

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035111	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER Lake Pleasant Post Acute Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 20625 North Lake Pleasant Road Peoria, AZ 85382	

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 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record review, staff interviews, review of facility process and policy the facility failed to ensure that all transfer/discharge notifications were made for one resident (#130). The sample size was four. The deficient practice could lead to notifications and pertinent information regarding the discharge/transfer not being provided. Findings include: Regarding Resident #130 - Resident #130 was admitted to the facility on [DATE] with diagnoses of orthopedic aftercare following surgical amputation, anemia, adjustment disorder, muscle weakness, and dysphagia. An admission Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating that the resident is cognitively intact. Additionally, the BIMS documented that the resident received physical therapy, occupational therapy, and speech therapy while at the facility. A physician order dated December 5, 2025 indicated that the resident would be discharged to a group home on December 9, 2025. A Discharge Summary - Nursing note dated December 5, 2025 revealed that the resident's planned discharge is on December 9, 2025. The note indicated that the discharge instructions were provided to the resident/resident representative. The note documented that the resident will be discharged to an assisted living group home. The note listed the contact information for the ombudsman. However, the note did not indicate whether a copy of the discharge notification was provided to the ombudsman. The discharge MDS assessment dated [DATE] revealed a planned discharge marked return not anticipated. The resident was noted to discharge to home/community. The Discharge Summary and Post-Discharge Plan of Care dated December 9, 2025 documented the reason for discharge as resident's health had improved sufficiently and that the resident no longer needed the services of the facility. The Notice of Proposed Transfer/Discharge dated December 9, 2025 indicated that the resident was transferred to an assisted living group home. The form indicated that the notice was provided on December 9, 2025. Additionally, the notice revealed that the State Agency (SA) was listed as an appeals authority. However, the SA is not an appeals authority for transfer/discharge issues. Review of the resident's clinical records did not reveal documentation that a copy of the proposed transfer/discharge was provided to the ombudsman. Additionally, review of the facility documentation did not reveal documentation that a copy of the proposed transfer/discharge was provided to the ombudsman. A Case Manager note dated December 9, 2025 documented that a denial letter was received from the insurance company and a copy was provided to the resident with instructions on how to appeal. Another Case Manager note dated December 9, 2025 indicated that resident was unable to provide information to go on private pay and case management spoke with resident to discuss discharge plan. The note revealed that the resident agreed to discharge to a group home the same day. A Case Manager note dated December 9, 2025 documented that the resident discharged to a group home. An interview with the facility's Ombudsman (staff #200) was conducted on February 23, 2026 at 12:00 p.m. The Ombudsman stated that she receives a monthly list of who discharges. However, she had not received any copy of discharge notices provided to the resident/resident representative. The Ombudsman indicated that she has informed the facility that per regulation, she should receive a copy of the notice of discharge but the facility has (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 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>not complied. Per the Ombudsman, due to this, she does not get informed about the discharge until after the resident has already left the facility. An interview with the Discharge Planner (staff #124) and Case Manager (staff #110) was conducted on February 25, 2026 at 11:43 a.m. Staff #110 said that the notice of proposed discharge/transfer is given to the nurse so that it can be given to the resident on the day of discharge. Staff #110 stated that a copy of the notice of proposed discharge/transfer is not given to any outside agency. However, it is sometimes provided to the resident's insurance company if requested. Staff #110 said that it is important to provide the notice of proposed discharge/transfer so that residents know where they are going and what the plan is. Staff #124 stated that discharge plan can sometimes change so notification is important in order for arrangements to be made. Staff #124 noted that the impact of not providing the notice of proposed discharge/transfer is that the resident would not have information and resources. Per staff #124 it is Social Services (staff #166) that sends out ombudsman notification. An interview with the Social Services Director (SS Dir/staff #166) was conducted on February 25, 2026 at 12:02 p.m. Staff #166 stated that she sends the ombudsman notification via email at the end of the month with a list of the discharge/admission and hospitalization report. Staff #166 also keeps a copy of what she sends in a binder. Staff #166 stated that she does not send the ombudsman a copy of the proposed discharge/transfer because she had never been told that she had to. Staff #166 noted that she had seen the form. Additionally, she is not given a copy of the form as it is directly uploaded into the resident's record. Per staff #166 ombudsman notification is important because the ombudsman is part of patient advocacy. The notification enables the ombudsman to be another resource and advocate for the resident. The impact of not notifying the ombudsman