

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035014	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2026
NAME OF PROVIDER OR SUPPLIER Desert Terrace Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2509 North 24th Street Phoenix, AZ 85008	

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)
<p>F 0839</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Employ staff that are licensed, certified, or registered in accordance with state laws.</p> <p>Based on interviews, review of clinical and personnel records, and review of facility policy and procedure, the facility failed to ensure that one sampled licensed nursing staff (#60) possessed a valid Arizona state license to practice as a Registered Nurse (RN) during employment, in accordance with state and federal regulations. The deficient practice could result in an unlicensed individual providing nursing care to residents for an extended period, and could potentially affect the safety and quality of care delivered to all residents receiving services. Findings include: Review of Staff #60's employment application dated March 20, 2025, revealed the applicant indicated she held a valid RN license; however, a hand-written notation revealed upon arrival, to be endorsed in the blank space on the application. A personnel file review revealed the following: A license verification report dated March 31, 2025, from an online database, revealed an active, unencumbered RN license that belonged to a different individual with the same first and last name but a different middle initial. No evidence of a valid state RN license or verification from another state belonging to Staff #60. A termination notice dated March 30, 2026, indicating involuntary termination due to loss of license. Review of staffing schedules and punch details revealed that Staff #60 worked as a floor RN, and her first shift started April 16, 2025, and her last shift was February 11, 2026. A Professional Profile for Staff #60, dated April 8, 2026, included the position of registered nurse (RN), a hire date of March 26, 2025, and a termination date of March 30, 2026. A telephonic interview was conducted with an Arizona State Board of Nursing (AZBN) staff on April 8, 2026, at 11:54 a.m. The AZBN staff stated that the RN (Staff #60) had been an RN license applicant by endorsement for a license from another state. Additionally, The AZBN staff stated that the licensing process required additional steps because Staff #60 was considered foreign-educated. The AZBN staff also stated that the licensing board received documentation that Staff #60 had been employed at the facility and had been practicing as an RN, without the Arizona state license or endorsement to do so. The AZBN staff further stated that Staff #60 had never held an Arizona state licensure to be able to practice as an RN in Arizona, until April 6, 2026. The AZBN staff stated that when the Board received the documentation that Staff #60 had been working without an Arizona state license or endorsement the facility HR Director (staff #166) was notified on February 4, 2026 that staff #60 did not have an active Arizona RN license and should not be working as an RN. The AZBN stated that the facility HR Director confirmed that Staff #60 had been employed and working as an RN. Additionally, the AZBN staff stated that Staff #60 had an active license from another state, issued March 25, 2025, however the other state was not part of the Nurse Licensure Compact, and Staff #60 could not practice in Arizona with that license. An interview was conducted on April 8, 2026, at 12:42 p.m. with a Certified Nursing Assistant (CNA / Staff #12) who stated that if she noticed a change of condition in a resident such as shortness of breath or rapid breathing, that she would notify the floor nurse right away to conduct a resident assessment. The CNA stated that when a change of condition is not assessed by a licensed nurse, the resident could be having a serious condition and could die. The CNA also stated that RN (Staff #60) had worked as a floor nurse at the facility, passing medications, and assessing and caring for residents. An interview was conducted with the Human Resources Director (HR Director / Staff #166) on April 8, 2026, at 12:49 p.m. and a review Staff #60's personnel file for a was conducted with the HR Director. The (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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0839</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>record review revealed:A passport issued June 26, 2024, revealed the first, middle, and last name of Staff #60.A license verification report dated March 31, 2025, from the online database, for a different individual than Staff #60, with the same first and last name, however a different middle initial.The termination notice dated and signed March 30, 2026.There was no evidence of any other RN license or license verification from another state.During the interview with the HR Director, she stated that she is in charge of obtaining all of the onboarding documents for new staff. She further stated that the facility's process for verifying a nurse's license was to search the nurse's name on the online portal for nursing license verification, and that the process did not include requesting a copy of the nursing license. The HR Director stated that there was no evidence of Staff #60's nursing license in her personnel file, and that the file included licensure verification from the online portal. The HR Director reviewed Staff #60's identification documents, and stated that the middle name of the individual on the nursing license verification form was different than Staff #60, and that the license verified was a different person, and that it must have been oversight. The HR Director stated that she received a call on February 4, 2026, from AZBN staff, who told her that Staff #60 had an RN license from another state, and no RN license in Arizona, and that the AZBN staff recommended that Staff #60 be removed from working as a floor nurse. The HR Director stated that she believed the facility removed Staff #60 from working as a floor nurse. The HR Director reviewed the payroll records of when Staff #60 last worked in the facility as a nurse, and she stated that Staff #60's last day of working in the facility was February 11, 2026. The HR Director stated that she did not know why there had been a delay from February 4, 2026, when she was notified by the AZBN that the staff did not have a license, until February 11, 2026, that Staff #60 had been removed from working the floor. She stated that she thought that the Director of Nursing (DON/Staff #41) and Administrator (staff #9) were working on trying determine what had occurred regarding Staff #60's nursing license. The HR Director further stated that the reason that Staff #60 was terminated was because she was not licensed as an RN in the state of Arizona.An interview was conducted with the Administrator (Staff #9) on April 8, 2026, at 3:05 p.m. who stated that he expected the HR Director would complete all the necessary documentation and steps for a nurse to be hired, including a background check, fingerprint clearance card, citizenship, and verifying the staff's license on the online portal. The Administrator stated that if a hired nurse did not have the required state license, then he would contact his resource for guidance, confer with the Board of Nursing, and do a facility audit to determine what occurred. The Administrator stated that there could be a risk to residents if an unlicensed staff was providing care to residents, and that is why those regulations are in place for required licenses. The Administrator also stated he was made aware that there was an issue with Staff #60's RN license on the same day that the AZBN contacted the HR Director (Staff #166). The Administrator stated that the AZBN told the HR Director that there was no need to remove Staff #60 from working on the floor. The Administrator also stated that he had never directly talked to the AZBN himself. The Administrator also stated that because the AZBN did not give a concrete answer on what was the going on regarding Staff #60's RN license, and the facility staff were still unsure of the status of her license, that it was decided to remove Staff #60 from working the floor approximately one week after being notified by the AZBN. The Administrator stated that he was aware that Staff #60 had a license from another state, and that the licensing issue was for Arizona. The Administrator stated he did not believe that an RN with a license from the other state could practice in Arizona because the other state was not part of the licensing compact. The Administrator further stated that Staff #60 was terminated because the facility was unable to resolve issue regarding Staff #60's RN license.An interview was conducted with the DON (Staff #41) on April 8, 2026, at 3:25 p.m. The DON stated that the facility's process for onboarding a new nurse included the HR Director (Staff #166) completing a background check, license verification, and other onboarding items, however, she was not sure of the exact process. The DON stated that there could be risks to residents if those onboarding steps were not completed accurately, because the staff may not be competent to provide care for the residents. (continued on next page)</p>		

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<p>F 0839</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Regarding Staff #60, the DON stated that the HR director was informed by the AZBN that they were looking into an issue with Staff #60's Arizona RN licensure, and that approximately a week after that, Staff #60 and the AZBN informed the facility staff that she was not able to work. The DON also stated that up until that point, she believed Staff #60's was licensed without restriction to practice in Arizona. The DON further stated she knew for sure that Staff #60 had an active RN license in another state, and that she believed that the other state was part of the compact with Arizona which would allow her to practice in Arizona. The DON then reviewed the nursing licensure compact website and stated that the other state was not part of the nursing licensure compact states, and that it would require a license endorsement through Arizona to practice as an RN. The DON stated that it would concern her if the HR Director was not properly vetting staff's licensure prior to staff working on the floor with residents, because the facility needed to ensure those providing care were qualified. An interview was conducted with the Staffing Director (Staff #17) on April 9, 2026, at 1:49 p.m. who stated that he was in charge of scheduling staff to work on the floor. The Staffing Director stated that as soon as the HR Director informed him to schedule new staff, that would mean the staff was cleared to work, and all the onboarding process was completed. The Staffing Director also stated that he was informed that there was an issue with Staff #60's RN licensure and that he had pulled her off of the schedule as soon as he became aware that she did not have a license. The Staffing Director stated that the facility cannot have unlicensed personnel on the floor working with patients. A telephonic interview was conducted on April 9, 2026, at 2:42 p.m. with Staff #60, who stated that she believed she had first applied for her RN license in Arizona some time in 2024, and had not received it. Staff #60 stated that then she applied for an RN license in another state, and quickly received the license within a few weeks, and that it was active effective March 25, 2025. After receiving her license from the other state, around the same time period of March 2025, Staff #60 stated she then applied to have a license through endorsement in Arizona. Staff #60 stated that she was working at the facility and waiting for her license through endorsement to be approved, but was having difficulty because she had to complete a language proficiency test and have her education verified through a third party. Staff #60 stated she received a call on February 12, 2026, from the AZBN, and was asked if she was still working at the facility, to which Staff #60 stated that she was and her last day worked was the day before, on February 11, 2026. Staff #60 stated that the AZBN staff informed her that the AZBN had already instructed the HR Director (Staff #166) that Staff #60 could not work because she did not have a license for Arizona. Staff #60 stated that she believed she could work under the license from the other state, and that she assumed it would be ok. Prior to the phone call with the AZBM on February 12, 2026, Staff #60 stated that the HR Director had asked her the week prior if her Arizona license had arrived yet, to which Staff #60 replied she was still working on meeting the requirements to submit to the AZBN. A follow-up interview was conducted with the DON (Staff #41) on April 9, 2026, at 4:15 p.m. who stated that it was oversight on the facility's part that when the AZBN called on February 4, 2026, to report there was an issue with Staff #60's Arizona RN licensure, that the HR Director's should have verified whether or not Staff #60 could practice as an RN under the other state license. Additionally, the DON stated that there was an error made when Staff #60 was hired, that the license verification for Arizona was actually for another person, not Staff #60. Another follow-up interview was conducted with the Administrator (Staff #9) on April 9, 2026, at 4:39 p.m., who stated that there was a mistake when the HR Director looked up Staff #60's name on the online license verification portal, and the license verification was for another person with the same first and last name, but with a different middle initial. Additionally, Staff #9 stated that the HR Director was also educated to ensure licenses from another state are part of the licensing compact with Arizona. The Administrator stated that this situation with Staff #60 not having an Arizona RN license, and the mistakes made in license verification, did not meet his expectations as far as properly vetting an applicant for hire. He further stated that per the facility policy, Staff #60 had not been qualified to work as an RN at the facility during the timeframe she worked. Review of the facility (continued on next page)</p>		

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<p>F 0839</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>policy titled, Pre-Employment Investigations, dated January 2024, revealed for any individual applying for a position that requires a state-issued license or certification, the hiring manager or designee should verify that the applicant's license(s) and certification(s) are current and in good standing. The license(s), certificate(s), licensing board license verification website pages or other documents establishing valid licensure should be photocopied/printed and placed in the applicant's confidential application file.</p>		