STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035141	A. Building B. Wing	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Health Care Center	1300 South Street Globe, AZ 85501

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, facility documentation, and policy review, the facility failed to ensure one of five sampled residents (Resident #36), was not administered pain medications outside provider-ordered parameters. This deficient practice places residents at risk for adverse drug reactions. The sample size was 5. The universe was 68. -Regarding Resident # 36 Resident # 36 was admitted to the facility on [DATE] with conditions that included Type 2 Diabetes Mellitus without complications, pressure ulcer of the right heel, and acute osteomyelitis of the right ankle and foot. Review of the quarterly Minimum Data Set, dated [DATE], revealed the resident had a Brief Interview Mental Status score of 15 indicating he was cognitively intact. The assessment indicated the resident received as needed (PRN) opioid therapy, and non-medication interventions for pain. The assessment failed to reflect the resident history of substance use disorder. An order for Acetaminophen 325 mg, dated October 20, 2025, instructed the staff to give two tablets every 6 hours as needed for a pain level 1-3; not to exceed 3 grams every 24 hours. A care plan initiated on October 20, 2025, identified the resident as being at risk for elopement and negative health outcomes related to continued substance use while in the facility. Interventions included administering medications as ordered and monitoring for side effects and potential drug interactions related to medication-assisted treatment (MAT). A care plan initiated on October 21, 2025, identified the resident as experiencing pain and discomfort related to a right heel wound. An intervention included evaluating the effectiveness of pain management interventions. Regarding Hydrocodone-Acetaminophen: An order for Hydrocodone-Acetaminophen (opioid) 5-325 mg (milligrams), dated November 8, 2025, instructed staff to give one tablet every four hours as needed for pain intensity 4-10 and to hold if the resident was drowsy. Review of the January 2026 Medication Administration Record (MAR) revealed Hydrocodone-Acetaminophen was given outside of the ordered parameter for a pain level of 1. Review of the February 2026 MAR revealed Hydrocodone-Acetaminophen revealed Hydrocodone-Acetaminophen was given outside of the ordered parameter on February 4, 2026 with a pain level of 0; and on February 7, 2026, with a pain level of 1. Regarding Acetaminophen: An order for Acetaminophen 325 mg, dated October 20, 2025, instructed staff to administer 2 tablets by mouth every 6 hours as needed for pain intensity 1-3, not to exceed 3 grams in 24 hours. Review of the January 2026 MAR revealed Acetaminophen was given outside of the ordered parameters on the following dates: January 6, 2026 with recorded pain level of 6January 9, 2026 with recorded pain level of 6January 10, 2026 with recorded pain level of 7January 19, 2026 with recorded pain level of 6January 20, 2026 with recorded pain level of 0January 21, 2026 with recorded pain level of 5January 25, 2026 with recorded pain level of 0January 26, 2026 with recorded pain level of 5 Review of the February 2026 MAR revealed Acetaminophen was given outside of the ordered parameters on the following dates:February 4, 2026 with a recorded pain level of 4.February 22, 2026 with a recorded pain level of 5. An interview was conducted on February 27, 2026 at 9:59 a.m. with Licensed Practical Nurse (LPN/Staff #95). The LPN stated that the administration outside of parameter with a resident with SUD can place the resident at higher risk for addiction and respiratory distress. The LPN revealed that medications are to be given according to provider order, and any concerns about the (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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	order should have been followed up with the provider. An interview was conducted on February 27, 2026, with the Director of Nursing (DON/Staff #15) in the presence of the Executive Director (ED/Staff#110) at 10:13 a.m. During the interview, the DON revealed having the opportunity to review the resident's January and February 2026 MARs, and had already emailed the compliance officer, a listing of the occurrences when Hydrocodone-Acetaminophen and Acetaminophen were administered outside of the ordered parameters. The DON stated she could not locate documentation in the resident's record authorizing administration outside of the provider's orders for the dates identified. The DON further stated that administering medications outside of ordered parameters for a resident with a history of SUD could place the resident at increased risk for adverse outcomes. The DON revealed that the nurse responsible has been coached and re-educated on the facility's policy of medication administration. The DON stated that the identified incidences of receiving medication outside of provider parameters without proper documentation failed to meet facility expectation. Review of the Administration of Medications policy, revised February 13, 2023, required the staff to note the resident's history and any parameters around drug administration. The policy in addition, referred to opioids as a high alert medication.