about the discharge/transfer is that the ombudsman will not be in the know and there can be a concern and the ombudsman will be unable to follow-up on that concern. In a follow up interview with staff #124 conducted on February 25, 2026 at 12:20 p.m., she stated that the use of the Notice of Proposed Transfer/Discharge started about a month ago. She was unable to say where the information regarding the appeals authority came from or who provided them the form for sure. During an interview with the Director of Nursing (DON/staff #40) conducted on February 25, 2026 at 12:27 p.m., staff #40 stated that ombudsman notification is sent monthly. The DON said that the notification is sent by the SS Dir and the information consists of name resident, date of transfer, and where resident is discharged. The DON stated that the importance of the notification is for coordination of care and for the purpose of ombudsman follow-up if needed. Per the DON she does not think that there is an impact if ombudsman notification is not accomplished since the ombudsman info is provided to the resident during discharge notification. The DON was not aware that a copy of the discharge/transfer notification had to be given to the ombudsman. Additionally, the DON noted that the form they are using had been there for awhile and was not aware that it contained erroneous information related to the appeals authority. The facility policy titled Discharge or Transfer reviewed May 2025 indicated that it is the policy of the facility to provide the resident with a safe, organized, and structured transfer and or discharge. Further review of the facility's policy for discharge/transfer did not reveal that it addressed transfer/discharge notification to resident/resident representative. Additionally, the policy did not indicate what the required information are that is to be provided to the resident/resident representative, and the ombudsman.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observations, staff interviews, review of facility documentation and policies and procedures, the facility failed to ensure that food was prepared, stored, distributed and served in accordance with professional standards for food service safety. The deficient practice could result in food-borne illness. Findings Include: Regarding Kitchen Cleanliness-An initial kitchen observation was conducted on February 23, 2026 at 8:12 A.M. in conjunction with kitchen staff #86. During the initial observation it was observed that floor had several areas of dark matter that appeared to have accumulation in the corners of the tile floor. It was observed that a square, depressed area under the dish sink had black matter that appeared wet within its perimeter. Various pieces of solid debris were located in this area. Visible debris was observed on the floor under food preparation counters. A gray, brown matter was observed covering the vent covers over the area where the food carts were stored in preparation for tray transportation to the units. An observation of the roll up door on the wall adjacent to the tray line revealed the hinges appeared to be rusted with an orange and brown substance on them. The painted wood under the roll up door had several areas of chipped paint along the length of the wood. An observation of the walls behind and adjacent to the dishwasher revealed many black spots. The follow up observation of the kitchen area on February 24, 2026 at 11:18 revealed the peeling paint and rusty hinges in direct proximity to the tray line, where food was plated to be served to the residents. Black matter and debris were visible in multiple areas of the floor, including no change to the appearance of the depressed area under the dish sink. Additionally, black spots were noted on the wall behind the dishwasher and a sticky brown substance was noted on the side of the range. The vents above the food carts appeared unchanged. Regarding Unit Nourishment Refrigerators-An observation on the 300 hall was made on February 24, 2026 at 12:44p.m. of the nourishment refrigerator accompanied by certified nursing assistant (CNA/ staff #176). A container of whole milk with a first name and no open date or use by date was observed. The bottom area of the refrigerator had several spills, differing in color. Upon this observation, staff #176 stated that the cleaning people should have cleaned the refrigerator and the milk should have been dated with an open and use by date. She was unclear as to how to determine the use by date on resident's food. An observation of nourishment refrigerator on the 200 hall was made on 12:49 p.m. on February 24, 2026 with CNA /staff #56. During this observation, a box of frozen tacos and a quart container of ice cream were found in the freezer area. Both were open with no open date or use by date on the containers. It was noted that the tacos were not individually wrapped and the ice cream was not in individual servings within the container. An observation of the freezer revealed several spills and small pieces of debris along the bottom of the freezer and on the freezer door shelves. An interview was conducted at that time, and CNA /staff #56 stated that the receive date, open date and use by date should be on the containers. She stated that once opened, the food should be served for 3 days and then discarded. Staff #56 further stated that the freezer appeared dirty and should have been cleaned. She stated that the kitchen staff was responsible to check for outdated food and the housekeeping staff were responsible to clean the refrigerator and freezer. A walk through of the kitchen along with a concurrent interview was conducted with the kitchen manager/ staff #138 on February 24, 2026 at 1:16 pm. The condition of the kitchen floor and walls were observed to be unchanged since the initial and follow up kitchen observations. He stated that he has been the kitchen manager for approximately 3 months. He stated that he had not created a kitchen cleaning