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	06/12/2026

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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interviews, and facility policy and procedure the facility failed to ensure that food items were stored, dated, and labeled in accordance to professional standards. The deficient practice could lead to food borne illnesses.Findings Include:Observation of freezer on June 9, 2026 at 8:21 A.M. with Food Service Director (staff #45) revealed two personal size pepperoni pizzas and four burritos were not covered, open to air and not dated. Observation of #1 refrigerator on June 9, 2026 at 8:23 A.M. revealed a tray of individual clear cups with lids containing tartar sauce and coleslaw that were not dated. Also, a gallon container of relish that was half full did not have an open date.Observation of dry storage area on June 9, 2026 at 8:35 A.M. revealed a box of rainbow sprinkles open and no date of when opened. Bread crumbs were in a large container and it was dated January 2, 2026 and the use by date was June 2, 2026. Also, a large container of salt was dated January 2, 2026 and the use by date was June 2, 2026. In addition, Corn Flakes were in a container dated January 2, 2026 and use by date June 2, 2026, and Raisin Bran dated January 2, 2026 and use by date June 2, 2026. Also, Caramel sauce and chocolate syrup which were both opened were not labeled with date opened or use by dates.Observation of the #2 refrigerator on June 9, 2026 at 8:50 A.M. revealed individual cups of liquid that were not dated. Also, 18 pitchers with tea and lemonade were on a cart unrefrigerated and open to air with no label or date. Observation on June 10, 2026 at 1:12 P.M. revealed a 3rd floor hydration cart with a blue cooler on top of the cart and an ice scoop that was lying next to the blue cooler on the cart and was not in the ice scoop holder. An interview on June 10, 2026 at 1:15 P.M. with staff #45 stated that the ice scoop should be in the scoop holder and not on the top of the cart. This could cause cross contamination or bacteria in the beverages. Staff #45 stated that she does weekly checks on food items placed in the refrigerators, freezers, and dry storage areas, to ensure that food items are labeled, dated, and stored correctly. She stated that the risk of the food items not labeled, dated, and stored correctly could cause food contamination and someone could get sick. Staff #45 stated she completes training with her staff every year and as needed if a new staff member starts or if there is a concern that she notices.An interview was conducted with the Administrator/ Executive Director (Staff #160) on June 11, 2026 at 9:25 A.M. to review food storage and labeling, expired foods, and sanitation practices for the ice scoop. Staff #160 stated the food items should be labeled and dated and thrown away if expired, and the ice scoop should be in the holder at all times.The facility policy on food safety and sanitation revised May 26, 2026 states food is stored and maintained in a clean, safe and sanitary manner following federal, state and local guidelines to minimize contamination and bacterial growth. Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Pre-packaged food is placed in a leak-proof, non-absorbent, sanitary container with a tight-fitting lid. The container is labeled with the name of the contents and date (when the item is transferred to the new container). The use by date is noted on the label or product when applicable. Food is labeled with the date received if not already indicated on the item. Opened packages of food are resealed tightly to prevent contamination of the food items and use by date will be used when applicable.