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, facility documentation, and policy review, the facility failed to ensure that a valid advance directive and an updated medical directive were completed and readily accessible for two residents (Residents #5, #22). The deficient practice could result in residents receiving services that are not in accordance with their wishes, and they may be unaware of services that may or may not have been provided to the resident. The sample was 4. The universe was 68.Findings include:-Regarding Resident #5:Resident #5 was initially admitted on [DATE], and re-admitted on [DATE], with the diagnosis that included malignant neoplasm of prostate; acute kidney failure, unspecified; hypothyroidism, unspecified; neuralgia and neuritis, unspecified; primary open-angle glaucoma, bilateral, mild stage; benign prostatic hyperplasia with lower urinary tract symptoms; and muscle weaknessA POLST (Physician Orders for Life-Sustaining Treatment) form dated [DATE], revealed that Resident #5 selected to have no CPR (cardiopulmonary resuscitation) if they were to have no pulse or not breathing. The POLST also revealed that Resident #5 selected to have selective treatment with the goal to attempt restorative function while avoiding intensive care and resuscitation efforts. The form was signed by the resident's representative, and a facility staff member., A care plan goal with the initiation date of [DATE], revealed that Resident #5 had an advance directive POLST, and that the resident's advance directive would be honored.An order dated [DATE], revealed that Resident #5 had a full code status, indicating that if a resident's breathing or heart stops, medical staff will use all available life-saving measures to revive them. Despite the POLST form dated [DATE] requesting to avoid resuscitation efforts.A Prehospital Medical Care directive dated February 25, 2026, revealed in the event of cardiac or respiratory arrest the resident refused any resuscitation measures.An order dated February 26, 2026 was placed in the resident's clinical record that indicated Do Not resuscitate.On February 25, 2026, at 2:06 PM, a review of physical code status forms located in the nursing station was conducted with an RN (Staff #20) and an LPN (Staff #57) who stated that should a resident wish to request to have a DNR/DNI, the facility policy will require the signatures of a provider, a witness, the resident, or a representative of the resident on the prehospital medical care directive orange advance directive form. The RN also stated that should a representative provide verbal consent, this same prehospital medical care directive orange advance directive form will require a two-person signature as the witness to the verbal consent. Regarding Resident #5, The RN and LPN were not able to locate an advance directive in the electronic health records, as well as within the nursing stations' resident binder. The RN confirmed that a POLST dated [DATE], had been in the records of Resident #5 and stated that the resident was DNR; however, The RN could not locate a prehospital medical care directive orange advance directive form with the above-listed signatures or documentation that supported the order for full code, as it states within the resident's active orders, and would need to be confirmed with the ADON (assistant to the director of nursing). Regarding Resident #7, Staff #20 and #57 were not able to locate an advance directive in the electronic health records, as well as within the nursing stations' resident binder. Staff #20 confirmed that the lack of a POLST and a prehospital medical care directive orange advance directive form with the above-listed signatures or documentation that supported the order for DNR/DNI was not within their facility's expectations. Regarding Resident #22, Staff #20 and #57 were not able to locate an advance directive and a POLST in the electronic health records, as well as within the nursing stations' resident binder. Staff #20 confirmed that the lack of a POLST and a prehospital medical care directive orange advance directive form with the above-listed signatures or documentation for DNR/DNI was not within their facility's expectations.At 7:45 AM, on February 26, 2026, an interview with Resident #5 was conducted. Resident #5 stated he could not recall signing the said prehospital medical care