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	12/04/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of clinical record, and review of facility policy and procedure, the facility failed to ensure an allegation of abuse was reported immediately and within 2 hours to mandated entities for one resident (#2). The deficient practice could result in continued abuse of a resident.-Findings include:Resident #2 was admitted to the facility on [DATE], with diagnoses that included displaced fracture of medial malleolus of right tibia, displaced fracture of lateral condyle of left femur, urinary tract infection, and acute kidney failure.A Cognitive Patterns note dated October 30, 2025, revealed Resident #2 had a brief interview for mental status (BIMS) assessment score of 12, indicating moderately impaired cognition.An incident report dated October 30, 2025, revealed that on the evening of October 31, 2025, Resident #2's family came to the nurses' station and told the nurse on duty that Resident #2 told the family member that the resident was raped. When the nurse entered the resident's room and asked the resident what happened, the resident claimed that a night shift male staff member came into her room and touched her inappropriately in her genital area with his knuckles. The report also revealed that Resident #2 was assessed head to toe for injury, with no injuries observed. The report revealed that the family member was notified of the incident on October 31, 2025 at 10:15 P.M., the provider and the local police were notified on October 31, 2025, at 10:30 P.M., and the State Agency was notified on November 1, 2025, at 1:18 P.M.A Nursing note dated October 31, 2025, revealed the nurse (Staff #29) was alerted by Resident #2's family that Resident #2 was claiming abuse. The note revealed that nursing management, administration, and the local police department were notified. Additionally, the police came to the facility and investigated, staff were interviewed, and an assessment of Resident #2 was performed.An Event Note dated October 31, 2025, revealed Resident #2 made an allegation of abuse against a male staff member from the night shift of October 30, 2025. The note revealed that Resident #2 was assessed by a female registered nurse (RN) right away, and no signs of any injury were noted. The alleged male staff member was placed on suspension pending investigation, and all authorities and agencies were notified. Additionally, the note revealed that the resident's family was present at the time.A Report of Allegation of Neglect, Abuse, Misappropriation of Property, and Exploitation Form revealed the alleged incident occurred on October 30, 2025, at 10:00 P.M. The report revealed that the local police were notified on October 31, 2025, at 10:30 P.M., the State Agency was notified on November 1, 2025, at 1:18 A.M., and Adult Protective Services (APS) was notified on November 1, 2025 at 1:30 A.M.An email to the facility Administrator (Staff #6) from the online APS submission portal, revealed a confirmation of submission of intake #599415 on November 1, 2025 at 1:30 A.M.An email dated November 1, 2025, at 1:39 A.M. from the facility Administrator (Staff #6) to the State Agency, revealed that the facility staff attempted to submit the self-report of alleged abuse on November 1, 2025, at 1:18 P.M., but could not due to a server error. The facility self-report complaint attached to the email revealed that on October 31, 2025, at around 10:00 P.M., Resident #2 reported to her nurse that yesterday a night male nurse raped her.An interview was conducted with the Social Services Director (Staff #19) on November 4, 2025, at 1:56 P.M. Staff #19 stated that if there was an allegation of abuse, that it would be reported to the Administrator (Staff #66), who is the abuse coordinator, and then Staff #19 would notify APS and the ombudsman of the allegation. Regarding Resident #2, Staff #19 stated that the resident's allegation of abuse came to staff's attention over the weekend, so the Administrator completed the reports to APS and the ombudsman.A telephonic interview was conducted on November 4, 2025, at 1:48 P.M. with an RN (Staff #22), who stated that he was a nurse on duty on October 31, 2025, and was first notified of Resident #2's allegation on October 31, 2025, at around 10:00 P.M., when the resident's family member approached Staff #22 in the hallway and stated that Resident #2 had been raped the night before. Staff #22 stated that he then went to Resident #2's room and took the resident's statement that she had been touched inappropriately by a male staff. Staff #22 stated that he notified nursing management, the local police, and the Administrator immediately, and that the Administrator came to the building within 20-25 minutes. Staff #22 stated that the Administrator started the investigation process right away, and the local police interviewed Resident #2.An interview was conducted with a certified nursing assistant (CNA / Staff #31) on November 5, 2025, at 9:51 A.M. Staff #31 stated that if there is an allegation of abuse of a resident, that staff would be expected to immediately inform the nurse, the charge nurse, and the Administrator. Staff #31 stated that the importance of immediate notification to facility management would be to ensure the safety of the resident by investigating the allegation right away