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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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, and policy and procedure, the facility failed to ensure that Preadmission Screening and Resident Review Screening (PASRR) was completed for one of two residents (#6), the universe was 125, with a diagnosis of a serious Mental Illness (MI) was referred to the appropriate state-designated authority and determination received. The deficient practice could result in residents not receiving the necessary specialized services that they require. Findings Include:Resident #6 was admitted to the facility on [DATE], with diagnoses that included schizophrenia, major depressive disorder, anxiety disorder, type 2 diabetes mellitus, heart failure and renal failure.The physician order dated included following:-Rexulti (Brexpiprazole) 1 mg give one tablet by mouth one time a day for schizoaffective disorder ordered August 19, 2025.-Prozac (Fluoxetine HCl) 40mg give 2 capsules by mouth one time a day for depression ordered on September 6, 2022.-Trazodone 100mg give 1 tablet by mouth at bedtime for anxiety ordered on May 9, 2026.A Minimum Data Set (MDS) assessment dated [DATE] for resident #6, revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the individual's cognitive abilities are fully intact with no significant impairment. The resident #6 was administered high risk medication that included Rexulti (Brexpiprazole) 1mg 1 tablet by mouth one time a day for Schizophrenia.A review of care plan dated April 7, 2026 revealed resident #6 had the potential of psychosocial wellbeing problem and change in mood or behavior related to diagnosis of anxiety disorder, major depressive disorder and schizoaffective disorder. The resident #6 is to be monitored every shift for sedation, drowsiness, dry mouth, blurred vision, tardive dyskinesia, and seizure disorder.Further review of the medical record revealed a PASSR Level 1, dated April 8, 2026, completed for resident #6 had no determination results received by the state-designated authority.A Pre-admission Screening and Resident Review (PASRR) Level 1, dated April 15, 2025, for resident #6 revealed the resident had a Mental Illness (MI) that included Schizophrenia. The screening was completed by the facility with no determination results received by the stated-designated authority.An interview was conducted on June 11, 2026 at 10:20 A.M. with the Social Services Assistant (staff #116) who stated that it was her responsibility to complete PASRR Level 1 and send it to the state-designated authority and track the determination results. She stated that on admission she ensures that all residents have a PASRR Level 1 completed and she then sends to the state-designated authority by email. If she receives a determination result she prints it out and places it in her PASSR binder. She stated that resident #6, there was a Level 1 PASRR dated April 15, 2025, which had no response indicating state review or determination results were received. Furthermore, she stated a PASSR Level 1 was completed for resident #6 on April 8, 2026 and no response indicating state review or determination results were received.An interview was conducted on June 11, 2026 1:44 pm the Director of Nursing (DON/staff #14) and Executive Director (ED/staff #160) who stated a PASSR Level 1 is sent to the state-designated authority for review for all residents and determination results should be received. The DON stated the risk of not receiving the Level 1 determination could result in the resident not receiving the appropriate level of care and services.An interview was conducted on June 12, 2026 with staff #116 at 8:23 A.M. who confirmed that she was not able to find determination results for resident #6 for PASSR dated April 15, 2025 and April 8th, 2026.The facility policy on pre-admission screening and resident review (PASARR), reviewed on 9/26/25 states the facility will ensure that potential admissions are to be screened for possible serious mental disorders or intellectual disabilities and related conditions. This initial pre-screening is referred to as a PASARR Level I. A negative Level I screen permits admission to proceed and ends the PASARR process. A positive Level I screen necessitates an in-depth evaluation of the individual by the state-designated authority, known as PASARR Level 2. The record of the pre-screening should be retained in the resident's medical record.