STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035116	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Rehabilitation Center at the Palazzo	6250 North 19th Avenue Phoenix, AZ 85015

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the clinical record review, facility documentation, and staff interviews, the facility failed to notify the Office of the State Long-Term Care Ombudsman (OSLTCO) of one resident's transfer (Resident #1). The deficient practice had the potential to limit the Ombudsman's ability to advocate for residents' rights and ensure safe, appropriate transitions of care.Findings include: Resident #1 was admitted to the facility on [DATE], with diagnoses that included unspecified dislocation of the left knee, subsequent encounter; paraplegia, unspecified; depression, unspecified; and muscle weakness (generalized).An admission MDS (minimum data set) assessment dated [DATE], revealed a BIMS (Brief Interview of Mental Status) score of 14, which indicated intact cognition. A skilled nursing facility to skilled nursing facility transfer referral dated February 6, 2026, revealed that a referral to another skilled nursing facility was made due to the resident's request.A social services progress note dated February 6, 2026, revealed that a skilled nursing facility to skilled nursing facility transfer referral was submitted to another facility.A social services progress note dated February 10, 2026, at 2:24 PM revealed that skilled nursing facility to skilled nursing facility transfer procedures were discussed with Resident #1's family member/ POA (power of attorney) on February 6, 2026. The progress note further stated that on February 10, 2026, the family member clarified that she was not actually the resident's family member or the POA, and that Resident #1 consented to have her treatment and care discussed with this individual. The progress note also revealed that a discussion was made with the individual regarding the potential transfer and that discharge planning would continue through the coordination of the social services director and the interdisciplinary team, and the attending physician. A notice of transfer or discharge date d February 10, 2026, at 3:58 PM revealed an effective transfer or discharge date of February 10, 2026, to another skilled nursing facility because the health of Resident #1 had improved sufficiently and she no longer required services provided by the facility, and, that if she should want to appeal the transfer/discharge, she would have needed to do so within 10 days of the notification.A nursing progress note dated February 10, 2026, at 4:31 PM revealed that the resident left the facility and that a discharge assessment had been completed. The note also stated that the transfer was reported to a POA/family member.There was no evidence of additional information regarding the discussion of the discharge planning or the notification to the ombudsman at the same time as the resident regarding the transfer or discharge in the resident's progress notes.There was no evidence of information regarding discharge planning in the resident's care plan.On March 25, 2026, at 11:47 AM, a telephone interview was conducted with the OSLTCO (Office of the State Long-Term Care Ombudsman). The OSLTCO stated that the notice of discharge had not been received in a manner that would advocate for the resident's rights to appeal the notice and stay in the facility. The OSLTCO had also stated that transfers and discharges of emergency hospital transfer or death are acceptable notifications at the end of each month. However, the OSLTCO stated that for any other types of discharges, the facility must provide notice of discharge to the resident or representation at least 30 days before the discharge on [DATE], at 12:00 PM, a telephone interview was conducted with Resident #1. Resident #1 stated that a male staff (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	member completed her admittance to the facility and expressed the desire to look into long-term care placement. Resident #1 stated that the male staff had told her she had been admitted to the wrong facility due to the facility being a short-term care facility, and that she would need to request looking into another facility. Resident #1 further stated that the male staff member did not say why the facility could not allow her to reside in the facility as a long-term resident. Resident #1 stated that due to this interaction with this male staff member, her overall view of the facility had been upset and geared her mind to find a facility that would accept her wishes for long-term care. Resident #1 stated that she received notification of a potential placement on Monday, February 9, 2026. Resident #1 also stated that the day of her discharge, February 10, 2026, she was provided a document to sign and had been unable to sign her full name, so she just signed an ?R' as an initial. Resident #1 stated she had been unaware of the opportunity to appeal the transfer and discharge, and that she could have had the opportunity to discuss the transfer and her concerns regarding the transfer with an ombudsman. Resident #1 stated that she had been unaware of the process until she had the opportunity to have a conversation with the ombudsman and her current facility.On March 25, 2025, at 12:23 PM, an interview was conducted with the social services director (Staff #80), who stated that the discharge process starts at the time of admission and will continue throughout their stay. Staff #80 also stated that transfers do occur if a resident decides to; at that point, the physician is included to assist with the communication from facility to facility. Staff #80 stated that if a short-term stay wishes to become a long-term stay, that discussion will develop over IDT (interdisciplinary team) meetings, where it would be determine of a long-term stay can be accommodated. Staff #80 stated that the facility is at capacity and that should a current short-term resident request to become a long-term stay resident, the facility would send the resident to another facility. Staff #80 stated that this has been an ongoing discussion where she has had to advocate for residents and provide re-education to leadership regarding the detail that each bed in the facility can be a long-term stay if they were to have the coverage for the stay. Staff #80 also stated that the beds in the facility are dually certified, and there should be no issues regarding whether a resident can stay or will require a transfer or discharge. Regarding Resident #1, Staff #80 stated that she had both skilled insurance and long-term care insurance. Staff #80 also stated that Resident #1 would have been a resident who could have stayed in the facility long-term due to the dually certified bed; however, Resident #1 expressed displeasure and unhappiness regarding their care and stated a desire to leave the facility. Staff #80 stated she did not ask Resident #1 what about her care made her unhappy due to a previous conversation where the resident declined to share her preferences with care. Staff #80 also stated that regarding the notification to the OSLTCO monthly, and that she had been unaware of any other expectations regarding discharges, such as transfers.On March 25, 2026, at 2:36 PM, it was advised by the DON (director of nursing/Staff #120) that there was no evidence of a facility policy for the notification to the ombudsman.On March 25, 2026, at 2:55 PM, an interview was conducted with the DON (Staff #120). Staff #120 stated that the facility expects to document everything, regarding the notification to the OSLTCO monthly, and that she had been unaware of any other expectations regarding discharges, such as transfers.A policy titled ?Transfer and Discharge (including AMA)', last reviewed April 15, 2024, revealed that it is the policy of this facility to permit each resident to remain in the facility and not initiate transfer or discharge for the resident from the facility, except in limited circumstances.