STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035084	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plaza Healthcare	1475 North Granite Reef Road Scottsdale, AZ 85257

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interviews, and review of facility policy and procedure, the facility failed to ensure that professional standards of practice and facility policies were followed for administration of medications via gastrointestinal tube. The deficient practice could cause the resident to aspirate, cause infection, and medications being administered to the wrong resident.Findings include:A medication administration observation was conducted with Licensed Practical Nurse (LPN/staff #142) on May 7, 2026 at 8:28 A.M. The LPN was observed carrying a tray with a clear cup of medications crushed in water and also a cup of water. When entering the resident's room the LPN introduced herself, but was not observed to identify the resident by the wrist band prior to medication administration. When administering the medication by gastrointestinal tube the resident was observed lying supine and the head of bed was not elevated. The LPN removed a syringe out of a dated, sealed bag that was lying in a container on the side table next to the resident's bed. Next, the LPN drew up the crushed medications mixed with water from the clear cup into the syringe and administered the medication with the syringe into the resident's gastrointestinal tube. Then the LPN removed water from the clear cup into the syringe and flushed the gastrointestinal tube. The LPN was observed to place the syringe onto the container at the bedside table without placing the syringe into the dated bag, or rinsing the syringe with water. The resident was observed to be lying flat on the bed with the head of the bed down when the LPN left the resident room.An interview was conducted immediately after the observation with LPN (staff #142) on May 7, 2026 at 8:30 A.M., who stated that the syringe used for gastrointestinal tube medication administration should be placed in a plastic bag that is dated and then placed in the container on the bedside table. The LPN stated the risk of not placing the syringe used for gastrointestinal tube medication administration in the bag could cause bacteria or infection to the resident.A second medication administration observation was conducted with LPN (staff #142) was conducted on May 7, 2026 at 8:45 A.M. The LPN was observed carrying a tray with a clear cup of medications crushed in water and also a cup of water, and entered another resident's room to administer medication via gastrointestinal tube. The LPN was observed introducing herself to the resident, and identified the resident by the wrist band. When administering the medication by gastrointestinal tube the resident was observed to be lying supine, and the head of bed was not elevated at the time. The LPN removed a syringe out of a bag that was sealed and dated from a container sittng on the side table next to the resident's bed. The LPN then checked the gastrointestinal tube for placement and residual by pulling back on the syringe and administered water to flush gastrointestinal tube. Next, the LPN then drew up the crushed medications mixed with water from a clear cup into the syringe and administered the medication to the resident by the gastrointestinal tube. The LPN then placed the syringe used for medication administration into a bag that was dated and placed in a container on the resident bedside table without rinsing the syringe with water. The resident was observed to be lying flat and the head of the bed down when the LPN left the room.An interview was conducted immediately after the observation with LPN (staff #142) on May 7, 2026 at 8:50 A.M. who stated the head of the bed should be at a 30-40 degree incline when administering the medications into a gastrointestinal tube. The LPN stated the risk of not elevating the head of the bed could cause the resident to aspirate medications.A medication observation was (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conducted on May 7, 2026 at 9:20 A.M. with Registered Nurse (RN/staff #41). The RN prepared the medications by crushing all of the medications together and added water to the medications in a clear medication cup. The RN was observed carrying a tray with a cup of water and the medication cup with medications mixed in water. The RN then removed 30cc of water from the clear cup with a syringe and then administered the water into the gastrointestinal tube, however the RN was not observed to check for placement or residual of the gastrointestinal tube prior to flushing with water. Next, the RN drew up the medications that had been crushed and in water with the syringe and administered the medications via gastrointestinal tube. Next, the RN drew up 30cc of water from the clear cup and flushed the gastrointestinal tube. The RN was observed to place the syringe used for the medication administration of the gastrointestinal tube in a container on the bedside table and not in a dated bag that was dated. The syringe was not rinsed after medication administration, or prior to placing in the container on the bedside table.An interview immediately after was conducted with RN (staff #41) on May 7, 2026 at 9:25 A.M who stated that she administered some of the 30cc of water to flush the gastrointestinal tube and then pulled back on the syringe to check placement of gastrointestinal tube and then continued administering the remaining water to flush the gastrointestinal tube. RN stated this was the procedure at the facility to check for gastrointestinal tube placement or residual prior to medication administration by gastrointestinal tube. The RN stated that the syringe used for medication administration of a gastrointestinal tube should be placed in a bag that is dated to protect the resident from bacteria or infection.An interview was conducted on May 7, 2026 at 11:45 A.M. with Director of Nursing (DON/ staff #34) who stated the process and procedure for administering medication via gastrointestinal tube is started by checking the placement and residual of the gastrointestinal tube by pulling back on the syringe placed in the gastrointestinal tube. Next, the staff is to flush the gastrointestinal tube with water, and then proceed to administer one crushed or liquid medication at a time through the gastrointestinal tube. Once completed, the staff is to place the syringe used for medication administration via gastrointestinal tube in a bag that is dated, and sealed. She