STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035126	A. Building B. Wing	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of North Glendale	13620 North 55th Avenue Glendale, AZ 85304

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581 Based on documentation, staff and resident interviews, the facility policy and procedures, the facility failed to ensure sufficient staffing to provide for the needs of the residents. The deficient practice could result in residents not receiving the assistance required to complete care tasks. Findings include: Resident #55 was admitted to the facility on [DATE] with diagnoses that included chronic kidney disease, depression, and anxiety. The care plan dated November 29, 2024 revealed that the resident had bowel incontinence. Interventions included to assist with toileting as needed. The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 15 which indicated that the resident was cognitively intact. -Resident #33 was admitted to the facility on [DATE] with diagnoses that included morbid obesity, vascular dementia, and an overactive bladder. The care plan dated February 10, 2023 revealed that the resident had bowel incontinence. Interventions included assist with toileting as needed. The care plan dated February 10, 2023 revealed that the resident had an activity of daily living (ADL) self-care performance deficit related to impaired mobility, and a recent right tibia/fibia fracture. Interventions included to assist with: bathing/shower, bed mobility, dressing, eating, personal hygiene, toilet use, and transfers. The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 15 which indicated that the resident was cognitively intact. -Resident #44 was admitted to the facility on [DATE] with diagnoses that included colostomy status, generalized weakness, and an overactive bladder. A care plan dated January 20, 2025 included that the resident is at risk for injury related to falls. Interventions included to assist with all ADLs. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan dated January 20, 2025 revealed the resident had an ostomy. Interventions included to provide ostomy care as needed. The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 12 which indicated that the resident had a moderate cognitive impairment. The care plan dated March 11, 2025 revealed that the resident has a Foley catheter and interventions included to provide catheter care each shift. -Resident #66 was admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses that included irritable bowel syndrome, chronic stage III kidney disease, and paroxysmal atrial fibrillation. The care plan dated July 30, 2017 revealed that the resident had weakness and poor endurance due to heart failure, neuropathy, chronic pain syndrome, mobility and ADL deficits. Interventions included to encourage the resident to use the bell for assistance. The care plan dated July 30, 2017 revealed that the resident was at risk for falls due to weakness, pain meds, psychotropic meds, occasional bladder incontinence, cardiovascular disease, cardiovascular meds, and diuretics. Interventions include to anticipate and meet the resident's needs and to assist with ADLs as needed. The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 15 indicating the resident was cognitively intact. -Resident #22 was admitted to the facility on [DATE] with diagnoses that included paraplegia unspecified, generalized muscle weakness, and disorder of muscle unspecified. The care plan dated May 27, 2024 revealed that the resident is incontinent of bowel. Interventions include to assist with toileting as needed. The care plan dated June 12, 2024 included a self-care performance deficit related to paraplegia. Interventions include to assist with ADLs as needed. The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 12 indicating the resident had a moderate cognitive impairment. -Resident #88 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included morbid obesity chronic obstructive pulmonary disease, and Diverticulosis. The care plan dated November 11, 2021 revealed mobility and ADL deficits due to weakness, decreased balance, left foot drop, decreased range of motion in the left hip and knee, and pain. Interventions included that the resident needs one to two staff for transfers. Use the Hoyer lift as needed. The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 8 indicating the resident had a moderate cognitive impairment. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident #99 was admitted to the facility on [DATE] with diagnoses that included chronic heart failure, unspecified dementia, and generalized weakness. The care plan dated June 7, 2022 revealed that the resident has an ADL self-care performance deficit related to dementia, disease process, and impaired balance. Interventions included a mechanical lift with two staff assistance for transfers. The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 14 indicating the resident was cognitively intact. Resident #110 was admitted to the facility on [DATE] with diagnoses that included vascular dementia, generalized muscle weakness, and irritable bowel syndrome with diarrhea. The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 15 indicating the resident was cognitively intact. The care plan dated August 