schedule yet and is not aware of any cleaning schedule in place during the previous kitchen managers tenure. He stated that the floor appeared dirty with accumulation in the corners and under tables and equipment. He stated that the floors should be swept daily and mopped nightly. He further stated that he assumed that kitchen staff were doing those tasks however, he was not sure that the kitchen staff actually completed the cleaning. Staff #138 confirmed that the depressed area under the dish sink has a wet, dark substance within the area (continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, facility policy and the Resident Assessment Instrument (RAI) manual, the facility failed to ensure MDS assessment for 2 of 3 sampled residents (#21 and #100) were accurate. The deficient practice could result in assessment inaccurately reflects the resident's status. Findings include:-Resident #100 was admitted on [DATE] with diagnoses of pathological fracture in neoplastic disease, benign neoplasm of left adrenal gland, cerebral palsy and muscle weakness. The face sheet of the clinical record revealed the preferred name of Resident #100. The clinical census sheet of the clinical record included the preferred name of Resident #100. The resident's insurance card on file revealed the resident's preferred name. The Resident #100's driver's license and Medicare card included that resident's legal name. The admission and 5-day MDS (Minimum Data Set) assessments dated October 8, 2025 revealed that the resident's legal name was entered in the A0500 -Legal name section of the MDS. The facility documentation revealed that this assessment was accepted in the QIES system on October 9, 2025. Review of the clinical record revealed that the resident was discharged to a group home on October 31, 2025. The Discharge MDS assessment dated [DATE] revealed the resident had a planned discharge to a home under care of organized home health service organization with return not anticipated. However, the resident's preferred name was documented under A0500-Legal Name section instead of the resident's legal name. Review of the clinical record revealed that a modification of Discharge MDS assessment was modified only on February 24, 2026 to change the A500 Legal Name section to reflect the resident's legal name. -Resident #21 was admitted on [DATE] with diagnoses of encephalopathy, polyneuropathy and UTI (urinary tract infection). The face sheet of the clinical record revealed the hyphenated last name of Resident #21. The insurance authorization form included part of the resident's hyphenated last name. The form also indicated that the hyphenated last name was also known as the resident's legal name. The State Medicaid eligibility information revealed part of the hyphenated last name of Resident #21. The facility's census list included Resident #21's hyphenated last name. The facility profile form revealed the resident's legal last name. The admission MDS assessment dated [DATE] coded for the resident's legal last name. The quarterly MDS assessment dated [DATE] coded for the legal last name of resident #21. However, the discharge MDS assessment dated [DATE] coded for the resident's hyphenated last name. An interview was conducted on February 25, 2026 at 2:33 p.m. with the MDS Coordinator (staff #150)who stated that she checks the dashboard daily for any admission the day before, will open an entry MDS on the day of admission and will open a comprehensive admission assessment for 7 days. She stated that when completing the MDS assessment, she uses all the information in their electronic record (PCC) including therapy documentation/notes, conducts bedside assessment and interviews the resident. She stated that when she goes to see the resident she would verify the identity of the resident by asking the resident their last name and ask them to tell her what their name is and what they preferred to be called. The MDS coordinator stated that Section A0500 in the MDS is auto populated with whatever name was entered in their electronic record system; and that, this section referred to the resident's legal name. She stated that the MDS has A1300 that allows her to enter the resident's preferred names. Regarding resident #100 and #21, the MDS Coordinator stated that completed the admission MDS assessments for both residents using their legal name; however, somehow the legal name on A0500 was changed to the residents preferred name on succeeding MDS assessments for both residents. Further, she stated that she did not complete the discharge MDS assessments for both resident #100 and #21; and did not know who did. An interview with the Director of Nursing, with the CR and CMR present, was conducted on February 25, 2026, at 4:06 p.m. The Corporate MDS Resource stated that they do not manually enter the resident's name in the MDS; the record system automatically populates it. She explained that MDS allows staff to enter a resident's preferred name (continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>and said she did not understand why this issue was triggered during the survey task. The DON stated it was surprising that the system did not recognize the assessment as referring to the same resident, even though the preferred name was used and the same Medicare ID and Social Security number were entered. Regarding Resident #100, the DON stated that the Medicare card listed the resident's legal name; and that, the resident's family reported the resident had changed her name while she was working. According to the DON, Resident #100 changed her name because she was tired of being identified as male due to her name. The DON further stated that this was the reason the insurance card listed the resident's preferred name. Regarding resident #21, the DON stated she does know what happened but that the record showed the resident had a hyphenated last name. The RAI manual coding instructions included to code the legal name of the resident in section A0500. Legal Name was defined as Resident's name as it appears on the Medicare card; and, if the resident is not enrolled in the Medicare program, use the resident's name as it appears on a Medicaid card or other government-issued document.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews, and policy review, the facility failed to ensure that one resident (#148) received care and treatment in accordance with professional standards of practice regarding intravenous antibiotic treatment. The sample size was 16. The deficient practice has the potential to cause the wound not to heal and increase the spread of infection. Findings include:-Resident #148 admitted to the facility on [DATE] with diagnoses of sepsis. A hospital Physician Progress Note dated February 16, 2026 documented that resident #148 will be discharged to a SNF (skilled nursing facility). Per the note, the resident had sepsis secondary to a right lower extremity diabetic wound infection with osteomyelitis. The resident al had MRSA (methicillin resistant staphylococcus aureus) and enterococcus bacteremia. The note indicated that resident is on broad spectrum intravenous antibiotics. The note indicated that the resident will need intravenous antibiotics at discharge. The note also indicated that PT (physical therapy). The Patient Discharge Instructions from the hospital printed February 18, 2026 documented that resident #148 was prescribed Vancomycin 1.25 g (grams)/250 mL (milliliter)-NaCl (sodium chloride) 0.9% intravenous (IV) solution. The instructions indicated 1250 mg (milligrams) IV continuous infusion with HD (Hemodialysis) on HD days through March 20, 2026. The instructions revealed that the resident had diagnoses of diabetic ulcer of the foot, MRSA infection, osteomyelitis, and sepsis. A Nursing note dated February 18, 2026 documented that the resident admitted from the hospital with diagnoses of osteomyelitis. The note indicated that resident was alert and oriented x 4 meaning he is fully conscious and aware of person, place, time, and situation. The Order Summary Report revealed an order dated February 18, 2026 which prescribed Vancomycin HCl (hydrochloride) Intravenous Solution. The order directed to use 1.25 gram intravenously one time a day every Tuesday, Thursday, and Saturday for sepsis until March 20, 2026 at 11:59 p.m. The order indicated to send IV ABX (antibiotic) to dialysis. Additionally, another order directed for Vanco (Vancomycin) IV and all labs related to IV ABX be monitored by the dialysis center. Review of the resident's progress notes did not reveal any documentation of whether he received or did not receive IV ABX on February 19, 2026 (Thursday) during his scheduled HD appointment. A care plan initiated on February 20, 2026 revealed that the resident is on IV antibiotic therapy related to sepsis. The care plan noted that the condition was on admission and the treatment is to be administered at HM. Interventions indicated to administer medication as ordered, monitor every shift for adverse reaction, observe for possible side effects, and report pertinent lab results to physician. An NP (Nurse Practitioner)/PA (Physician Assistant) Progress Note dated February 20, 2026 documented that on February 19, 2026 the resident was seen for consult regarding right foot osteomyelitis/diabetic foot infection complicated by prior MRSA/enterococcus bacteremia. The note indicated that resident was receiving IV vancomycin with hemodialysis (Tuesday/Thursday/Saturday) and is tolerating therapy without reported adverse effects. Additionally, an eMAR-Medication Administration Note dated February 20, 2026 documented that resident vitals are within normal limits and that resident was Receiving Iv Abx per order. An NP/PA Progress Note dated February 21, 2026 documented that NP was notified by nursing staff that resident was at HD and that the HD center was unable to administer vancomycin provided by the facility. Per the note, the NP spoke with nurse at the HD center who stated that the vancomycin order had to be faxed to the HD center. The note indicated that the IV ABX will not be administered that day with the next expected dose to be administered at next HD appointment on Tuesday. An eMAR-Medication Administration Note dated February 21, 2026 documented that a report was received from the dialysis nurse that the scheduled dose of vancomycin was not administered during dialysis session due to medication not being approved by the dialysis physician and pharmacy. The note indicated that the attending physician was notified of missed vancomycin dose. The note also documented that the SNF was awaiting further orders regarding antibiotic administration and (continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>clarification with dialysis pharmacy and physician.During a screening interview with resident #148 conducted on February 23, 2026 at 10:00 a.m., resident #148 stated that he transferred from the hospital to the facility to receive dialysis and antibiotic treatment for his foot wound. Resident #148 said that the IV antibiotics were supposed to be administered during dialysis. However, he has had two dialysis treatment and his antibiotics had not been provided. He had missed two sessions of antibiotic treatment. Per the resident he informed everyone - facility staff and State Medicaid Agency. However, there has been no resolution thus far. The resident stated that his dialysis days are Tuesday, Thursday, and Saturday. So far, during his Thursday and Saturday appointment, he was not given his antibiotic treatment.A Nursing note dated February 23, 2026 documented that the DON spoke with the dialysis center to coordinate continued care for resident's antibiotics. Per the dialysis center, the nephrology consult indicated for facility to get PICC line placed and manage the ABX in house at the SNF on dialysis days per original order. The note indicated that the PICC line was ordered and provider notified that Vanco will be given on site tomorrow February 24, 2026. Orders placed to draw a random trough for Vanco monitoring levels. The resident was placed on change of condition monitoring due to missed doses of antibiotic for monitoring purposes.The Order Summary Report revealed the following orders dated February 23, 2026:- Place central line to LUE (left upper extremity) midline/PICC (Peripherally Inserted Central Catheter) line related to Vanco therapy one time only for Vanco therapy for 1 day.- Vancomycin HCl Intravenous Solution. The order directed to use 1.25 gram intravenously in the afternoon every Tuesday, Thursday, and Saturday for sepsis until March 20, 2026 at 11:59 p.m. The order indicated that it is to be given after resident returns from dialysis.- Vanco-Trough one time only related to other specified sepsis until February 23, 2026 at 11:59 p.m. Random trough to be drawn for Vanco dosing.An order dated February 24, 2025 indicated Vanco trough before dialysis one time only for 1 day. Further review of the Order Summary Report did not reveal an updated order for monitoring of IV ABX after the administration of the medication changed from the dialysis center to the facility.Additionally, further review of the care plan did not reveal any revision addressing the change in administration of treatment from HM center to the facility. The care plan still reflected that IV ABX was administered at HM center. A NP/PA Progress Note dated February 24, 2026 documented that resident was seen that day for follow-up for right diabetic foot osteomyelitis and history of MRSA/enterococcus bacteremia. The note indicated that it was identified that the resident had not been receiving scheduled IV Vancomycin after HD sessions.Review of the February 2026 Medication Administration Record (MAR) revealed that the order for Vancomycin HCl Intravenous Solution with order date of February 19, 2026 had the following entry:Marked X on February 19.Coded as 7 meaning Other/See Nurse Notes on February 24.An eMAR-Medication Administration Note dated February 24, 2026 documented that resident complained that he should have gotten his Vanco at HD today but did not receive it.The IV Medication Administration Record documented that Vancomycin HCl Intravenous Solution was administered on February 24, 2026 at 4:32 p.m. on the resident's left arm.A follow-up interview with resident #148 was conducted on February 25, 2026 at 2:48 p.m. Resident #148 stated that he finally received his antibiotic treatment last night. The antibiotic treatment was provided in the facility after dialysis treatment. The resident reiterated that prior to last night's treatment, he missed two sessions of IV ABX treatment. An interview with the Dialysis Center's Administrative Assistant (staff #201) was conducted on February 26, 2026 at 9:06 a.m. According to staff #201 the dialysis center was not aware that resident #148 required IV ABX until he came in for his dialysis appointment on February 19, 2026 with the IV ABX. Staff #201 said that per the center's policy, if the medication/treatment is not part of dialysis treatment then the center have to be provided cultures if drawn, receive an order from the physician, and the IV has to come directly to the dialysis center and not from the resident. In the case of resident #148, the resident's infectious disease doctor put progress note regarding the treatment but he was not a practicing doctor at the center and with the medication brought in by the resident the dialysis center cannot administer it. Staff #201 said that she called the hospital case (continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Lake Pleasant Post Acute Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 20625 North Lake Pleasant Road Peoria, AZ 85382	
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>manager but due to the resident already being discharged it was out of the case manager's control. The SNF did not coordinate or contact the dialysis center prior to the resident showing up on February 19 for his scheduled dialysis appointment to verify that treatment can be provided. Staff #201 stated that she called the SNF on February 19 and February 20 to coordinate treatment, asked for the order, and determine if the SNF's pharmacy could deliver the IV ABX directly to the dialysis center. Staff #201 noted that there was no communication with the SNF to inform the dialysis center that the resident discharged from the hospital and will need IV ABX. Staff #201 noted that SNFs normally verifies chair time and schedule, and informs the dialysis center if there are issues that will affect how the resident dialysis. Per staff #201 the resolution ended up being that the resident was given IV ABX at the SNF which was on February 23 after he was cleared to get a PICC line. Staff #201 said IV ABX is important since the resident had a wound on the foot that required that treatment. The impact of the IV ABX not being provided as ordered is that the resident could get re-admitted to the hospital. During an interview with a Licensed Practical Nurse (LPN/staff #58) conducted on February 26, 2026 at 10:36 a.m., staff #58 stated that orders for admitting residents are entered into the system at least an hour before the resident arrives. Staff #58 said that she enters orders into the system as soon as she receives the documents. Per staff #58 when she received the orders she inputted that resident #148 was to receive Vanco and copied the orders and follow-up lab. Staff #58 indicated that she believed she spoke with the dialysis center last Friday to ensure that the Vanco was administered. Staff #58 noted that the medication was at the facility the day that the resident was supposed to go on his first day of dialysis (since arriving at the facility). However, the resident brought the medication back with him. Staff #58 said that she followed-up because she was concerned that it was not administered. Staff #58 stated that she had only dealt with a situation in which the resident had additional treatment that had to be done at the dialysis center once previously. According to staff #58 she assumed that if the medication was sent unopened with the order that it would be administered by the dialysis center. Staff #58 said that resident #148 was supposed to be administered Vanco because he had a foot ulcer/osteomyelitis. Per staff #58 the impact of the resident not receiving Vanco is that a delay in treatment means delay in healing. According to staff #58, facility staff reached out to the dialysis center to coordinate the care after it was determined that the resident had not received his ABX. Staff #58 said that her main job is to set up residents for their admission. It was then the floor nurse's job to ensure that that dialysis went as planned. Staff #58 noted that there should be a progress note if there was an issue with the dialysis treatment on the day that it happened. Additionally, staff #58 indicated that she is unsure if the MAR should have had an X marked on the day that treatment was supposed to be given. However, it was her, then she would have coded it appropriately with a corresponding progress note. An interview with the Nurse Practitioner (NP/staff #202) was conducted on February 26, 2026 at 3:12 p.m. Staff #202 stated that if a resident has an order to receive treatment in addition to dialysis treatment at the dialysis center then she expects the SNF to coordinate with the dialysis center since each dialysis center have different policy/procedures. The NP noted that she expects the SNF's admission nurse to coordinate and ensure that the additional treatment can be provided at the dialysis center. Furthermore, the NP stated that she expects that the resident gets the treatment as ordered. The NP said that Vancomycin is used for osteomyelitis or infection. It is important for the resident to receive ABX since it is managed by the infectious disease doctor to treat infection. The impact of not receiving ABX as ordered is that it can worsen the infection or prolong the infection. It is inappropriate for the resident to not receive ABX as ordered since it would extend the treatment. In the case of resident #148, she was at the SNF doing rounds while the resident was at dialysis and she was informed by a nurse that the dialysis called and explained that they could not administered the ABX. The NP stated that the resident missing his ABX treatment did not meet her expectation. However, she commented that she was not surprised because it is common that there is a delay when the treatment had to be coordinated with the dialysis center. Regarding resident #148, he ended up getting a PICC line placed (continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>and the ABX ended up being administered at the SNF after dialysis. The NP stated that she is unsure if the delay will result in the course of treatment being extended. During an interview with the Director of Nursing (DON/staff #40) conducted on February 26, 2026 at 3:41 p.m., staff #40 stated that her expectation is that the admission nurse transcribe orders from hospital, meet resident when they arrive, conduct assessments, document admission notes, obtain consents, and coordinate with provider and family regarding care/issues. The DON stated that with regards to treatment administered at the dialysis center, it depends on the resident and the center. When the resident is first admitted to the facility, the admission team will find out about dialysis and coordinate with the unit clerk, set up transportation, and nurse put it the orders. However, the hospital normally coordinates the additional treatment that would need to be administered at the dialysis center. The DON said that typically, once the resident goes to the dialysis center, the center contacts the facility if there are any questions or if there is something unusual. The IV ABX order for resident #148 was transcribed as ordered. The DON noted that she was involved after the resident was not provided the IV ABX. Per the DON the SNF is not typically involved in the coordination of care prior to the dialysis since it is case management at the hospital who coordinates the treatment at the dialysis center. The DON said that Vanco is typically used for infection. It is important for residents prescribed Vanco to receive it since it is part of the plan of care and the resident should get it as ordered. The impact of not administering Vanco is case-by-case but infection could increase. In the case of resident #148 it is inappropriate that he did not receive his treatment. The DON explained that the SNF got involved to get the appropriate orders. Resident #48 missed two doses from the two dialysis days in which the Vanco was not administered. However, the resident received his dose once the PICC line was placed. According to the DON, the issue was documented to the provider but she is unsure if it was documented on the resident's chart. During review of the resident's record with the DON, she confirmed that there is no progress note/documentation regarding issue administering the Vanco until February 21. The DON acknowledged that the resident should have received his IV ABX. During review of the resident's February 2026 MAR, the DON acknowledged that February 21 had been coded but that there was no code on February 19 and instead was marked X so it appeared like nothing was brought to dialysis or given. An email correspondence with the Corporate Resource dated February 26, 2026 documented that the facility does not have a Quality of Care policy or a Coordination of Care Policy. The facility policy titled Admission reviewed July 2025 indicated that it is the policy of the facility to have well defined guidelines for processing the resident's entry into the nursing facility. The policy noted that the LPN will initiate any required treatments as ordered. The facility policy titled Physician Orders reviewed July 2025 indicated that it is the policy of the facility to accurately implement orders in accordance with the resident's plan of care. The policy Documentation and Charting reviewed May 2025 noted that it is the policy of the facility to provide a complete account of the resident's care, treatment, response to care, signs, symptoms, and progress of the resident's care.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on observations, clinical record review, staff interviews and facility policy review, the facility failed to ensure there was a physician order for oxygen use for one sampled resident (#12). This deficient practice could result in the resident receiving unnecessary oxygen or not receiving the correct oxygen flow rate needed. Findings include: Resident #12 was readmitted at the facility on February 17, 2026 with diagnoses of polyosteoarthritis, chronic pain syndrome and schizoaffective disorder bipolar type. The initial admission record included the resident was alert and oriented x4 and had oxygen at 2 LPM (liters per minute) via NC (nasal cannula). The nursing note dated February 17, 2026 revealed the resident had O2 (oxygen) saturation of 86% on RA (room air); and that, O2 saturation of the resident improved to 94% after resident was placed on 2 liters of oxygen. The documentation also included that the resident was instructed to keep the oxygen on at this time. The initial care plan dated February 17, 2026 included focus areas such as cognition, skin, ADLs (activities of daily living), nutrition, pain, falls and infection. The initial care plan did not include oxygen use as focus area with interventions in place. The physician readmission note dated February 18, 2026 included the resident was on 2 liters of oxygen via NC; and, the resident reported that her breathing was much better. Despite documentation that the resident was on oxygen, the clinical record revealed no evidence of a physician order for its use including orders for replacement of nasal cannula or oxygen tubing, cleaning and filling of the oxygen concentrators. The IDT (interdisciplinary team)-BIMS (Brief Interview for Mental Status) note dated February 20, 2026 included that the resident was able to repeat 3 words with no cuing required after first attempt, was able to report correct year and month. In an observation conducted on February 23, 2026 at 11:41 a.m., Resident #12 was in her room and had her oxygen nasal cannula on her forehead. The oxygen concentrator was on and was at 2LPM. Resident #12 stated that she uses oxygen only on as needed basis. An observation was conducted on February 24, 2026 at 1:08 p.m. Resident #12 was watching television in her room with the one of the oxygen NC prong on her nose and the other NC prong on the side of her nose and the oxygen tubing was connected to the oxygen concentrator which was running at 2 LPM. Resident #12 stated that she had been on oxygen for a while and it used to be on as needed basis only. However, the resident stated that she was told to keep it on today. In an interview with the assistant director of nursing (ADON/staff #184) conducted on February 25, 2026 at 2:01 p.m., the ADON stated that residents with oxygen needed to have a physician order for its use; and that, oxygen rate had to be followed as ordered by the physician. An interview was conducted on February 25, 2026 at 2:14 p.m. with a licensed practical nurse (LPN/staff #46) who stated that residents who are on oxygen had to have an order for its use; and staff had to follow the oxygen rate/dose as ordered by the physician. She stated that if she finds a resident on oxygen and there was no order for its use, she would assess the resident, notify the physician who will then order for oxygen use with prescribed rate for the resident. She said that she would then document this in the clinical record and will ensure that an order is written in the clinical record. An interview was conducted with another LPN (staff #68) on February 25, 2026 at 2:25 p.m. The LPN stated that residents on oxygen have to have a physician order for its use including the parameter such as oxygen rate/dose range depending on the resident's oxygen sat. She stated that the orders usually will tell staff how much to give to ensure the O2 sat of the resident was above 90%. She further stated that if she sees a resident on oxygen and there was no order for its use, she will call and inform the doctor. Another observation was conducted on February 25, 2026 at 2:52 p.m. Resident #12 was laying in her bed watching TV, had her oxygen NC on and had her oxygen concentrator running at 2 LPM. Resident #12 stated that she had been using oxygen for about a couple of months now. In an interview with another LPN (staff #146) conducted on February 25, 2026 at 3:58 p.m., the LPN stated that oxygen use had to have a physician order; and, a resident cannot use oxygen without a physician order except on an emergency. She stated that in the hall/unit where resident #12 was, there were only 2 residents that has or were using oxygen; and this does not (continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>include resident #12. During the interview, an observation of resident #12 was conducted with the LPN who stated that resident #12 had nasal cannula on and was using oxygen at 2 LPM. A review of the clinical record was also conducted with the LPN who stated that the clinical record revealed no evidence of a physician order for oxygen use for resident #12. Further, she said that resident #12 was transferred the hall/unit from another hall/unit at the facility; and, resident #12 must have used the oxygen when she was in the other unit/hall. During an interview with the Director of Nursing (DON) conducted on February 25, 2026 at 4:06 p.m., the DON stated that there must be a physician order for oxygen use; and that, if the resident comes with oxygen, the order for its use comes from the hospital. She stated that if there was no order for the oxygen, staff were expected to call, inform the