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Form Approved OMB
No. 0938-0391

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	03/20/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 50116 Based on clinical record review, staff and resident interviews, facility documentation and policy review, the facility failed to confirm that an allegation of misappropriation was appropriately reported to the state agency (SA). Failing to report could lead to other residents property being misappropriated. Findings include: Upon review investigation of the allegation of misappropriation complaint, the source of complaint was found not to be from the facility but by another reporting source. A federally reported incident number was not located in the (SA) reporting portal or the Complaint system for federal complaints. A call was placed by the surveyor to the state agency (SA) on March 20, 2025 at 09:05 am to verify that the reportable from the facility was received via the reporting system. At 09:06 am, is was confirmed that no submission for the initial report was found submitted from the facility. An interview was conducted with resident #2 on March 20, 2025 at 12:11 pm who revealed that the resident originally reported the missing wallet in February, to a certified nursing assistant (CNA), a staff member that always helps the resident, but resident #2 could not think of her name. Nothing was done. Then resident #2 told social services director staff #6. An interview was conducted on March 20, 2025 at 1:05 pm with social services director staff #6 who confimed that she placed the initial report into the complaint portal for the state agency. Staff #6 stated a verification link appeared immediately when attempting to submit the complaint. When asked how long did you wait until clicking on the link to verify the email address? Staff #6 stated it was immediately then stated, maybe 2 to 3 minutes later and nothing happened. Staff #6 stated that you could be putting your residents in harms way, and not protecting your staff/families if not reporting abuse, neglect, misappropriation or any issues. Staff #6 confirmed that she did not call the SA to see if the report went through when asked if she followed up with the SA to see if it went through. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility staff claimed to have reported the incident on March 11, 2025, however, review of the State Agency incident/complaint intake program did not document submission of the incident. The staff reported that they received an email requiring email verification in order to complete the incident/complaint submission process, however, the staff failed to verify their email address and then failed to follow up with the State Agency to ensure the incident was received. A copy of the email received from the Arizona Department of Health Services Licensing, to verify your email address was obtained from staff #6. The email revealed, Hi (Staff #6): Click below to verify your email address. Once your email address is verified, your complaint will be submitted to the Department for you review. This email was sent on Tuesday, March 11, 2025 at 2:53 PM within the time 2 to 3 minute time frame that Staff #6 claimed to have not received a response from the complaint submission. Further the 5-day facility investigation report, confirms documented by facility manager (Staff # 8) that at 2:52 PM the complaint was reported to the state agency. The link to verify was sent to staff #6 on March 11, 2025 2:53 pm. No other documentation available by facility that the complaint was submitted succesfully was received. An interview was conducted on March 20, 2025 at 2:13 pm with director of nursing (DON) staff #7 and revealed that not reporting abuse, neglect, misappropriation or any issues will leave residents at risk and the staff are mandated reporters. Review of the policy Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating has a policy statement that reads: All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Reporting allegations to the administrator and authorities, section 3. Immediately is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury b. states within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50116 Based on closed clinical record review, staff interviews, facility documentation and policy review, the facility failed to implement adequate supervision to one resident (#3) which resulted in a fall with injury. The deficient practice could result in other injuries to residents. Findings include: Resident #3 was initially admitted on [DATE] and most recently on February 8, 2025, with diagnoses of Parkinson's disease, dementia, trans ischemic attack (TIA), fracture of nasal bones. A brief interview for mental status (BIMS) assessment dated [DATE], revealed resident #3 had a score of 6, indicating severe cognitive impairment. A minimum data set (MDS) assessment dated [DATE], revealed the resident had a fall history in the last month. A care plan dated January 13, 2025, revealed that resident #3 was at risk for falls, listing three falls after admission to the facility. January 14, 2025, January 18, 2025, January 24, 2025. Educate resident/family/caregivers/IDT as to causes date initiated: January 13, 2025. Fall interventions included: anticipate and meet needs with a revision on January 14, 2025, Psych eval, therapy screens date initiated: January 14, 2025. Floor mat next to bed while bed is occupied date initiated: January 15, 2025 with a revision on February 10, 2025. Follow facility fall protocol. Front wheeled walker next to bed, initiated January 21, 2025. Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter remove potential causes if possible. Staff to intervene when ambulating without appropriate assistive devices, date initiated: January 27, 2025. A progress note dated January 20, 2025 at 12:52 pm revealed that the interdisciplinary team (IDT) met and reviewed the fall from January 18, 2025. The IDT recommended continuing with all current interventions at this time. A progress note dated January 27, 2025 at 7:18 pm revealed that the IDT met regarding the fall from January 24, 2025. Prior interventions, and anticipate needs. Current interventions, staff to intervene when ambulating without appropriate assistive device. Although careplan was reviewed and revised, progress notes revealed resident #3 required surgical care due to sustaining another fall. A progress note dated February 4, 2025 at 17:02:45 by registered nurse (RN) staff #2 revealed that resident #3 had, a skin tear on his right elbow today, patient got injured when rolling on the floor and certified nursing assistant (CNA) was attempting to assist him back on his floor mat. A progress note dated February 4, 2025 19:40 by RN staff #2 revealed resident #3 was sent to the emergency department (ED) for evaluation of right hip deformity. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated February 8, 2025 18:05 revealed that the resident returned to the facility with bruising to the left upper extremity (UE), bruising to left flank, left groin, right hip with three areas of staples (#10 to proximal, #10 to distal and #3 to medial), right lateral knee with #6 staples. Review of progress notes revealed s/p R ORIF hip fracture with IM rodding R femur (status post right open reduction internal fixation hip fracture with intramedullary rodding right femur). An interview was conducted on March 20, 2025 at 11:51 am with resident #3 family member who revealed was told that resident #3 fell out of bed, was on the floor, not walking anymore, and was sent to the hospital; and that the resident had a broken femur. An interview was conducted on March 20, 2025 at 1:10 pm with certified nursing assistant (CNA) staff #1 who revealed that she did not remember the resident falling, but would notify the nurse immediately and refrain from touching a resident until the nurse does an assessment. Then they will assist the resident up. An interview was conducted on March 20, 2025 at 1:12 pm with registered nurse (RN) staff #3 who revealed that if a resident falls you stay with them and ask if they hit their head, or if they have pain. Do not get them up. Get help and contact the provider, contact the unit manager, and contact the family. Lastly, fill out the risk management form. An interview was conducted on March 20, 2025 at 2:13 pm with director of nursing (DON) staff #7 who revealed that when a resident falls, the process is to ask the resident how it happened, call the provider, family if the provider wants to send to the hospital, look at the interventions, and review the fall event with the interdisciplinary team. Review of the policy titled, Falls and Fall Risk, Managing (revision date March, 2018) was reviewed revealed unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred. Section Monitoring Subsequent Falls and Fall Risk in the Falls and Fall Risk, Managing, revealed that if the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified.