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	10/21/2024

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** 50116 Based on documentation, staff interviews and the facility policy and procedures, the facility failed to ensure that one resident (#2) was free from abuse from another resident (#12). This deficient practice could result in other residents being abused. Findings include: Resident #2 was admitted on [DATE] with diagnoses that included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. The minimum data set (MDS) included a brief interview for mental status (BIMS), with a score of 03. Indicating the resident had a severely cognitive impairment. The care plan revealed that Resident #2 had potential to demonstrate physical and verbal behaviors towards staff during cares. The date initiated was August 19, 2024. Goals were written to demonstrate effective coping skills through the review date. Interventions included to analyze key times, places, circumstances, triggers, and what de-escalates behavior and document. Resident #12 was admitted on [DATE] with diagnoses that included essential primary hypertension, and unspecified dementia. The MDS included a BIMS of 09, which showed mild cognitive impairment. The care plan for resident #12 listed a focus on the use of psychotropic medications related to dementia with behaviors as evidence based (aeb) verbal aggression. The date initiated was July 16, 2024 and revised on September 20, 2024. Additionally, had the potential to demonstrate physical behaviors related to dementia, physical aggression towards staff, refusing care meds, food and tube feed flushes, self isolation. PEG tube discontinued on September 11, 2024. There was a date initiated of July 17, 2024 and a revision date of October 01, 2024. A focus of psychosocial well-being problem related to dementia, physical aggression initiated September 22, 2024 and revision on September 23, 2024. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of progress notes in resident #12's chart, dated September 22, 2024 at 5:49 PM, revealed staff were in the dayroom passing out dinner trays to resident; and that, at the time peer was cursing and yelling. Resident left his table and started yelling back at her, and before the staff could stop him, he hit her in the eye. Staff separated the residents right away. Administrator, Director of Nursing (DON/staff #3), Unit Manager, Nurse Practitioner, Social Services, Police, and Psychiatry were informed. Review of resident #2's progress notes, dated September 22, 2024 at 6:46 PM by Licensed Practical Nurse (LPN/staff member #1), revealed that a peer was standing over resident and staff member seen peer hit resident in the face, staff ran to separate them from each other. A small open area to LT lower brow was noted, resident refused for me to look at it. Administrator (staff #2) , Director of Nursing (DON/staff #3), Police, Social Services, Nurse Practioner were all informed. Family was at bedside with resident. An interview was conducted with Certified Nursing Assistant (CNA/Staff member #4), on October 21, 2023 at 2:45 PM, who stated that she was working on the day of the incident. She did not see the actual incident but heard the commotion and stated that staff immediately separated the two residents and informed the nurse and reassured the residents. An interview was conducted with LPN/Staff member #1 on October 21, 2024 at 2:50 PM. Staff member #1 stated that staff were sitting at nurses station and resident #2 was screaming; and that, Resident #12 got upset. First thing we did was take them apart. Took her to her room and him to his room. Then called the cops and everybody that needed to be notified. Incident occured on a Sunday, family came in, and the police arrived. The right upper brow needed cleaning and the doctor to assess. An interview was conducted with the DON/staff #3 on October 21, 2024 at 3:11 PM who stated that she expects staff to intervene and start different interventions right from the start. If it gets to any altercations, they need to be separated. DON added that staff have regular abuse training and with the education, can redirect. Review of State Operations Manual (SOM), Appendix PP (Rev. 211; Issued: 02-03-23; Effective: 10-21-22; Implementation: 10-24-22), revealed resident has the right to be free from abuse. Abuse, is defined at S483. 5 as the willful infliction of injury. In the definition of abuse, and means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Staff should monitor for any behaviors that may provoke a reaction by residents or others, which include, but are not limited to: verbally aggressive behavior, such as screaming.