physician and get an order for the oxygen use. She said that the order include oxygen care, tubing changed which was usually 1st of every month and as needed, whether staff were able to titrate oxygen and oxygen rate between 1-5 to maintain oxygen saturation. A review of the clinical record was conducted with the DON who stated that the clinical record did not show that the resident had an order for oxygen use. The facility policy on Physician Orders, revised on May 2021, revealed that it is their policy to accurately implement orders in addition to medication orders (treatment, procedures) only upon the written order of a person duly licensed and authorized to do so in accordance with the resident's plan of care; and, no drugs or biologicals shall be administered except upon the order of a person lawfully authorized to prescribe for and treat human illnesses. All drug and biological orders shall be written, dated, and signed by the person lawfully authorized to give such an order.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on clinical record review, staff interviews, and facility policy, the facility failed to ensure that hand hygiene was maintained during dining services. The deficient practice could place residents at risk for infection. Finding include: During a dining room observation conducted on February 24, 2026, at 12:24 PM, a certified nursing assistant (CNA/Staff #66) was observed cleaning the dining tables after several residents were done eating their lunch. Staff #66 picked up used plates, used cups, then threw the leftover food from the plates in the trash can located in the dining area between the 2 brown doors next to the kitchen. While Staff #66 was holding the plate with the leftover food and throwing the leftover food in the trash can using her right hand, Staff #'s left hand was observed next to the trash can's lid while the lid was open. After Staff # threw the leftover food in the trash can, she placed the dirty plates in a container bin parked by the wall. Staff # proceeded to take a resident out of the dining room via his wheelchair. When Staff #66 came back to the dining area, Staff # started taking plates and cups out of the dining table, emptying leftover food in the trash can, and then took another resident out of the dining room via her wheelchair. An interview was conducted on February 24, 2026, at 12:40 PM, with a CNA (Staff #66). She stated that all shower aids assist in the dining room for lunch which includes passing out food and beverages, and assisting any residents that needs assistance with eating. She said that once their residents were done with their meals, she cleans the dining room by picking up dirty plate, and then taking the residents out of the dining area by wheeling the resident as they finish. She said that she wheeled 2 residents out of the dining room today. Regarding hand hygiene, she said that she performs hand hygiene by using the hand sanitizer located where the food service at, by the dirty dish bin and another hand sanitizer mounted on the wall by the entrance where the State Surveyor was standing. Further, she said that she threw the empty cartoons of milk and the food from the plate in the garbage can, and said that she might have open the lid with her hand, and used her foot to push to open the trash can. She stated that she sanitized her hand after she had placed the plates in the gray basin. She also said that she sanitized her hands to prevent spreads of bacteria to other residents. Another interview was conducted on February 25, 2026, at 12:10 PM with another CNA (Staff #88). Staff #88 stated that she picks up plates, cups and table cloth after their residents were done eating. She said that she uses the hand sanitizer in dining room located close to the door entrance to hand sanitize her hands. She also said that she uses the hand sanitize in between residents and before she leaves the dining room. She said that she hand sanitize her hands for infection control to prevent cross contamination. She said that after a resident was done eating in the dining room, she uses a hand sanitizer before touching the resident's wheelchair handle to wheel the resident out of the dining room because she does not want germs to get on the wheelchair handles. The Infection Preventionist (IP/Staff #184) was interviewed on February 26, 2026, at 4:48 PM. The IP stated that regarding hand hygiene, she expects the staff to perform foaming or hand sanitizing before going in the resident's room and after leaving the resident's room. The IP stated that if the staff was performing patient care such as peri care, the staff should foam out, the staff should be foaming in between patient, when the staff past meal trays to everybody that the staff should wash their hands or use the hand sanitizer, staff to use hand sanitizer after clearing up plates from the table then the staff can walk the residents back to their rooms or touch the resident's wheelchair handles. She said that she expects the staff to hand sanitized before touching patients and provide any care to prevent the spread of infection. An interview was conducted on February 26, 2026, at 4:59 PM with the Director of Nursing (DON/Staff #40). The [NAME] stated that her staff should be performing hand hygiene prior and after performing patient care to prevent spread of infection or germs. The DON also stated that the staff should be performing hand hygiene when assisting resident with their meals, after touching stuff like removing table linens, removing used plates and cups during clean up time in the dining area. A review of the facility policy titled Infection Prevention and Control Program reviewed on May 2025, revealed prevention of infection, staff and (continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>resident education is done to identify risk of infection and promote practices to decrease risk, and hand hygiene procedures will be followed by staff involved in direct resident contact.</p>