STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035255	A. Building B. Wing	03/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Valley Post Acute	13575 West McDowell Road Goodyear, AZ 85395

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** 47576 Based on clinical record reviews, staff interviews, facility documentation, policies and procedures, the facility failed to protect resident rights (#4002) to be free from sexual abuse by another resident (#4805). The deficient practice has the potential for further abuse resulting in harm to residents. Findings include: -Resident #4002 (alleged victim) was admitted on [DATE] with a diagnosis of Unspecified Dementia, Bipolar disorder, unspecified and Anxiety Disorder, unspecified. The annual MDS (minimum data set) assessment dated [DATE] revealed a BIMS (Brief Interview for Mental Status) of 14 suggesting that the resident had intact cognition. A progress notes on 3/6/24 at 1:26 AM revealed that the resident #4002 was being monitored for 72 hours related to being inappropriately touched by a male resident. The eINTERACT summary dated March 5, 2024 revealed resident #4002 was inappropriately touched in her left buttock by another resident (#4805); and that, resident #4002 complained that a male resident touched her left butt cheek and pulled her pants down an inch. Per the documentation, resident #4002 pushed resident #4805's right hand away and told him that she was married. The documentation also included that the incident happened in the dayroom after activity while resident #4002 was putting her stuff away. According to the documentation, resident #4002 was monitored and staff made sure that resident #4002 was separated from resident #4805. The 72-hour charting dated March 6, 2024 included that the resident was on charting for being inappropriately touched by a male resident. -Resident #4805 (alleged perpetrator) was admitted on [DATE] with diagnoses of toxic encephalopathy, major depressive disorder and adjustment disorder. The admission MDS assessment dated [DATE] revealed the resident had a BIMS score of 9 indicating the resident had moderate cognitive impairment. (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	The behavior progress note dated March 5, 2024 included that the resident was restless, sexually inappropriately touching staff. The eINTERACT summary note dated March 5, 2024 revealed resident #4805 admitted that he touched a female resident's butt cheek but denied that he pulled her pants down. Per the documentation, the incident happened in the dayroom after activity. A nurse practitioner (NP) note dated March 5, 2024 included that per staff reporting, the resident had an inappropriate interaction with a female resident. The care plan dated March 6, 2024 included that the resident exhibited or was at risk for behavioral symptoms i.e., striking out, grabbing others, combative, verbally or physically abusive due to adjustment disorder. Interventions included to administer medications as ordered, closely supervise when out of the room or around other residents and to document and record behavioral episodes. In an interview with the Director of Nursing (DON/staff #137) conducted during entrance conference on March 7, 2024, the DON stated that she was aware of the complaint; and that, resident #4805 (alleged perpetrator) admitted to it. An interview was conducted on March 7, 2024 at 11:53 a.m., with resident #4002 who stated that the incident happened 2 days ago; and that, resident #4805 squeezed her butt 2 times and then pulled her pants down 1 inch. Resident #40002 said that she told resident #4805 no, that was not allowed and that she was married. Resident #4002 stated that she then yelled for the CNA and told the nurse about it. Further, resident #4002 said that she felt safe when she was in her room and safe in common areas only if staff were present. However, resident #4002 said that she was afraid of resident #4805. An interview was conducted with a certified nursing assistant (CNA/staff #164) on March 7, 2024 at 12:02 p.m. The CNA stated that resident #4805 attempted to touch her inappropriately but she was able to redirect the resident. Further stating that she is not aware of any other times resident #4805 has attempted to touch another resident before but we do watch him because he has a history of touching female staff. Staff #164 stated that resident #4002 is able to make her needs known. An interview with a licensed practical nurse (LPN/staff #189) was conducted on March 7, 2024 at 12:57 p.m. The LPN said that when resident #4805 was admitted at the facility, the staff were told that the resident had a history trying to touch female staff and makes inappropriate statements to staff. The LPN said that resident #4805 was placed on cares in pairs because of this. The LPN also said that to address the behaviors of resident #4805, staff ensures that residents were separated for resident #4805; and that, the LPN was not aware of any checks that need to be done for resident #4805. In another interview with the DON (staff #137) conducted on March 7, 2024 at 2:15 p.m., the DON said that resident #4805 was sexually verbal to staff only and not toward residents; and that, the resident was already on a behavioral unit as part of the intervention to address the behavior. During the interview, a review of the clinical record was conducted with the DON who stated that the resident's care plan did not address these behaviors are not addressed. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy on Resident Rights, revised February 2021 revealed that Federal and State laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to, part C; be free from abuse, neglect, misappropriation of property, and exploitation.