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	08/01/2025

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 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. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews, review of facility documentation and policy, and observation of current practice, the facility failed to evaluate and implement effective care plan interventions related to falls for one of two sampled residents (#156). The deficient practice resulted in the resident experiencing multiple falls in the facility, and could result in other residents failing to receive effective fall-prevention measures. The census was 172.Findings include:Resident #156 was admitted to the behavioral unit of the facility on June 25, 2025, with diagnoses displaced intertrochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing, unspecified symptoms and signs involving cognitive functions and awareness, other abnormalities of gait and mobility, fall on same level, pain in left hip, parkinsonism, unspecified, unspecified dementia.Review of the Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 99, indicating mental status interview was not successfully completed.Review of the resident care plan initiated on June 26, 2025, revealed that the resident had a witnessed fall and was at risk for a history of ground-level fall with Left hip fracture status post arthroplasty, weakness, decreased mobility, Parkinson's Disease. Initial intervention initiated on June 26, 2025, indicated evaluation of medications for side effects that may increase fall risk. Another Initial intervention was initiated on June 27, 2025, which included placing fall mats against the wall with family agreement.Review of the admission progress notes dated June 25, 2025, revealed that Resident #156 had a history of Chronic Obstructive Pulmonary Disease, Diabetes Mellitus Type 2, Dementia, Parkinson's, and falls; and, the patient recently fell, resulting in a clavicle fracture and two rib fractures; and that, the daughter stated the patient is a fall risk and will try to get out of bed on her own.Review of the resident fall risk assessment dated [DATE], revealed that resident #156 is non-ambulatory, uses a wheelchair, and has a history of three or more falls for the last ninety days.Further review of the resident's progress notes dated July 3, 2025, revealed that the resident was transferred from the behavioral unit to the dementia unit, accompanied by her daughter. The resident is alert and oriented with generalized weakness, Dementia, hip fracture, Surgical incision to the left hip, multiple bruises to the bilateral arms, and LE high fall risk. Introduced to the room and call light the bed is placed in a low position call light.On July 29, 2025, at 9:16 AM, the surveyor observed Resident #156 on the floor next to her Geri chair, which was located by the bedroom door. At the time of the incident, there were no staff present. A Certified Nursing Assistant (CNA) emerged from one of the resident rooms and informed the nurses, who were at the nursing station at that time. The staff then assisted the resident in assisting her back into her Geri chair.Review of the progress note dated July 30, 2025, revealed that the Interdisciplinary Team (IDT) met and reviewed fall for July 29, 2025 the resident noted purposefully placing self onto the floor from wheelchair. The resident had a full spoon, one fell onto the floor, and the resident purposefully placed herself onto the floor to get the spoon. Range of motion at baseline, no complaints of pain or discomfort noted. Per family resident who used to hoard items at home states she has pictures of what she used to do at home. She used to put herself down onto the floor all the time and would scooch on the floor.Further review of the Interdisciplinary Team (IDT) progress notes, regarding the resident's fall on July 29, 2025, revealed that prior intervention(s) included a fall mat next to the resident's bed while the bed is occupied. Perimeter overlay, anticipate and meet needs, and call light within reach. Additionally, the Interdisciplinary Team (IDT) recommends current intervention(s) such as staff provides frequent safety reminders.Review of the resident's revised care plan dated July 29, 25, revealed that the resident had two falls on June 27, 2025, before the resident transferred to the dementia unit from the behavioral unit, and on July 29, 2025, the resident purposefully placed herself on the floor.Further review of the resident's care plan initiated July 30, 2025, revealed that on July 29, 2025, the staff were to provide frequent safety reminders.An interview was conducted on August 1, 2025, at 9:45 AM with the Certified Nursing Assistant (Staff #243), who stated that if a CNA witnesses a fall, they must stay with the resident for their safety and use the pager to call the nurse. The nurse will then conduct an assessment. She stated that she has not witnessed an incident where the resident (#156) slid from her wheelchair. She added that the resident can grab onto the bar in the bathroom, pivot, and sit on the toilet. The CNA indicated that she wouldn't classify the resident as needing maximum assistance; rather, the resident's level of assistance required depends on how tired she is. The resident may require extensive or minimal assistance, but not maximum assistance. She stated that if the resident slides from the chair or wheelchair, that would be considered a fall.An interview was conducted on August 1, 2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and policy review, the facility failed to ensure the medication error rate was not 5% or greater, by failing to administer medications as ordered for two of four residents (#139, #87). The deficient practice could result in adverse effects and further medication errors.Findings include:Eight medication administration errors were identified out of twenty-six opportunities during medication administration observation. The medication error rate was 30.77%.Regarding Resident #139Resident #139 was admitted to the facility on [DATE] with diagnoses that included hydronephrosis, type two diabetes mellitus, and immunodeficiency. A medication administration observation was conducted with a Registered Nurse (RN/Staff #26) on July 31, 2025 at 8:34AM for Resident #139. During this administration, the RN was observed to take out a bottle of Cholecalciferol (Vitamin D3) 2.5mcg/1000IU, and the RN placed one tablet into the medicine cup. After preparing the resident's other medications, Resident #139 was observed to swallow the medications, including the single tablet of Cholecalciferol. Upon reviewing the provider orders for Resident #139, the following order was found:- Cholecalciferol Tablet 1000 UNIT - Give 5 tablet by mouth one time a day for supplementRegarding Resident #87Resident #87 was admitted to the facility on [DATE] with diagnoses that included type two diabetes mellitus with ketoacidosis, need for assistance with personal care, and reduced mobility. Review of the provider orders for Resident #87 revealed the following medications to be administered at 08:00AM:- Allopurinol Oral Tablet 200 MG (Allopurinol) - Give 200 mg by mouth two times a day for GOUT- amLODIPine Besylate Oral Tablet 10 MG (Amlodipine Besylate) - Give 10 mg by mouth one time a day for HTN- Amoxicillin Oral Capsule 250 MG (Amoxicillin) - Give 1 capsule by mouth three times a day for Dental pain for 5 Days- Aspirin Tablet 81 MG- Give 1 tablet by mouth one time a day for CAD- Carvedilol Oral Tablet 12.5 MG (Carvedilol) -Give 12.5 mg by mouth two times a day for HTN- Gabapentin Oral Tablet 100 MG (Gabapentin)- Give 100 mg by mouth three times a day for Neuropathy- levETIRAcetam Oral Tablet 500 MG (Levetiracetam) - Give 500 mg by mouth two times a day for SeizuresA medication administration observation was conducted with a Registered Nurse (RN/Staff #244) on July 31, 2025 for Resident #87. The RN was observed preparing the medications for administration on July 31, 2025 at 09:06AM. While preparing the medications, the RN stated that the medication orders were all red, referring to the Electronic Health Record. At this time, it was observed that the medication orders on the EHR were mostly red, with only a couple orders being yellow. When asked what the red meant on the EHR, the RN stated that the red meant they were overdue, while yellow meant due. The RN explained that these medications were due at 08:00AM, and it was currently 09:06AM, therefore the medications were past due. When asked why the medications were being administered at this time, and if she felt she had enough help and resources to administer medications timely, the RN stated that she had to care for twenty-seven patients, and she had to work really fast. The RN finished preparing the medications and then proceeded to administer the medications to Resident #87. Interview was conducted on August 1, 2025 at 10:18AM with a Licensed Practical Nurse (LPN/Staff #14), who stated that medications should be administered per the orders, and that staff typically have one hour before and one after a medication is due to administer the medication. Interview was conducted on August 1, 2025 at 1:59PM with the Director of Nursing (DON/Staff #125), who stated she would expect that her nurses ensure they check the rights of medication administration, including that they ensure they have the right person, right medication, and right dose. She also stated she would expect the staff to call the doctor if they found any errors. The DON stated the staff typically have an hour before and after a medication's scheduled time to administer the medication, and she would expect the staff to call the doctor if they were not administering within this timeframe. When asked to review Resident #139's order for Cholecalciferol, the DON confirmed that she would read the order as to administer 5 tablets of 1000 units, for a total dose of 5000 units, so this is what she would expect to be administered. Review of the facility policy titled, Administering Medications, revealed that medications should be administered in a safe and timely manner, and as prescribed. This policy indicated that medications should be administered in accordance with prescriber orders, including any required time frame. Additionally, medications should be administered within one hour of their prescribed time, unless otherwise specified.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, and review of facility policy, the facility failed to ensure that there were no expired supplies readily available for resident use and that medications available for resident use had visible expiration dates. The deficient practice could result in an increased risk for side effects or ineffective drug therapy. The census was 172 and the sample consisted of 34 residents.Findings include:Observation of a medication cart conducted on [DATE] at 12:58PM revealed several single-dose blister packets of Omeprazole within a small compartment in the top drawer of the medication cart. These medications were stored without the original box. Observation of the individual medication packets revealed that the packaging did not indicate an expiration date for the medication.Interview was conducted on [DATE] at 1:00PM with the Licensed Vocational Nurse (LVN/Staff #77) who was assigned to this medication cart. The LVN looked at the packets of Omeprazole and confirmed that she could not locate an expiration date. The LVN stated that the medications come from a big box, which may have the expiration date, but the box was not retained. The LVN left to ask her supervisor how to locate the expiration date. Upon return, the LVN stated that she could not verify the expiration dates of the medications or how long the medications had been in the cart in this state, so she would dispose of the medications. The LVN then proceeded to remove the Omeprazole packets from the medication cart for disposal.Observation was conducted on [DATE] at 1:26PM in one of the facility's medication storage rooms. Observation in this room revealed a pile of blood culture collection kits on a shelf containing supplies and medications. Closer inspection of one of the kits revealed an expiration date of [DATE]. The nursing staff in the medication room were asked what the date meant. The staff then called in the Executive Director (ED/Staff #4) for assistance. The ED confirmed that the blood culture collection kit was expired, stating that the hourglass symbol beside the date symbolized the expiration date. The ED explained that the kits are not being used by the staff, but stated that they should not be in the medication room if they are expired. The ED then removed the expired kits for disposal. Interview was conducted on [DATE] at 1:59PM with the Director of Nursing (DON/Staff #125), who stated that she would expect medications would have the correct expiration date and should be the correct medication for the patient. Review of the facility policy titled, Medication Labeling and Storage, revealed that medications and biologicals should be stored in the packaging, containers or other dispensing systems in which they are received. The policy also indicated that if the facility had discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy should be contacted for instructions regarding or destroying these items.