STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035270	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silverwood Post Acute	15810 South 42nd Street Phoenix, AZ 85048

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49199 Based on closed clinical record review, staff interviews, facility documentation and policy review, the facility failed to ensure that their abuse policy was implemented regarding major injury that one resident (#5) sustained. The deficient practice could result in other facility policies not being followed. Findings include: Resident #5 was initially admitted to the facility of December 26, 2018 with a diagnosis of dementia, major depressive disorder, hyperlipidemia and gout. Review of the progress note dated December 18, 2024 states resident laying on right side of bed, stating pain in the right upper leg. Assessment completed and 911 call, resident transferred by gurney to ER. Review of an IDT Note dated December 20, 2024 states Resident had fall with injury. Resident has dementia and became increasingly agitated. Upon speaking with the nurse she stated that the resident has not walked for years but kept telling the LN that she was leaving and wanted to leave this place. LN sent out resident immediately. Family and provider notified. Review of the hospital History and Physical dated December 23, 2024 stated the resident had sustained a left periprosthetic femur fracture and a right hip fracture. Review of SA (State Agency) Database revealed that there was no evidence found that the facility reported Resident's (#5) major injury to the SA. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on March 5, 2025 at 1:03 PM with the DON (Director of Nursing, Staff #20) and the ADON (Assistant Director of Nursing, Staff #50). Staff #20 stated that resident #5 fell from her bed, the nurse went into the resident's room and the resident was on the floor beside the bed and she called 911. Staff #50 stated that she was informed from the insurance representative that resident #5 was discharged to another facility. Staff #50 contacted the resident's daughter, primary contact for the resident, who stated she choose the facility because it was closer to her home. Staff #50 stated that resident was denied therapy and her daughter had her transferred to another facility. Staff #50 stated the second facility therapy was also denied and the daughter had resident #5 readmitted to the facility on [DATE]. Staff #50 stated that Resident #5 was denied therapy here also but was under her long-term care insurance. Staff #50 also stated that the resident was on palliative care and had been for years. An interview was conducted on March 5, 2025 at 2:07 PM with Staff #20 who stated the injuries resident #5 sustained were not witnessed. Her conclusion is that this resident fell out of bed due to the statement the resident made to the nurse that found her I want to go home. I don't want to stay here. The only investigation that was completed by staff #20 was speaking to the nurse that found the resident. She stated that she did not feel this incident should have been reported to the state. She does submit any allegations of abuse and those are investigated. Staff #20 also stated that she can understand how the situation could be looked at in a different way. She stated However I do see what you are saying and the way you are looking at this from an outside person. The staff know this resident because she's been here for so long and just concluded there is no other explanation for her on the floor. I get what you are saying. Review of the facility's policy on Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating dated 2001 with a revision on April 2021, states upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions (if any) are needed for the protection of residents. Immediately is defined as: within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49199 Based on closed clinical record review, staff interviews, facility documentation and policy review, the facility failed to report a major injury that one resident (#5) sustained. The deficient practice could result in other injuries of unknown origin to residents. Findings include: Resident #5 was initially admitted to the facility of December 26, 2018 with a diagnosis of dementia, major depressive disorder, hyperlipidemia and gout. Review of the progress note dated December 18, 2024 states resident laying on right side of bed, stating pain in the right upper leg. Assessment completed and 911 call, resident transferred by gurney to ER. Review of an IDT Note dated December 20, 2024 states Resident had fall with injury. Resident has dementia and became increasingly agitated. Upon speaking with the nurse she stated that the resident has not walked for years but kept telling the LN that she was leaving and wanted to leave this place. LN sent out resident immediately. Family and provider notified. Review of the hospital History and Physical dated December 23, 2024 stated the resident had sustained a left periprosthetic femur fracture and a right hip fracture. Review of SA (State Agency) Database revealed that there was no evidence found that the facility reported Resident's (#5) major injury to the SA. An interview was conducted on March 5, 2025 at 1:03 PM with the DON (Director of Nursing, Staff #20) and the ADON (Assistant Director of Nursing, Staff #50). Staff #20 stated that resident #5 fell from her bed, the nurse went into the resident's room and the resident was on the floor beside the bed and she called 911. Staff #50 stated that she was informed from the insurance representative that resident #5 was discharged to another facility. Staff #50 contacted the resident's daughter, primary contact for the resident, who stated she choose the facility because it was closer to her home. Staff #50 stated that resident was denied therapy and her daughter had her transferred to another facility. Staff #50 stated the second facility therapy was also denied and the daughter had resident #5 readmitted to the facility on [DATE]. Staff #50 stated that Resident #5 was denied therapy here also but was under her long-term care insurance. Staff #50 also stated that the resident was on palliative care and had been for years. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on March 5, 2025 at 2:07 PM with Staff #20 who stated the injuries resident #5 sustained were not witnessed. Her conclusion is that this resident fell out of bed due to the statement the resident made to the nurse that found her I want to go home. I don't want to stay here. The only investigation that was completed by staff #20 was speaking to the nurse that found the resident. She stated that she did not feel this incident should have been reported to the state. She does submit any allegations of abuse and those are investigated. Staff #20 also stated that she can understand how the situation could be looked at in a different way. She stated However I do see what you are saying and the way you are looking at this from an outside person. The staff know this resident because she's been here for so long and just concluded there is no other explanation for her on the floor. I get what you are saying. Review of the facility's policy on Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating dated 2001 with a revision on April 2021, states upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions (if any) are needed for the protection of residents. Immediately is defined as: within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.

