April 6th or 7th of 2026. The NP stated that there was no documentation in the record about the fall aside from her own note, and that the facility did not complete any assessments or progress notes, and she did not know if the care plan was updated. The NP stated that despite her note saying that the facility updated the care plan, she did not know if they did, but that she always put that in her note and assumed that the care plan would be updated. The NP also stated that Resident #82 confirmed and corroborated that he had a fall, and that he admitted he made a wrong turn. The NP stated that she was surprised that they were ambulating the resident to begin with because his condition was rough. Review of an undated policy titled, Fall Management Program, revealed that the facility would provide the highest quality care in the safest environment for the residents residing in the facility. The policy revealed that the facility developed a fall management program that intended to prevent resident falls through meaningful assessments, interventions, education, and reevaluation. The policy further revealed that following a resident's fall, the licensed nurse would complete an incident report and a Postˆ Fall Assessment & Investigation within 24 hours or as soon as practicable. The policy revealed that the licensed nurse would review the circumstances of the fall, review the plan of care, implement new interventions as appropriate, and revise the plan as indicated. The policy revealed that the IDT (interdisciplinary team) Committee would meet within 72 hours of a fall to review and document the summary of the event, following a fall, root cause analysis, referrals, as necessary, and interventions to prevent future falls. The policy also revealed that Fall Risk Assessments would be maintained in the resident's medical record, and the IDT Committee would document findings and recommendations in the resident's medical record. The policy revealed that nursing staff would document the resident's response to interventions being utilized in the resident's medical record, and that the resident's care plan would be updated as necessary.