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	01/09/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47911 Based on clinical record review, staff interviews, and the facility policy and procedures, the facility failed to ensure a thorough investigation for one abuse allegation out of three on a resident to resident abuse complaint, involving resident #88 and #77. The deficient practice could result in appropriate corrective action not taken and an inaccurate investigative outcome. Findings include: -Resident #77 was admitted on [DATE] and discharged on [DATE] with diagnosis including dementia of unspecified severity with other behavioral disturbance, Alzheimer's disease, polyarthritis, chronic obstructive pulmonary disease, end stage renal disease and polyneuropathy. A review of the quarterly MDS (minimum data set) dated April 16, 2024 revealed a BIMS (brief interview of mental status) score of 9, indicating moderate cognitive impairment. -Resident #88 was admitted on [DATE] with diagnosis including dementia with unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, encephalopathy, Alzheimer's disease, epilepsy, depression and muscle weakness. A review of the quarterly MDS dated [DATE] revealed no overall BIMS score but indicated that the resident is rarely or never understood, had memory problems and cognitive skills for daily decision making were severely impaired. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the 5-day investigative report with a noted date of discovery of July 12, 2024 revealed that the nature of the incident was a resident to resident physical altercation which occurred in the dayroom of the dementia unit. It was noted that resident #77 struck resident #88 in the face, after resident #88 was being disruptive. The report further revealed that the residents were separated and that no injuries were noted at the time of the incident; however, a skin assessment for resident #88, dated July 12, 2024, revealed that the skin was intact but redness was noted to the left side of the face. The report noted both resident's admitted s, diagnosis, care plan documentation, post-incident interventions, staff interviews, interviews of resident #77 and resident #88; however, there was no evidence in the report that other resident's in the day room or unit had been interviewed. Interviews with staff revealed that staff #254 LPN (licensed practical nurse) at 6:40 P. M. heard resident #88 yelling and that resident #77 had propelled himself across the room, made a fist and swung toward the left side of the face of resident #88. The outcome of the 5-day investigation was that there was insufficient evidence to prove physical contact was made and that both resident #77 and resident #88 denied that the incident had occurred; however, it was noted in the report, that staff #253 had observed that resident #77 made a fist and swung at the face of resident #77. An observation was conducted on January 8, 2025 at 12:08 P.M. in the 300-unit dining/ day room. It was observed that 9 residents were present with 3 staff members assisting. No observed concerns. An observation was conducted on January 8, 2025 at 12:30 P.M. in the 100-unit dining/ day room. It was observed that 17 residents were present along with 2 CNA's (certified nursing assistants) and a nurse who was seated at the unit desk but was able to observe. On January 8, 2025 at 12:03 P.M. a telephone call was placed to staff #253. A voice message was left requesting a call back. An interview was conducted January 8, 2025 at 12:33 P.M. with resident #88. He stated that he had no problems with anyone and that he was fine. The resident did not recall the incident. An interview was conducted on January 8, 2025 at 12:10 P.M. with staff #165 CNA (certified nursing assistant). Staff #165 stated that there is always at least one nurse monitoring the day room, but often there are more staff present. She stated that after an incident, she was aware that those who observed were interviewed but that was all she knew about the process. She stated that there were no staffing concerns at the facility that she was aware of. An interview was conducted on January 8, 2025 at 12:17 P.M. with staff #224 RN (registered nurse). Staff #224 stated that staff receive frequent dementia and abuse training. She stated that if resident to resident abuse occurs, that the residents are separated immediately and checked for injuries. She stated that skin related injuries are noted on the skin assessment form. She further stated that notifications post incident would take place and that the DON (director of nursing), staff #5, would conduct nursing and staff interviews. A follow-up telephone call was placed on January 8, 2025 at 12:48 P.M. to reach staff #253. Another voicemail was left requesting a call back. A telephone call was placed on January 8, 2025 at 12:51 P.M. to staff # 64 (CNA-) who was noted to have worked the day of the incident. A voicemail was left requesting a call back. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A telephone call was placed on January 8, 2025 at 12:52 P.M. to staff #159 LPN. A message was left on voicemail requesting a call back. No call back was received. An interview was conducted on January 8, 2025 at 3:50 P.M. with staff #5 DON (director of nursing). Staff #5 stated that she felt that the 5-day investigation conducted on July 12, 2024 for resident #77 and #88 were thorough. She stated that she was not aware that additional resident interviews were required as the state had always accepted the investigations as written before, without additional resident interviews. She stated that she had received additional guidance from her current administrator that it would be a good idea to always interview the residents, which she stated that she had been doing since December 2024, as evidenced by the investigative report for resident #80 and #56 Staff #5 further stated that there is no documentation as to when the change, incorporating resident interviews, occurred, but that she would incorporate it into QAPI (quality assurance and performance improvement) going forward. A telephonic interview was conducted on January 8, 2025 with staff #300 administrator. Staff #300 stated that, as he was new, he could not answer for what had occurred in the past, but stated that best practice is to always interview residents post incidents. He stated that he had provided guidance to the DON, to include the resident interviews, in the 5-day investigations going forward. He stated that his expectation was to have resident interviews and an inclusive timeline noted in all 5-day investigations and further stated that if these were not included it would not meet his expectation. Staff #300 stated that the risk for not completing a thorough investigation, to include resident interviews, could include not having a complete picture of what transpired and or being able to either confirm the allegations or exonerate. A return call was received on January 9, 2025 at 10:20 A.M. from staff #253. Staff #253 stated that she thought her patient was resident #88 and that he was in the dining room yelling, not at anyone specific but just in general on July 12, 2024. She stated that it was around dinner time and there were about 3 to 4 other residents seated at resident #88's table and about the same number for resident #77. She stated that she recalled that the dining room was pretty full with residents, as most tables were full. She stated that resident #77 became irritated when resident #88 was yelling and wheeled himself over and struck resident #88 in the face. She stated that she further recalled that it left a red mark on resident #88's face. She stated that she immediately separated the residents to ensure their safety and elevated the incident. She stated that to her knowledge the DON conducts the follow-up interviews after an incident. A review of the policy entitled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, revised September 2022 revealed that all reports of resident abuse are thoroughly investigated by facility management and that all findings of the investigations are documented and reported. The policy further revealed that the individual conducting the investigation, interviews any witnesses to the incident; however, given that it was reported that there were other residents present at the time of the incident, as reported by staff #253, and there was no evidence in the 5-day investigation that these residents were interviewed, a thorough investigation was not conducted. Furthermore, the 5-day investigation noted that there was insufficient evidence that contact had occurred, when in fact staff #253 had observed resident #77 propelling to the other side of the room, making a fist and striking the left side of resident #88's face. The report and electronic health records further revealed a skin assessment on July 12, 2024 showing redness to the left side of the face, in spite of the comment in the report noting no injuries were reported at the time of the incident.