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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 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** 49199 Based on closed clinical record review, staff interviews, facility documentation and policy review, the facility failed to investigate a major injury that one resident (#5) sustained. The deficient practice could result in other injuries of unknown origin to residents not being investigated thoroughly. Findings include: Resident #5 was initially admitted to the facility of December 26, 2018 with a diagnosis of dementia, major depressive disorder, hyperlipidemia and gout. Review of the progress note dated December 18, 2024 states resident laying on right side of bed, stating pain in the right upper leg. Assessment completed and 911 call, resident transferred by gurney to ER. Review of an IDT Note dated December 20, 2024 states Resident had fall with injury. Resident has dementia and became increasingly agitated. Upon speaking with the nurse she stated that the resident has not walked for years but kept telling the LN that she was leaving and wanted to leave this place. LN sent out resident immediately. Family and provider notified. Review of the hospital History and Physical dated December 23, 2024 stated the resident had sustained a left periprosthetic femur fracture and a right hip fracture. An interview was conducted on March 5, 2025 at 1:03 PM with the DON (Director of Nursing, Staff #20) and the ADON (Assistant Director of Nursing, Staff #50). Staff #20 stated that resident #5 fell from her bed, the nurse went into the resident's room and the resident was on the floor beside the bed and she called 911. Staff #50 stated that she was informed from the insurance representative that resident #5 was discharged to another facility. Staff #50 contacted the resident's daughter, primary contact for the resident, who stated she choose the facility because it was closer to her home. Staff #50 stated that resident was denied therapy and her daughter had her transferred to another facility. Staff #50 stated the second facility therapy was also denied and the daughter had resident #5 readmitted to the facility on [DATE]. Staff #50 stated that Resident #5 was denied therapy here also but was under her long-term care insurance. Staff #50 also stated that the resident was on palliative care and had been for years. An interview was conducted on March 5, 2025 at 2:07 PM with Staff #20 who stated the injuries resident #5 sustained were not witnessed. Her conclusion is that this resident fell out of bed due to the statement the resident made to the nurse that found her I want to go home. I don't want to stay here. The only investigation that was completed by staff #20 was speaking to the nurse that found the resident. She stated that she did not feel this incident should have been reported to the state. She does submit any allegations of abuse and those are investigated. Staff #20 also stated that she can understand how the situation could be looked at in a different way. She stated However I do see what you are saying and the way you are looking at this from an outside person. The staff know this resident because she's been here for so long and just concluded there is no other explanation for her on the floor. I get what you are saying. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy on Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating dated 2001 with a revision on April 2021, states upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions (if any) are needed for the protection of residents. All allegations are thorougly investigated. The individual conducting the investigation as a minimum: a. reviews the documentaion and evidence:; b. reviews the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident; c. observes the alleged victim, including his or her interactions with staff and othr residents; d. interviews the person(s) reporting the incident; e. interviews any witnesses to the incident; f. interviews the resident (as medically appropriate) or the resident's representative; g. interviews the resident's attending physician as needed to determine the resident's condition; h. interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; i. interviews the resident's roommate, family members, and visitors.