

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035255	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/10/2024
NAME OF PROVIDER OR SUPPLIER Palm Valley Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49399</p> <p>Based on clinical record reviews, staff and resident interviews, facility documentation and policies, the facility failed to ensure that one resident (#1) was free from abuse by another resident (#2).</p> <p>Findings include:</p> <p>Regarding Resident #1:</p> <p>Resident #1 was admitted at the facility on October 13, 2023 with diagnoses of encephalopathy, Alzheimer's disease, and dementia.</p> <p>A review of resident #1 Quarterly Minimum Data Set (MDS) dated [DATE] revealed the Brief Interview of Mental Status (BIMS) score section was blank. In addition, revealed resident #1 had short and long-term memory problems, cognitive skills for daily decision making was severely impaired, physical and verbal behavioral symptoms directed towards others were not exhibited, and wandering behavior occurred daily.</p> <p>A review of care plan initiated on November 1, 2023 revealed resident #1 was at risk for psychosocial behaviors or was at risk for behavioral symptoms such as physical aggression toward staff, throwing items (food tray), verbal aggression and purposefully placing self onto floor due to dementia. The interventions included administer medication as ordered, monitor for side effects and notify physician if observed, anticipate needs and meet promptly.</p> <p>Review of Skin Wound Note clinical record progress note, dated July 12, 2024 at 21:35 by a licensed practical nurse (LPN)/Staff #226 revealed resident left side of face was red. No complaints of pain.</p> <p>A review of clinical record, 72-hour Charting, dated July 13, 2024 at 07:02 revealed resident on CIC (change in condition) for alleged aggression received, resident in good spirits.</p> <p>A review of clinical record, 72-Hour Charting, dated July 13, 2024 at 15:56 revealed Resident manifest no signs of pain, discomfort and has no apparent signs of bruising to the face and body. Continues to scream at times but was re-directed.</p> <p>(continued on next page)</p>

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>Regarding Resident #2:</p> <p>Resident #2 was admitted to the facility on [DATE] and discharged from the facility on August 8, 2024 with diagnoses of end stage renal disease (ESRD), Alzheimer's disease and dementia.</p> <p>A review of resident #2 annual MDS dated [DATE] revealed a BIMS score of 8 which meant was cognitively impaired and had verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) and other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds). Moreover, the behavioral symptoms put the resident and others at significant risk for physical injury and significantly disrupt care or living environment. Resident #2 used a wheelchair for mobility device.</p> <p>A review of clinical record titled, eINTERACT Change in Condition Evaluation dated July 12, 2024 at 19:00 revealed a behavioral symptom alleged physical aggression initiated.</p> <p>A review of clinical record eINTERACT SBAR Summary for Providers progress notes dated July 12, 2024 at 19:00 revealed change in condition and a Neurological Status Evaluation: Nursing observations, evaluation, and recommendations are: Alleged altercation between this resident and another resident. Staff reports that there was some yelling and resident might of struck the other in the face. Skin assessment completed, no bruising or redness noted to residents' hands, rest of skin CDI (clean dry intact). No complaint of pain or discomfort.</p> <p>A review of clinical record progress note, 72-Hour Charting, dated July 13, 2024 at 07:04 revealed resident on CIC (change in condition) for alleged aggression initiated.</p> <p>A review of resident #2 care plan initiated on April 6, 2024 and revised on July 13, 2024 revealed a psychosocial behavior: Resident #2 exhibits or is at risk for behavioral symptoms (verbal outbursts/aggression) due to dementia, alleged verbal aggression initiated. Yells out shut up at times when he believes surroundings are too loud. The interventions include administer medication as ordered, monitor for side effects and notify physician if observed, encourage resident to go to an area with less stimulation, encourage resident to verbalize feelings, maintain a calm, slow, understandable approach, notify physician, responsible party/power of attorney/legal guardian of episodes of aggression & abusive behaviors, observe and document changes in behavior, including frequency of occurrence and potential triggers, observe whether the behavior endangers the resident and/or others. (Intervene if necessary: removing others from the surrounding area), provide simple, direct reminders as indicated, and Social Services visits as indicated.</p> <p>An interview was conducted on October 10, 2024 at 10:51 am with LPN unit manager/Staff #179 who stated that resident #2 hit resident #1, it happened in the day room around dinner time. Staff #179 stated that resident #1 was yelling and resident #2 came and hit resident #1.</p> <p>(continued on next page)</p>		

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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>An interview was conducted on October 10, 2024 at 11:38 am with the director of nursing (DON)/Staff #75. The DON stated that for an alleged resident to resident altercation, they did an investigation and neither resident remembered and no one saw a direct contact made. DON stated that they separated the residents right away, they reported it, they started their investigation, notified everyone, the PRN (as needed) nurse reported redness on the face, and they do not use camera in the building. DON stated that regarding behavioral monitoring documentation, they do psychosocial monitoring. They document it if something is abnormal such as isolation, decreased intake, or if they notice something had occurred, it is documented in the progress notes. The DON stated that the staff identified that resident #2 swung in the direction of resident #1.</p> <p>An interview was conducted via phone on October 10, 2024 at 12:02 pm with LPN/Staff #226 who stated that she worked in July but does not remember the exact date when one of her patients was yelling curse words and the other man came across the room by wheeling himself and punched the other resident on his left side in the dining room. The resident who got punched was her resident and she pulled the resident away that threw the punch. She stated that she assessed resident #1, making sure that resident #1 was okay, and resident #1 calmed down, he stopped yelling after he got punched. Staff #226 stated that there was actual physical contact between the two residents. She stated that they called the police, they called the residents' fiduciary, and the unit manager notified the DON. Staff #226 stated that resident #1 face was slightly red on his cheek but no bruising. Staff #226 stated that resident #1 did not have a red cheek before the incident and resident #1 was not laying on his cheek but resident #1 kept rubbing his face.</p> <p>A review of facility's policy titled, Resident Rights, revised date February 2021 revealed 1. Federal and state laws guarantee certain rights to all residents of this facility. These rights include the resident's rights to: c. be free from abuse.</p>		