

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035088	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2026
NAME OF PROVIDER OR SUPPLIER Camelback Post Acute Care and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 4635 North 14th Street Phoenix, AZ 85014	

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 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff and resident interviews, facility documentation, and policy and procedures, the facility failed to protect the rights of one resident, resident (#1) to be free from verbal abuse by staff. The deficient practice could result in further abuse. Findings Include: Resident #1 was admitted on [DATE], with a diagnosis that included spinal stenosis, retention of urine, hypertension, fibromyalgia, obesity, muscle weakness, abnormalities of gait and mobility, need for assistance with personal care, and low back pain. The care plan dated November 26, 2025, had a focused care area for risk of impaired cognitive function/dementia or impaired thought process related to the new environment. Interventions included engaging in simple, structured activities that avoid overly demanding tasks, identifying yourself at each interaction, face when speaking, and making eye contact, reducing any distractions-turn off the TV and radio, and closing the door. Use simple, directive sentences. Provide with necessary cues-stop and return if agitated. An admission Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating that Resident #1 was cognitively intact. Review of the Progress Notes for Dates December 17, 2026, and December 18, 2026, no evidence was found of the incident. The Daily Skilled notes dated December 17 and 18, 2026, revealed that the Resident #1's skin was warm and dry with no active skin condition or treatments observed. Review of the grievances log for December 2025, there were no grievances filed by Resident #1. Review of the facility's 5-day report dated December 18, 2025, revealed that the witness (Resident #1's roommate) heard the Certified Nursing Assistant (CNA/Staff #5) tell Resident #1, you are okay, your feet are not broken, while they were transferring the resident with the Hoyer lift. The staff member #3, who was a licensed Nursing assistant (LNA), was helping Staff #5 to assist the resident who stated that she, told the resident to be quiet, then she corrected Staff #3 that she can not talk to Resident #1 like that. Employee file for the staff #5 revealed that disciplinary action was taken against her on December 18, 2025, regarding how she told resident #1 to be quiet during a Hoyer transfer. Staff #3, who was with Staff #5, corrected her on what she said. An interview was conducted on January 13, 2026, at 11:24 AM with a CNA (Staff #5), who stated that she had been working at the facility for 20 years. She stated that if she hears or witnesses abuse, she will ensure the resident's safety and then notify the administrator. She stated that if a resident is screaming in pain, while doing a transfer, she will try to calm the resident first, then if they still do not stop, she will wait until the resident is feeling better, and notify the nurse of the Resident #1's pain. Staff #5 stated that she worked with Resident #1 on November 17, 2025. She stated that she assisted Staff #3 with the transfer of Resident #1. The CNA stated that while they were transferring Resident #1 from bed to chair, Resident #1 began to scream, my legs, my legs. Staff #5 stated that when Resident #1 did not stop screaming, she told Resident #1 to calm down, and please don't scream like that, you already have your muscle relaxant and pain medication. Further,</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 035088	If continuation sheet Page 1 of 3

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Staff #5 stated she was not trying to diminish her or tell her to shut up, but she could not understand why she had so much pain. She stated she apologized after Staff #3 stated she can not talk like that. This was reported to the nurse who was on the shift. Staff #5 stated that she does not recall stating whether she told her that her feet were broken. An interview was conducted on January 13, 2026, at 12:52 PM with the witness, a LNA (Staff #3), who stated that using the hoyer should be done by two people, because one person puts the sling under the resident and the other holds the resident and checks the sling to ensure it is attached. She stated staff should lift the resident when transferring to the wheelchair or bed. She stated that in the process, they hold the resident's legs so the bar does not hurt the resident or cause any pain. However, if a resident is screaming due to any pain during a staff transfer, should stop and find out where the pain is and what the level of the pain scale of 1 to 10. If the resident refuses the transfer, they will not force them. Staff #3 confirmed working on November 17, 2026. Staff #3 stated she was called by Staff #5 to do a hoyer transfer of Resident #1 from the bed to the wheelchair. She stated that she was behind the wheelchair and while transferring Resident #1's foot was on the Hoyer bar which was when Resident #1 started screaming out that her foot was hurting, due to her foot hitting the Hoyer bar. While the resident was screaming, staff #5 shouted at Resident #1, be quiet, you're behaving as if your foot is broken. Staff #3 stated that she immediately corrected Staff #5, telling her she can not say that. She stated that after putting Resident #1 in the chair, they immediately reported it to the nurse, and Staff #5 went back to apologize to the resident. Staff #3 went back into the room. Resident #1 was crying and stated that Staff #5's words had made her feel like she was abused. An interview was conducted on January 13, 2026, at 2:38 PM with CNA (Staff #1), who stated that she will immediately report to anyone in charge if she is aware of abuse. She stated that it is not appropriate to tell residents to be quiet while they are screaming in pain. She stated that staff members are trained not to talk to others like that; and, to always hear the resident out regarding their concerns and pain. An interview was conducted on January 13, 2026, at 2:45 PM with a Registered Nurse (RN/Staff# 2) who stated that she will immediately notify the administrator and follow up with the resident about who the person if she hears about any abuse. She also stated she would remove that person from further abuse to ensure that the resident was safe. Staff #2 stated that Resident #1, during transfer, will complain about pain in her legs. She stated that it would not be good to tell a resident, be quiet, you are behaving as if your foot is broken, while a resident is in pain, because it is disrespectful. An interview was conducted on January 13, 2026, at 3:01 PM with the Operations Manager (Staff #6), who stated that he is the temporary Administrator until the facility administrator is back from vacation. He further stated that his role as of right now is to take care of financials, keep the facility in line, have a good culture, hire staff, provide good care of the residents, and be the abuse coordinator. He stated that as the abuse coordinator, they make sure the resident is kept safe and start the reporting process. Then stated that if anyone hears about the abuse, he would expect the staff to report it immediately. An interview was conducted on January 13, 2026, at 3:49 PM with the Director of Nursing (DON/staff #10), who stated that the process for abuse is that when someone hears about abuse, they will report it to the administrator, depending on the alleged abuse. The abuse should be reported immediately to the DON or the administrator, and they have two hours to report if it is necessary. She stated that if the abuse is witnessed, they will expect the staff member to separate the alleged abuser. She stated that if the CNA tells the resident to be quiet, it is inappropriate and unprofessional language. Further, Staff #10 stated that when they tried to talk to Resident #1, she did not want to talk. A week later, she stated that the CNA #5 told her to shut up while on the mechanical</p> <p>(continued on next page)</p>		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	lift and reported alleged abuse. Staff #10 also stated that Staff #5 was just trying to calm down Resident #1, even though she had made bad choices of words. A Policy titled Abuse Prevention of and Prohibition Against was revised in October 2022, revealing that each resident has the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary inclusion. Verbal abuse is defined in the policy as the use of oral, written, or gestured language that wilfully includes disparaging and derogatory terms to residents or their representatives, or within hearing distance, regardless of their age, ability to comprehend, or disability.		