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, staff and resident interviews, and facility policies and procedures, the facility failed to ensure that pain medication for one (Resident #132) of nineteen sampled residents was administered in accordance with physician orders. The facility census was 125. This deficient practice had the potential to result in overmedication, adverse drug effects, impaired pain management, and inaccurate assessment of the resident's pain status.Findings include:Resident #132 was admitted to the facility on [DATE], with diagnoses that included cellulitis of the left and right lower extremities, muscle weakness, cognitive communication deficit, psychoactive substance abuse, and alcohol abuse in remission.Resident #132's care plan dated May 16, 2026, revealed a focus stating that the resident experienced pain related to infection of the bilateral lower extremities. Interventions included administering pain medication as ordered and attempting non-pharmacological interventions prior to pain medication administration.Review of a physician's order dated May 17, 2026, revealed Hydromorphone HCl Tablet 2 mg was to be administered by mouth every four hours as needed for pain levels of 6-10 on a 0-10 pain scale.Review of the Medication Administration Record (MAR) for May 2026 revealed Hydromorphone was administered four times when the documented pain level was below the physician-ordered parameter of 6-10. These administrations included: May 21, 2026 - Pain level 4; Hydromorphone administered at 10:39 a.m. May 21, 2026 - Pain level 4; Hydromorphone administered at 2:49 p.m. May 28, 2026 - Pain level 1; Hydromorphone administered at 4:53 p.m. May 29, 2026 - Pain level 3; Hydromorphone administered at 7:49 p.m.Review of the Medication Administration Record (MAR) for June 2026 revealed Hydromorphone was administered three times when the documented pain level was 0. These administrations included: June 5, 2026 - Pain level 0; Hydromorphone administered at 7:49 a.m. June 5, 2026 - Pain level 0; Hydromorphone administered at 12:51 p.m. June 5, 2026 - Pain level 0; Hydromorphone administered at 5:27 p.m.On June 12, 2026, at 9:57 a.m., an interview was conducted with Licensed Practical Nurse (LPN/Staff #25). Staff #25 stated that when a resident has an as-needed order for pain medication, the nurse should ask the resident to rate their pain on a scale of 1 to 10 and attempt non-pharmacological interventions, such as repositioning. Staff #25 stated that pain medication should only be administered within the physician-ordered pain scale and time parameters.On June 12, 2026, at 12:21 p.m., an interview was conducted with the Director of Nursing (DON/Staff #14). Staff #14 stated it was her expectation that when a resident reports pain, the nurse should assess the resident's pain level using a 1-to-10 pain scale, implement non-pharmacological interventions when appropriate, and administer medication according to the physician's order. Staff #14 stated that medications should only be administered as ordered. Staff #14 further stated that administration of pain medication outside physician-ordered parameters could negatively affect pain management and place the resident at risk for adverse outcomes associated with inappropriate medication administration.Review of the facility policy titled Administration of Medications, reviewed September 9, 2025, revealed that the facility must ensure medications are administered safely and appropriately in accordance with physician orders to address residents' diagnoses, signs, and symptoms.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure toenail care was provided in accordance with professional standards of practice for one of two sampled residents (Resident #66). This deficient practice places residents with diabetes at risk for inadequate nail care which can result in infection, pain, discomfort, impaired mobility, and worsening nail conditions. The universe was 125 and the sample 2. Findings include:Resident #66 was admitted on [DATE] with diagnoses of diabetes mellitus, venous insufficiency, thrombocytopenia, anemia, and end-stage renal disease.A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Health Status (BIMS) score of 14, indicating the resident was cognitively intact. The assessment revealed no indicators for mood or behaviors. The resident required set up or clean up assistance with personal hygiene, and was dependent on staff for putting on and taking off footwear.A care plan review date of April 21,2026 revealed a focus area of activities of daily living (ADL) and therapy services needed to maintain the highest level of function. Interventions included assistance with mobility and ADLs as needed.A physician order dated 01/16/2026 revealed an order for podiatry or ophthalmology care as needed.A podiatry Subjective Objective Assessment Plan (SOAP) note dated 04/22/2026 revealed that the podiatrist used a mechanical grinder on the resident's toes 1-5 on left and right toenails to debride the toenails.During initial screening conducted on June 9, 2026 at 10:36 AM, Resident #66 feet were observed outside of the bed linen. The resident's toenails were long and chipped. Blood was present around the edges of several toenails, and black discoloration was noted on the left and right great toe. The toenails were thick, yellow, and the skin around the toenails was dry and flaky.A second observation was attempted on June 10, 2026 at 11:15 AM, but Resident #66 was out for paracentesis.A third observation on June 11, 2026 at 12:10 PM was conducted with Resident #66. The resident had socks on both feet. The resident stated that nail care had not been performed.An interview was conducted on June 11, 2026 at 12:29 PM with a Licensed Practical Nurse (LPN/staff #74). Staff #74 observed Resident #66's toenails and stated they were overgrown and thick. She stated the toenails required trimming and exhibited signs consistent with fungal infection. She further stated that the thickened portions of the nails demonstrated fungal changes and stated she would contact the podiatrist regarding the resident's condition. She stated that failure to regularly trim toenails could result in increased risk of infection, ingrown toenails, fungal growth, pain, discomfort, impaired mobility, and decreased quality of life.A physician order dated June 11, 2026 at 12:49 PM revealed orders to apply vitamin A and D ointment to both lower extremities and feet, and obtain a podiatry evaluation.An interview was conducted on June 11, 2026 at 1:46 PM with staff #74. She stated she had contacted the podiatrist, who subsequently completed the resident's nail care. She further stated the podiatrist prescribed medication for treatment of the toenail fungus. She also applied vitamin A and D ointment to resident's feet and lower legs for dry, flaky skin.An interview was conducted on June 12, 2026 at 11:10 AM with the Director of Nursing (DON/staff#14). The DON stated nail care is provided by nursing staff or nursing assistants unless a podiatry order exists. She stated the podiatrist visits the facility every 60 to 90 days and residents requiring more frequent care may be referred out or seen at the facility sooner. She stated nurses and CNAs are responsible for monitoring residents' feet and identifying nail care needs. She further stated residents with diabetes or other food concerns should be referred to podiatry. The DON stated staff are expected to notify nursing when nail maintenance is needed and acknowledged the failure to provide nail care could result in resident discomfort.Review of the policy titled Foot Care, issued August 28, 2018 and reviewed September 4, 2025, stated:The facility will ensure that foot care provided is consistent with professional standards of practice and that foot care includes treatment to prevent complications from conditions such as diabetes, peripheral vascular disease, or immobility. This facility will ensure that foot care also includes assisting the resident in making necessary appointments with qualified healthcare providers such as podiatrists and arranging transportation to and from appointments.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, resident and staff interviews, observations, facility documentation, and policy and procedure, the facility failed to ensure respiratory care was provided with professional standards of practice for one resident (#59). The deficient practice could result in care or services that do not meet residents' needs. The universe was 125 and the sample size was 1.Findings includeResident #59 was admitted on [DATE], with diagnoses including pneumonia, chronic respiratory failure with hypoxia, and congestive heart failure.A care plan dated April 29, 2026, revealed a focus for oxygen therapy. Interventions include observing for signs and symptoms of respiratory distress and reporting to the medical doctor as needed, monitor for respiratory distress including respiratory rate, pulse oximetry, increased heart rate, restlessness, diaphoresis, headaches, lethargy, confusion, atelectasis, and changes in skin color.A quarterly Minimum Data Set (MDS) assessment date May 5, 2026 included a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The assessment revealed the resident had no indicators for mood or behavior. Further review of the MDS revealed the resident was on oxygen therapy while a resident.Review of the Electronic Health Record (EHR) from May 11, 2026 to June 10, 2026 revealed no pulse oximeter readings.A physician's order dated June 9, 2026 revealed an order for oxygen to be administered at 2 liters per minute (LPM) via nasal cannula, as needed. During initial screening, an interview was conducted on June 9, 2026 at 9:56 am with resident #59. The resident stated he relies on oxygen for breathing support during the night. He further stated he had not been receiving oxygen and his oxygen tubing had not been re-applied after his shower the previous night. During the interview, the resident's oxygen tubing was observed lying on the floor beneath the bed and was not within residents reach. No label or date was observed on the oxygen tubing. The oxygen concentrator was on and set to 3.5 LPM.A second observation was conducted on June 9, 2026 at 10:52 am with Licensed Practical Nurse (LPN/staff #108). Staff #108 observed the nasal cannula lying on the floor underneath the resident's bed. She picked up the oxygen tubing from beneath the bed, removing it from the concentrator and disposed of it in the garbage can. She stated the risk of the nasal cannula being on the floor places the resident at risk of infection. She further stated that having the oxygen tubing out of the resident's reach placed the resident at risk of not being able to access oxygen therapy if needed.A physician's order dated June 10, 2026 revealed an order to check oxygen saturation rates every eight hours.An observation was conducted on June 10, 2026 at 9:23 am of resident #59. There was no oxygen tubing connected to the oxygen concentrator located in the resident's room. The resident stated he experienced difficulty breathing the night before because staff had not replaced his oxygen tubing from the night before, nor had the checked on his oxygen needs.An observation was conducted on June 10, 2026 at 12:26 pm of resident #59. The resident was sleeping and wearing a nasal cannula. The oxygen tubing was connected to the oxygen concentrator which was set to a flow rate of 2.6 LPM.An interview was conducted on June 10, 2026 at 1:34 pm with staff #108. She stated upon entering the resident's room at lunchtime, she observed the resident's oxygen saturation level was at eight-eight percent and noted the resident was wheezing. She stated she was unable to provide documentation of the oxygen level check, as the information had not been entered into the resident's records. Staff # 108 stated she contacted the physician to request new orders to increase the oxygen levels and to conduct a chest x-ray. She stated there were no standing orders to check the resident's pulse oximetry. She further stated facility policy states oxygen saturation levels should be monitored each shift and documented during observations. She stated nurses are responsible for placing orders for oxygen saturation checks, and stated the oxygen saturation checks had not been completed for this resident.An observation was conducted on June 10, 2026 at 1:40 pm by staff #108. She assessed the resident's oxygen level, and stated she originally set the oxygen concentrator to 3 LPM, but the concentrator was now set to 2.6 liters. She further (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated the resident had a continuous oxygen order for 3 LPM. Staff # 108 stated it is the responsibility of nursing staff to adjust oxygen flow rate or monitor oxygen saturation levels could result in shortness of breath or respiratory issues for the resident.An interview was conducted on June 10, 2026, at 2:00 pm with the Certified Nursing Assistant (CNA/staff #71). She stated CNAs are not permitted to adjust the oxygen flow rate for any resident. She further stated if a resident's oxygen tubing falls off, the CNA is supposed to replace the tubing and reapply the nasal cannula to the resident.An interview was conducted on June 12, 2026, at 11:39 AM with the Director of Nursing (DON/staff # 14). The DON stated oxygen tubing should be disposed of properly and replaced to prevent risk of infection. She stated nurses must ensure that oxygen tubing is not left on the floor. The DON further stated vital signs for oxygen therapy are dependent on physician orders, including saturation levels. If oxygen is prescribed on an as needed basis, the resident should have an order for pulse oximetry checks, which allows the nurse to determine if the oxygenation level is therapeutic for the resident. She stated if nurses do not have an order to check oxygenation saturation levels, they should contact the provider to obtain one. The DON stated there is no facility policy specifying when oxygen saturation levels should be checked, but nurses are expected to regularly assess the resident's skin color and level of orientation. She stated failure to monitor pulse oximetry readings and maintain the ordered oxygen flow rate could result in residents experiencing shortness of breath.A review of the facility policy titled Oxygen Administration (Infection Control, Safety, and Storage) revised 03/03/2026 states to ensure that oxygen is administered and storedOxygen supplies weekly and when visibly soiled, equipment should be labeled with resident name and dated when set up or changed out.Store oxygen and respiratory supplies in bag labelled when not in use.A review of the facility policy titled A review of the facility policy titled Pulse Oximetry revised 10/14/2021 and reviewed 09/24/2025 states:The facility will provide pulse oximetry in accordance with professional standards of practice as outlined by Lippincott procedures.