STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035092	A. Building B. Wing	12/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bella Vita Health and Rehabilitation Center	5125 North 58th Avenue Glendale, AZ 85301

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 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. (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 0609 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 closed record review, staff interviews, review of facility documentation, policy and procedures, the facility failed to ensure that one resident's (#911) injury of unknown origin was reported to the state agency. The deficient practice could result in injury of unknown origin not being reviewed for potential abuse.Findings include: Resident #911 (alleged victim) was initially admitted on [DATE] and readmitted on [DATE] with diagnoses that included dementia, borderline personality disorder, anxiety disorder, age-related cognitive decline, and depression. Review of a care plan initiated on October 26, 2024 revealed that the resident is on anticoagulant therapy. Interventions indicated to monitor/document/report to MD (Medical Doctor) PRN (Pro Re Nata = as needed) signs/symptoms of anticoagulant complications such as bruising, and to monitor/document location, size and treatment of skin injury. A care plan pertaining to resident's impaired thought process/dementia, and cognitive-loss initiated October 26, 2024 revealed an intervention which directed psychosocial support as needed. Review of a care plan initiated on November 5, 2024 revealed that the resident wanders on the unit. Interventions indicated for resident to be in secured unit and to provide structured activities. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident has both short-term and long-term memory problems. Per the MDS the resident was severely impaired regarding cognitive skills for daily decision making. The assessment noted that the resident was negative for indicators of psychosis. However, the resident exhibited physical behavioral symptoms toward others and verbal behavior symptoms directed towards others 1-3 days during the assessment period. Additionally, the resident exhibited other behavioral symptoms not directed toward others 1-3 days during the assessment period. The assessment also noted that the resident wandered 1-3 days during the assessment period. The MDS documented that the resident has had a fall since admission/reentry. According to the assessment the resident has had one fall with no injury since admission/reentry and one fall with injury since admission/reentry. A Skin Evaluation dated October 27, 2025 documented that the resident had no new skin issues noted. However, a Skin Evaluation with an effective date of November 1, 2025 documented that the resident had abrasion to back of head with a lump size of golf ball, lip redness to left sclera. A care plan initiated on November 1, 2025 documented that the resident had actual impairment to skin integrity related to abrasion to back of head, bottom lip, and redness to left sclera. Interventions included monitor/document location, size, and treatment of skin injury. A late entry Nursing note dated November 1, 2025 documented that resident woke up with an abrasion on her lip. Per the note the abrasion was cleaned up. Additionally, the note indicated that the family and ADON (Assistant Director of Nursing) were notified and resident will be monitored. Review of the facility's self-reports in the last 90-days revealed that the facility has had no self-reports during that time frame. Review of the facility's Incident Report log for the last 90-days did not reveal an incident involving resident #911 matching the documented injury. However, review of the facility's internal Incident Report dated November 1, 2025 documented that resident #911 had an unwitnessed incident. The incident described that the resident was observed wandering the unit when she approached a nurse and was noted with an abrasion to the bottom lip, left eye redness, and bump the size of a golf-ball with discoloration. The report indicated the location of the injuries for the abrasion and hematoma as the top of the scalp. Additionally, the report indicated that the resident is unable to describe what happened due to end stage dementia. According to the report, the ADON and the physician were notified of the incident on November 1, 2025. However, the report did not indicate that the stage agency was notified. A Nursing note dated November 3, 2025 documented that at approximately 7:00 p.m., the resident's family member approached staff about a bruise on the back of the resident's head. The staff informed the family member that she would follow up with the ADON (Assistant Director of Nursing), but the family member called 911 to have the resident transferred to the ER (Emergency Room) to be evaluated. However, review of the Stage Agency database revealed no evidence that the facility submitted a self-report regarding an injury of unknown origin pertaining to resident #911. An interview with a Certified Nursing Assistant (CNA/staff #5) was conducted on December 29, 2025 at 12:55 p.m. According to the CNA anything that is outside of the resident's baseline is reported immediately to the nurse. Specifically, injury of unknown origin is reported to the nurse right away. Per staff #5, it is important that injury of unknown origin is reported so that the facility can follow its protocols and try to figure out what happened and if something happened that caused the injury. The CNA stated that the impact of not reporting an injury of unknown origin is that problems can go

