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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION           | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>035255 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing  | (X3) DATE SURVEY COMPLETED<br><br>06/24/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Palm Valley Post Acute |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>13575 West McDowell Road<br>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.

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| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews, review of records, and review of facility policy and procedure, the facility failed to protect the rights of one of five sampled residents (#1) to be free from abuse by another resident (#3). The deficient practice could lead to ongoing abuse leading to harm of other residents.</p> <p>-Findings include:</p> <p>Resident #1 was admitted to the facility with an original admission date of November 02, 2021, with diagnoses that included psychotic disorder with hallucinations due to known physiological condition, personality change, alcohol dependence with alcohol induced persisting dementia, vitamin deficiency, generalized anxiety disorder and type 2 diabetes mellitus.</p> <p>A review of the quarterly minimum data set (MDS) dated [DATE] for Resident #1 revealed a brief interview of mental status (BIMS) of 07, which indicated the resident was severely cognitively impaired.</p> <p>Review of the electronic medical records (EMR) progress note dated June 20, 2025, 22:30, revealed Resident #1 was questioned by the police department regarding the altercation with another resident (#3). Resident #1 stated that he hot punched in the stomach a couple of times and that it didn't hurt.</p> <p>Review of the electronic medical records (EMR) progress note dated June 20, 2025, revealed nursing - comprehensive skin evaluation assessment type change of condition, section skin assessment comments documented, Resident has skin discoloration to arms and upper body.</p> <p>Resident #3 was admitted on [DATE] with diagnoses that included schizoaffective disorder, essential primary hypertension and type 2 diabetes mellitus.</p> <p>A review of the minimum data set (MDS) dated [DATE] for Resident #3 revealed a brief interview of mental status (BIMS) of 09, which indicated the resident was moderately cognitively impaired.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>035255   | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing  | (X3) DATE SURVEY COMPLETED<br><br>06/24/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Palm Valley Post Acute   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>13575 West McDowell Road<br>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<br>(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>A care plan initiated on April 30, 2024 with a revision on December 23, 2024 revealed that Resident #3 had a behavior problem related to schizoaffective disorder as evidenced by verbal aggression to staff/peers, physical aggression to staff/peers. Interventions initiated on April 30, 2024 included to intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to an alternate location as needed. Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes.</p> <p>A behavioral progress note dated June 20, 2025 at 7:39 pm, revealed that Resident #3 was in the hallway between rooms [ROOM NUMBERS] when he came into contact with another resident and started punching that resident. That resident was Resident #1. Staff intervened and separated the two residents. Resident #3 started to yell and use foul language and hit staff.</p> <p>An interview was conducted on June 24, 2025 at 2:44 p.m. with certified nursing assistant (CNA/Staff #3) who stated that staff would need to separate both parties and make sure they are okay, and report immediately when abuse happens.</p> <p>A telephonic interview was conducted on June 24, 2025 at 2:58 p.m. with Licensed Practical Nurse (LPN/Staff #5) who stated, regarding the incident, that she was at the nurse's station and heard noises in the hall. A certified nursing assistant (CNA) was there with the residents. First CNA Staff #7 was there then CNA Staff #4 came to assist. CNA Staff #4 then stayed with Resident #3. Staff #5 stated that the incident was reported by LPN Staff #8 to the Director of Nursing (DON/Staff #6), right away.</p> <p>A telephonic interview was conducted on June 24, 2025 at 3:04 p.m. with CNA Staff #4 who stated that he did not see how the situation initiated, but jumped in to help separate the two residents and took Resident #3 back to his room; and that, Resident #3 was yelling and cursing when he returned to his room. Staff #4 stated the incident was reported immediately to the Administrator.</p> <p>An interview was conducted on June 24, 2025 at 3:33 p.m. with DON/Staff #6 who stated that psychiatrist and the medical provider were notified and got involved. Staff members were in-serviced about abuse and what to do if abuse happens. The staff were educated on keeping the residents separated; and that, if residents abuse other residents, they can be harmed.</p> <p>Review of facility's policy titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, last revision date of September 2022 revealed 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.</p> <p>Review of facility's policy titled, Resident Rights, last revised date of February 2021 revealed the resident has the right to be free from abuse, neglect, misappropriation of property, and exploitation.</p> |   |  |