12, 2024 revealed an ADL self-care performance deficit related to activity intolerance. Interventions included to assist with ADLs. Review of the staffing schedules, daily staff posting, and time cards for staff working on Hall 200 for the months of February and March 2025, revealed that the facility was short staffed. Review of the resident council meeting notes: -August 13, 2024 revealed a concern regarding call-light response time and staff turning off the call-light without helping the resident if the resident is asleep. -October 12, 2024, DON came to the resident council meeting and addressed issues. She will be doing an in-service for all issues that were brought up. -November 16, 2024, requesting help on the second floor (Hall 200) with trays as soon as they come out because by the time they are served, the food is cold, which is a food safety concern after twenty-three minutes. -January 14, 2025, no resident council meeting due to COVID outbreak. -February 17, 2025, food trays on the second floor are not being passed in a timely manner, needing more aides on the floor, issues with getting up for activities and the aides are not bringing them to activities. An interview was conducted on March 11, 2025 at 9:34 a.m. with resident #55, who stated that she has had to wait up to two hours for her call-light to be answered and this mostly happens during the night shift. She has waited up to three hours for continence care and has a rash. She has asked certified nursing assistants (CNAs) why it is taking so long to answer the call-lights and was told that that staff have too many patients. She stated that she had to wait a couple of hours yesterday to be changed. She also stated that the food is often cold by the time it is served. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on March 11, 2025 at 9:45 a.m. with resident #33, who stated that she has had to wait up to four hours for staff to answer her call-light and provide continence care. She stated that her roommate (resident #55) had to wait for four hours to be changed and it was reported. She stated that sometimes there is only one CNA. She stated that the food is always cold by the time it is served and the CNAs will heat it if asked, but begrudgingly, because they are so busy. An interview was conducted on March 11, 2025 at 9:55 a.m. with resident #44, who stated that that she has waited forty-five minutes for her call-light to be answered more than once. She stated that this morning she was supposed to get up at 6:00 a.m. and waited for staff until 7:15 a.m. with the call-light on. She asked staff what took so long and staff told her that she was too busy. She stated that one time her colostomy bag was leaking, got all over her clothes, and she waited 30 minutes to be taken to the toilet and change her clothes. An interview was conducted on March 11, 2025 at 10:25 a.m. with resident #66, who stated that she waits twenty to thirty minutes on a good day for her call-light to be answered and sometimes staff don't come. She stated that about 50% of the time, staff don't answer her call-light and she has to get in her wheelchair and go find staff to assist with things like taking her tray away, get ice water and to get clean sheets and linens. She has complained to the Resident Council President. She stated that the food is always cold by the time it is served. An interview was conducted on March 11, 2025 at 10:38 a.m. with resident #22, who stated that he has waited two hours for his call-light to be answered. He stated that one time he had a bowel moment and urinated, and when the CNA answered the call light, she told him that he would have to wait for his CNA to return from lunch. He referred to his binder and stated that on - February 21, 2025, a CNA came and told him that she had to help other residents and left. He waited one and a half hours to be changed and he also had waited from 11:30 a.m. to 1:30 p.m. for a CNA to bring him ice water. He stated that there were only two CNAs working. -On February 23, 2025, the CNA answered his call-light and told him that she needed to help other residents; she returned after an hour and a half to get him some ice water and to dump his pee bottle. -On February 24, 2025, his call-light was on and the CNA told him that he had to wait because the CNA was helping other residents. He stated that he waited from 3:30 p.m. to 5:30 p.m. to be changed and he got a rash around his groin area. -On February 27, 2025, he had a bowel movement at 7:40 p.m. and wasn't changed until about 11:00 p.m. and he had diarhea. He stated that the CNA told him that she had to go down the line because other residents needed to be changed. -On March 1, 2025, his call-light was on at 10:00 a.m. because he needed to be changed and the light was not answered until 10:45 a.m. -On March 5, 2025 his call-light was on at 9:00 a.m. and was answered at 11:00 a.m. and he needed to be changed. Staff told him that she was sorry, but they were short staffed again and there were other residents ahead of him. -On March 10, 2025, he stated that he waited two hours to get changed. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on March 11, 2025 at 11:46 a.m. with resident #88's spouse, who stated that he asked a female staff to get the resident up out of bed. The resident was observed lying in bed. He stated that the staff told him that she would help the resident after serving the lunch trays. He stated that they have waited twenty to thirty minutes for the call-light to be answered and needed assistance with getting and being changed. An interview was conducted on March 11, 2025 at 11:52 a.m. with resident #99, who stated that she had placed the call-light on about 10:30 a.m. because she wanted staff to help her get up and staff did not respond until about 11:30 a.m. She stated that staff got her up right before lunch. She stated that had waited for thirty minutes for her call-light to be answered when she needed to use the toilet and ended up having a incident in her brief. Staff has told her that she is not the only one here. She stated that sometimes there is only one CNA working on the hall. An interview was conducted on March 11, 2025 at 1:15 p.m. with resident #110, who stated that the food is often cold because staff are very busy, so residents may have to wait for food trays to be served for fifteen to twenty minutes after the food cart has been delivered to the hall. She also stated that there are plastic covers for the food carts, but they aren't being used, so food may lose heat faster. She stated that residents are complaining about call-light response time and say that they are waiting more than an hour. She stated that the Director of Nursing (DON/staff #1) came to a resident council meeting that the facility is trying to hire more staff, but right now the facility doesn't use registry staff and the current staff are working doubles, so staff are getting burnout, look physically tired, seem apathetic, and lack enthusiasm. She stated that she doesn't have the stamina to stay up all day and has waited up to an hour for staff to transfer her to bed. An interview was conducted on March 11, 2025 at 2:06 p.m. with the Staffing Coordinator (staff #33), who stated that she is responsible for the staffing schedules and there are three shifts for the CNAs: 6:00 a.m. to 2:30 p.m., 2:00 p.m. to 10:30 p.m., and 10:00 p.m. to 6:30 a.m. She stated that there are two shifts for the nurses, 7:00 a.m. to 7:30 p.m. and 7:00 p.m. to 7:30 a.m. She stated that Hall 200 is long-term care, so the census basically stays the same, which is approximately 56 and in order to provide care the facility needs: -two nurses and a unit manager from 7:00 a.m. to 7:30 p.m, two nurses 7:00 p.m. to 7:30 a.m. -five to six CNAs from 6:00 a.m. to 2:30 p.m. -five to six CNAs from 2:00 p.m. to 10:30 p.m. -three CNAs from 10:00 p.m. to 6:30 a.m. Staff #33 reviewed that the staffing schedules, the daily staff postings, and hours worked by staff for Hall 200 and stated: -February 1, 2025, there were only four CNAs on Hall 200 from 6:00 a.m. to 2:30 p.m. because she was not able to find anyone to work. -February 1, 2025, there were only four CNAs on Hall 200 from 6:00 a.m. to 2:30 p.m. -February 2, 2025, there were only four CNAs on Hall 200 from 6:00 a.m. to 2:30 p.m. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-February 4, 2025, there were only four CNAs on Hall 200 from 6:00 a.m. to 2:30 p.m. -February 5, 2025, there were only four CNAs on Hall 200 from 6:00 a.m. to 2:30 p.m. -February 11, 2025, there were only four CNAs on Hall 200 from 6:00 a.m. to 2:30 p.m. -February 15, 2025, there were only four CNAs on Hall 200 from 6:00 a.m. to 2:30 p.m. -February 17, 2025, there were only four CNAs on Hall 200 from 6:00 a.m. to 2:30 p.m. -February 18, 2025, there were only four CNAs on Hall 200 from 6:00 a.m. to 2:30 p.m. -February 21, 2025, there were only four CNAs on Hall 200 from 6:00 a.m. to 2:30 p.m. -February 24, 2025, there were only four CNAs on Hall 200 from 6:00 a.m. to 2:30 p.m. -February 25, 2025, there were only four CNAs on Hall 200 from 6:00 a.m. to 2:30 p.m. -February 1, 2025, there were only two CNAs on Hall 200 from 2:00 p.m. to 10:30 p.m. and then two CNAs came at 6:00 p.m. -February 3, 2025, there were only three CNAs on Hall 200 from 2:00 p.m. to 10:30 p.m. and then one CNAs came at 6:00 p.m. -February 5, 2025, there were only four CNAs on Hall 200 from 2:00 p.m. to 10:30 p.m. -February 6, 2025, there were only four CNAs on Hall 200 from 2:00 p.m. to 10:30 p.m. and then one CNAs came at 6:00 p.m. -February 11, 2025, there were only four CNAs on Hall 200 from 2:00 p.m. to 10:30 p.m. -February 12, 2025, there were only four CNAs on Hall 200 from 2:00 p.m. to 10:30 p.m. and then one CNAs came at 6:00 p.m. -February 13, 2025, there were only four CNAs on Hall 200 from 2:00 p.m. to 10:30 p.m. and then one CNAs came at 6:00 p.m. -February 14, 2025, there were only three CNAs on Hall 200 from 2:00 p.m. to 10:30 p.m. and then one CNAs came at 6:00 p.m. -February 14, 2025, there were only three CNAs on Hall 200 from 2:00 p.m. to 10:30 p.m. and then one CNAs came at 6:00 p.m. -February 15, 2025, there were only four CNAs on Hall 200 from 2:00 p.m. to 10:30 p.m. and then one CNAs came at 6:00 p.m. -February 17, 2025, there were only four CNAs on Hall 200 from 2:00 p.m. to 10:30 p.m. and then one CNAs came at 6:00 p.m. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-February 18, 2025, there were only four CNAs on Hall 200 from 2:00 p.m. to 10:30 p.m. -February 19, 2025, there were only four CNAs on Hall 200 from 2:00 p.m. to 10:30 p.m. and then one CNAs came at 6:00 p.m. -February 20, 2025, there were only four CNAs on Hall 200 from 2:00 p.m. to 10:30 p.m. -February 21, 2025, there were only two CNAs on Hall 200 from 2:00 p.m. to 10:30 p.m. One CNA from the day shift stayed about two hours and one CNA came in around 8:00 p.m. -February 22, 2025, there were only one CNAs on Hall 200 from 2:00 p.m. to 10:00 p.m., one CNA from the day shift stayed about two hours, one CNA worked from 2:00 p.m. to 6:00 p.m. and two CNAs worked from 6:00 p.m. to 10:30 p.m. -February 23, 2025, there were three CNAs from 2:00 p.m. to 10:00 p.m. on Hall 200 and one CNA from CNA from 6:00 p.m. to 10:30 p.m. -February 24, 2025, there were four CNAs from 2:00 p.m. to 10:30 p.m. and one CNA from 6:00 p.m. to 10:30 p.m. -February 25, 2025, there were four CNAs from 2:00 p.m. to 10:30 p.m. -February 14, 2025, two CNAs worked the 10:00 p.m. to 6:30 a.m. on Hall 200 and she couldn't find anyone else to work the shift. -February 16, 2025, there were only two CNAs on Hall 200 from 10:00 p.m. to 6:30 a.m. -February 22, 2025, there were only two CNAs on Hall 200 from 10:00 p.m. to 6:30 a.m. -February 23, 2025, there were only two CNAs on Hall 200 from 10:00 p.m. to 6:30 a.m. -February 24, 2025, there were only two CNAs on Hall 200 from 10:00 p.m. to 6:30 a.m. -March 1, 2025, there were four CNAs from 2:00 p.m. to 10:30 p.m. and the fifth CNA was scheduled from 6:00 p.m. to 10:30 p.m. but five CNAs are needed for the shift. -March 5, 2025, there were four CNAs from 6:00 a.m. to 2:30 p.m. on Hall 300 because one CNA was on vacation, so she pulled the fifth CNA from Hall 200, which left Hall 200 short staffed. -March 6, 2025, there were four CNAs scheduled for Hall 200 because one CNA was on vacation and she couldn't get anyone to cover the shift. -March 9, 2025, there were only two CNAs from 10:00 p.m. to 6:30 a.m. because the third CNA was on FMLA and she couldn't get anyone to pick up the shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	After reviewing the above staffing ratios, staff #33 stated that the facility is short staffed. She stated that she is scheduling interviews, but people are not showing up and she cannot use registry staff. She can have restorative staff (RNA) help, but then the restorative program doesn't get done. She stated that the (DON/staff #1) supervises the staffing and they go over the schedules together; they have discussed the above staffning needs. She stated that there is a risk of skin breakdown if residents aren't being changed timely and residents have a the right to get up and get out of bed when they want to get up. An interview was conducted on March 12, 2025 at 9:50 a.m. with a certified nursing assistant (CNA/staff #3), who stated that there are a lot of residents who need assistance with bowel movements on Hall 200; she has one resident in room [ROOM NUMBER] who always needs something, so she takes a lot of her time and she has explained that she needs to care for other residents. She stated that sometimes they are short staffed, but there are usually two to three CNAs on Hall 200 during the evening shift and one to two CNAs during the NOC shift. She stated that it takes her approximately fifteen minutes to answer a call-light and she tells the resident that she will come back after helping another resident, which takes twenty minutes or less for her to return, but it is possible that residents are waiting thirty to forty minutes while she is changing other residents. She stated that the supervisors know that they are short staffed and say that they are trying to hire more CNAs. An interview was conducted on March 11, 2025 at 3:34 p.m. with the Director of Nursing (DON/staff #1), who stated that together with the Executive Director are responsible for monitoring the staffing ratios and sufficient staffing is determined by the number of residents and the the acuity, the needs of each resident. She stated that the second floor (Hall 200) is long-term care and the Staffing Coordinator (staff #33) knows how many staff, CNAs, are needed on each floor and lets her know when they are not able to cover a shift. They are trying to hire more CNAs, it is an ongoing process. She stated that resident complaints regarding staffing is nothing new and when residents make a complaint, she tells them that they are trying to hire more staff. She thinks that a 15-minute response time for care is appropriate. An interview was conducted on March 12, 2025 at 10:29 a.m. with (CNA/staff #79), who stated that she has answered call-lights and told the resident that she is finishing up with another resident and will be right back. She stated that if she is in the middle of giving another resident a shower, the resident is going to have to wait for at least twenty to thirty minutes before she can provide care. She stated that residents have complained about waiting all morning, up to three hours for care, but this was mostly before she has arrived for her shift and she reported it to the nurse. She stated that she thinks there is supposed to be five CNAs scheduled to work, but there have been days when there were only four CNAs for the 6:00 a.m. to 2:30 p.m. shift on Hall 200. The facility policy, Staffing revealed that the facility maintains adequate staff on each shift to meet residents' needs.