further stated that a new syringe is required every 24 hours for a medication administration through a gastrointestinal tube. The DON stated that if a syringe used for medication administration is not placed in a bag that is not dated and sealed could cause a resident infection due to contamination. Also, medications are to be given one at a time due to possible interactions of multiple medications given at the same time or the medications could clog the gastrointestinal tubing if given together. Furthermore, medications are to be crushed one at a time and not all together.A second interview was conducted on May 9, 2026 at 9:55 A.M. with DON (staff #34), who stated that prior to medication administration via gastrointestinal tube the head of the bed should be elevated at least 30-40 degrees prior to medication administration and elevated for 30-45 minutes after medication administration. The DON stated if the process is not followed it could cause the resident to aspirate medications. A policy titled, Medication Administration and General Guidelines, dated January 2026, revealed staff must identify residents by checking the identification band. A policy titled, Nasogastric, Gastric and Jejunostomy, Medication Administration, reviewed March, 2025, revealed to elevate the head of the bed to 30-45 degrees, check gastric contents for residual feeding prior to medication administration, and to rinse the syringe with tap water and place in graduated cylinder.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interviews, and review of facility policy and procedure, the facility failed to ensure that expired medication were not available for use. The deficient practice could lead to residents receiving medications that are expired.Findings include:An observation was conducted on May 7, 2026 at 9:38 A.M. with Licensed Practical Nurse (staff #142). The observation of the medication cart revealed eight medications loose at the bottom of the medication cart under the resident medication cards. At this time the Resident Nurse Unit Manager (staff #16) removed the medications from the cart and placed them in a medication cup.Immediately after the observation an interview was conducted on May 7, 2026 at 9:40 A.M. with RN Unit Manager (staff #16) who stated he did observe the eight pills loose and the bottom of the cart and that they were not identifiable. The RN stated that the risk of loose medications in the medication cart and not in the original container, could result in residents not receiving medication as ordered and the medication count could be off. The RN stated he is not sure who organizes and cleans the medication carts.A second observation was conducted on May 7, 2026 at 9:59 A.M. with RN Unit Manager (staff #16) of five medication rooms. The following observations revealed:North Subacute Dialysis - four 10ml syringes of Sodium Chloride were observed in the medication refrigerator freezer with an expiration date of January 1, 2026. Subacute South Medication Room - an open bottle of Fish Oil 1,600mg ,without an open date, was observed in the refrigerator.An interview was conducted with RN (staff #16) on May 7, 2026 at 10:15 A.M. who stated that the risk of expired medications could cause harm to residents and that the medications would not be effective, and further stated when medications are opened should be labeled with an open date.A third observation on May 7, 2026 at 11:10 A.M., with Registered Nurse Unit Manager (staff #15), of Station 2 Medication Room revealed Chlorhex Gluconate Solution .12% with an expiration date of December, 22, 2025. An interview was immediately conducted with RN (staff #15) on May 7, 2026 at 11:12 A.M. who stated that the Chlorhex Gluconate Solution 12% (germicidal mouthwash) expired on December 22, 2025 she further stated that expired medications administered to a resident could result in adverse or delayed effects of the medication.Further observation of another medication cart was conducted on May 7, 2026 at 10:19 A.M. with LPN (staff #21), which revealed one white pill lying loose on the bottom of the medication drawer that was not identifiable or labeled. Additionally, a Milk of Magnesium bottle was open and had an observed expiration date of April, 2026, along with Pramoxine Hydrochloride1% (to treat pain/itching) with an expiration date of January, 2024, and Biofreeze Gel (treats temporary pain) with an expiration date of March 2025. Immediately following an interview was conducted on May 7, 2026 at 10:30 A.M. with LPN (staff #21) who stated she observed a white pill at the bottom of the drawer and was not able to name the medication and stated it was not identifiable. The LPN immediately discarded the medication. The LPN further stated the risk of administering expired medications to a resident could result in the resident becoming ill. An interview was conducted with Director of Nursing (DON/ staff #34) on May 8, 2026 at 9:05 A.M. who stated that the process of handling expired non-narcotic medications would be to place the medication in the bin located in the medication storage room to return to the pharmacy, or the medication would be destroyed. She further stated the destruction of narcotics is performed by two DON's. The DON also stated that the proper way to label and store medications is with the pharmacy labels, and over the counter medications should be labeled, checked for expiration and open dates. The DON stated that the risk of having expired medications in the medication cart or in the medication rooms could result in the medications being ineffective and liquid medications could become moldy and harbor infection. The DON stated that it is the responsibility of the night nurses to clean and organize the medication carts every night, and should check to make sure medications are not expired and there are no loose medications in the drawers. The DON stated (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that loose medications in the medication cart could lead to diversion of medications or medications could be administered to the wrong resident. The DON further stated that liquid medications in the refrigerator should be labeled with a date and time of when the bottle was opened, and the date when the medication should be discarded.Review of facility policy titled Medication Storage in the Facility, dated January, 2026, revealed that outdated medications are to be removed from stock and disposed of according to procedures for medication destruction. Medication storage areas are kept clean, well lit, and free from clutter