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record reviews, facility documentation, staff and resident interviews, and policy and procedures, the facility failed to ensure that medications were secured in a locked storage area and were accessible only to authorized personnel for Residents #27 and #66. The universe was 125, and the sample size was 2. Findings include: -Regarding Resident #66: Resident #66 was admitted on [DATE], with diagnoses that included type 2 diabetes mellitus, venous insufficiency, and end-stage renal disease. A quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview of Mental Status (BIMS) score of 14, indicating intact cognition. The assessment revealed no indicators for mood or behavior. Further review revealed the resident is at risk for developing pressure ulcers and skin injuries. The resident was always incontinent of bowel and bladder. During initial screening, an observation conducted on June 9, 2026, at 10:27 a.m. revealed a container of Coloplast Hydrophilic Wound Dressing Ointment located at the resident's bedside on the windowsill. An observation was conducted on June 9, 2026, at 10:42 a.m. A Certified Nursing Assistant (CNA/Staff #142) was observed entering the resident's room to provide care. An interview was conducted on June 9, 2026, at 10:51 a.m., with Licensed Practical Nurse (LPN/Staff #108). Staff #108 observed the wound dressing ointment at the windowsill. She stated the wound dressing ointment should not be kept at the resident's bedside and should only be administered by a nurse. She stated the risks associated with leaving the ointment in the room are that a Certified Nursing Assistant (CNA) may accidentally use the dressing as a barrier cream and place the resident at risk for infection. A physician's order dated June 11, 2026, at 9:55 a.m. revealed an order for TRIAD cream application to the wound bed on the right buttock and cover with bordered foam dressing. The Medication Administration Record and Treatment Administration Record (MAR/TAR) for June 2026 revealed that the TRIAD cream treatment was administered by licensed nursing staff. An interview was conducted on June 11, 2026, at 11:20 a.m. with a Wound Care Nurse (Staff #74). Staff #74 stated that Hydrophilic Wound dressing is used for treating open wounds, particularly those that are draining. She stated that the medication is used to dry out the wound and promote healing. She stated that this should be applied by nursing staff only. The medication should not be kept at the resident's bedside. She further stated the resident is currently receiving treatment for a skin tear and abrasion on the right lower leg. She stated that the hydrophilic dressing was not included in the current orders. She stated that most wound care is scheduled during the day shift, Monday through Friday. She further stated that wound care medications are stored in the medication cart, which is (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	locked. She stated access to these medications is limited to authorized personnel. She also stated nurses are to return the supplies and medications to the medication rooms. She stated that all nurses are responsible for applying wound care treatments and providing comprehensive care to all residents within the facility. She further stated that the risk associated with leaving medication at the resident's bedside could lead to improper application, and the medication must be applied by nursing staff to ensure safety and effectiveness. An interview was conducted on June 11, 2026, at 10:21 a.m., with (LPN/Staff #61). She stated nurses administer topical medications and store them in the medication storage room. She stated medications should never be stored in a resident's room. She stated the risks associated with medications being left in resident rooms included rashes, overmedication, sickness, and medication interference. An interview was conducted on June 11, 2026, at 10:35 a.m., with a Certified Nursing Assistant (CNA/Staff #57). Staff #57 stated that medications should never be stored in resident rooms. He stated that if staff observed medication in a resident's room, they would notify nursing staff. He stated risks included another resident taking the medication or accidentally dropping the medication on the floor. An interview was conducted on June 12, 2026, at 11:25 a.m., with the Director of Nursing (DON/Staff #14). The DON stated that medications and treatments are not to be left at the bedside and that nursing staff routinely monitor resident rooms. She stated residents may only self-administer medications if a physician order is obtained and an interdisciplinary team assessment determines the resident is capable of safe self-administration. The DON stated that medications and treatment supplies are expected to be stored in the medication cart or medication room. She further stated wound care products, ointments, and similar treatment items should not be kept in resident rooms, and staff would be expected to remove them if found. She stated the risks of having ointments or medications at the bedside could result in a resident taking the medication by mouth and could cause a stomachache. -Regarding Resident #27: Resident #27 was admitted on [DATE], with diagnoses including acute embolism and thrombosis, quadriplegia, and osteoarthritis. A quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The assessment revealed no indicators for mood or behavior. Further review of the MDS revealed the resident had frequent pain, which occasionally interfered with sleep and daily activities, and a reported pain intensity of 7 out of 10. A care plan dated April 30, 2026, revealed no care area for medication self-administration. Further review of the care plan revealed a focus area for knee pain and chronic arthritis. Interventions included observing and reporting complaints of pain and administering analgesics as ordered by the physician. A review of the resident's electronic health record (EHR) indicated no assessment for self-administration. (continued on next page)