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (continued on next page)

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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 0628 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 closed record review, staff interviews, and review of facility policy and procedures, the facility failed to ensure that the receiving facility was provided the required documentation pertaining to one resident's (#911) transfer/discharge. The deficient practice could lead to the receiving facility not having the appropriate information regarding the resident's medical status and cause a delay in treatment/care.Findings include: Resident #911 (alleged victim) was initially admitted on [DATE] and readmitted on [DATE] with diagnoses that included dementia, borderline personality disorder, anxiety disorder, age-related cognitive decline, and depression. Review of a care plan initiated on October 26, 2024 revealed that the resident is on anticoagulant therapy. Interventions indicated to monitor/document/report to MD (Medical Doctor) PRN (Pro Re Nata = as needed) signs/symptoms of anticoagulant complications such as bruising, and to monitor/document location, size and treatment of skin injury. A care plan pertaining to resident's impaired thought process/dementia, and cognitive-loss initiated October 26, 2024 revealed an intervention which directed psychosocial support as needed. Review of a care plan initiated on November 5, 2024 revealed that the resident wanders on the unit. Interventions indicated for resident to be in secured unit and to provide structured activities. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident has both short-term and long-term memory problems. Per the MDS the resident was severely impaired regarding cognitive skills for daily decision making. The assessment noted that the resident was negative for indicators of psychosis. However, the resident exhibited physical behavioral symptoms toward others and verbal behavior symptoms directed towards others 1-3 days during the assessment period. Additionally, the resident exhibited other behavioral symptoms not directed toward others 1-3 days during the assessment period. The assessment also noted that the resident wandered 1-3 days during the assessment period. The MDS documented that the resident has had a fall since admission/reentry. According to the assessment the resident has had one fall with no injury since admission/reentry and one fall with injury since admission/reentry. A Nursing note dated November 3, 2025 documented that resident #911's family member approached staff about a bruise on the resident's back of the head. The staff informed the family member that she would follow-up with the ADON (Assistant Director of Nursing). However, the family member called 911 to transfer the resident to the ER (Emergency Room) for evaluation. Per the note, once the paramedics arrived, they only requested a facesheet for the resident. The note indicated that the staff member called the hospital to give report to ER Nurse. Review of the SNF/NF to Hospital Transfer Form dated November 3, 2025 documented that it indicated that the primary reason for transfer was not for diagnostic testing. The form did not contain information regarding the resident's relevant diagnosis, vital signs, or pain level. The form noted that the name of the hospital that the resident was transferred to. The form also indicated that at 7:30 p.m., a report was called in and noted the name of the nurse that the report was relayed to. However, the Document Checklist section of the form was left blank indicating that none of the documents were provided or accompanied the resident during transfer. An interview was conducted with the Assistant Director of Nursing (DON/staff #15) was conducted on December 29, 2025 at 2:40 p.m. Staff #15 stated that it was resident #911's family that first noticed the resident's injuries and called 911 to transfer the resident to the hospital. During an interview with the Executive Director (ED/staff #25) conducted on December 29, 2025 at 4:57 p.m., staff #25 stated that he was not familiar with required documents/information that needs to go with the resident during a hospital transfer. An interview with the Director of Nursing (DON/staff #50) on December 29, 2025 at 5:15 p.m. Staff #50 stated when a resident is transferred to a hospital, her expectation is that the information regarding the resident's name, age, allergy to medications, and synopsis of the reason for transfer is provided to the receiving facility. The DON said that in the case of resident #911, fire (paramedics) only wanted the face sheet and would not tell the facility where the resident was going. Staff #50 noted that a report was called into the hospital and was documented on the nurse's note. However, since the report was called in it does not say exactly what information was provided. Furthermore, there is no actual documentation of what was provided to the hospital. The DON said that the importance of providing the required documents during transfer for the resident can receive continuity of care when the hospital assumes care. Staff #50 stated that the impact of not having the required document is that the hospital would not be able to get ahold of the family to provide information or not know how to treat the resident. Review of the facility's policy titled Discharge or Transfer reviewed July 2025 stated that it is the facility's policy to