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	06/12/2026

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During initial screening, an observation was conducted on June 9, 2026, at 10:45 a.m., in resident #27's room. A container of Icy Hot topical analgesic was observed on the resident's bedside table. The resident stated she used the product for aching bones, applied it herself, and believed staff were aware she had it. An interview was conducted at 10:48 a.m. with Licensed Practical Nurse (LPN/Staff #108). Staff #108 observed the Icy Hot ointment at the resident's bedside and stated the resident was not supposed to have the Icy Hot ointment in her room. She stated the risks of having the ointment at the bedside are that the resident could put too much on, become confused, and eat the ointment. She further stated the ointment is to be kept by nursing staff and requires a physician's order. She stated that if the resident wanted to use Icy Hot, the nurse would need to administer it. A physician's order dated June 9, 2026, at 11:15 a.m. revealed an order for Icy Hot PM External Lotion 7.5% Menthol Topical Analgesic application to the lower back topically every 12 hours as needed for pain. A review of the Medication Administration Record and Treatment Administration Record (MAR/TAR) revealed that the resident had no documented administration of Icy Hot in June 2026. An interview was conducted on June 11, 2026, at 10:21 a.m., with (LPN/Staff #61). She stated nurses administer topical medications and store them in the medication storage room. She stated medications should never be stored in a resident's room. She stated the risks associated with medications being left in resident rooms included rashes, overmedication, sickness, and medication interference. An interview was conducted on June 11, 2026, at 10:35 a.m., with a Certified Nursing Assistant (CNA/Staff #57). Staff #57 stated that medications should never be stored in resident rooms. He stated that if staff observed medication in a resident's room, they would notify nursing staff. He stated risks included another resident taking the medication or accidentally dropping the medication on the floor. An interview was conducted on June 12, 2026, at 11:25 a.m. with the Director of Nursing (DON/Staff #14). The DON stated that medications and treatments are not to be left at the bedside and that nursing staff routinely monitor resident rooms. She stated residents may only self-administer medications if a physician order is obtained and an interdisciplinary team assessment determines the resident is capable of safe self-administration. The DON stated that medications and treatment supplies are expected to be stored in the medication cart or medication room. She further stated wound care products, ointments, and similar treatment items should not be kept in resident rooms, and staff would be expected to remove them if found. The DON stated that if a resident possessed Icy Hot, nursing staff would be expected to secure the product and obtain appropriate physician orders if its use was indicated. She stated that having ointments or medications at the bedside could lead a resident to take the medication by mouth, causing a stomachache, or to apply the ointment to their face, which could cause numbness and require saline drops to reduce it. Review of the facility policy titled Self-Administration of Medication, revised 10/01/2021 and reviewed on 09/15/2025, revealed the facility will ensure each resident who requests to self-administer medications is assessed by the interdisciplinary team (IDT) to determine if the resident is safe to self-administer medications. The facility will determine through an interdisciplinary assessment if the resident is able to either safely administer medications that are requested from a (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	central location, or the resident is able to safely store the medication in a secure area in their room, and safely administer the medication as prescribed. Review of the facility policy titled Administration of Medications, revised on 02/13/2023 and reviewed on 09/09/2025, revealed the facility will ensure medications are safely and appropriately administered per physician order to address residents' diagnoses and signs and symptoms.