directive orange advance directive form, nor could he recall a (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conversation with a staff member the day before regarding the prehospital medical care directive orange advance directive form and his wishes regarding life resuscitation interventions in the event of an emergency. At 8:28 AM, on February 26, 2026, the ADON (Staff #67) provided a newly updated prehospital medical care directive orange advance directive form for Resident #5 with a new signature provided by the resident and the social services director (Staff #14) as the witness, with the date of February 26, 2026. The healthcare provider and the original signature of the resident were still present on this form. A newly updated prehospital medical care directive orange advance directive form for Resident #7 was also received, with a new note that the resident's representative was reached out to with two witnesses confirming the verbal consent over the phone, and the social services director (Staff #14) as the witness, with the date of February 26, 2026. The healthcare provider's signature was still present on this form. Staff #67 also stated that the social services director was an acceptable witness for the prehospital medical care directive orange advance directive form.Regarding Resident #22:Resident #22 was admitted on [DATE], with the diagnosis that included personal history of traumatic brain injury; hypertension; gastro-esophageal reflux disease without esophagitis; tremor; long term use of anticoagulants; long term use of insulin; schizoaffective disorder, bipolar type; Guillain-Barre syndrome; generalized anxiety disorder; bipolar disorder, current episode depressed, mild or moderate severity; unspecified dementia, unspecified severity, with other behavioral disturbance; neoplasm of unspecified behavior of bone, soft tissue, and skin; protein-calorie malnutrition; dyspnea, unspecified; type 2 diabetes mellitus with diabetic polyneuropathy. Per the resident's face sheet, there is no evidence of additional information that states if Resident #22 had been in the facility on a date before [DATE].An order dated [DATE], revealed that Resident #22 had a DNR and no feeding tube status, indicating that if a resident's breathing or heart stops, medical staff will not complete CPR if the patient's breathing stops or if the patient's heart stops beating.An Advance Directive Statement Form, dated [DATE], revealed that should Resident #22 be unable to accept nutrition by mouth, they would not want nutrition to be administered via feeding tube; or unable to accept hydration by mouth, they would want hydration to be administered via intravenous line; or if a physician were to believe they were in pain, they would want to be given enough pain medications to eliminate apparent pain, even if the physician believes it posed a risk of depressing respiration and hastening their death; or in the event of cardiac arrest, they would not want CPR measures to be taken; or in the event their medical status changes or worsens to a terminal or irreversible condition, they would want to be transferred to the hospital; and if their heart stops functioning, they would not want defibrillation performed CPR to be initiated; and would want a blood transfusion if necessary and would not life support via mechanical ventilation.Resident #22's care plan revealed no evidence of a focus or interventions related to advance directives following admission on [DATE]. However, a revision to a care plan goal stating that the resident has an advance directive for CPR, do not shock, and DNI, was revised on [DATE], that stated that the resident's advance directives will be honored.A POLST form, dated February 25, 2026, revealed that the POLST form was voluntary, and was a medical order, no an advance directive. The form was marked as Yes, CPR, attempt resuscitation. Completion information on the form included that the resident's advance directive was reviewed to confirm no conflict with POLST orders, and that no advance directive exists. Despite the [DATE] Advance Directive Statement Form, that indicated in the event of cardiac arrest, they would not want CPR measures to be taken. There was no additional evidence regarding the discussion of an advance directive for Resident #22. An interview was conducted on February 25, 2026, at 10:47 AM, with an LPN (Staff #95) who stated a resident's code status could be found on the electronic chart of the resident, as well as located in the book located at each nursing station. Staff #95 also stated that should a resident's code status change, the expectation is to have that requested within the resident's electronic chart and physical book located at their nurses' station. Should an advanced directive be incorrect, the Staff #95 stated that staff could go against the wishes of the resident's rights.An interview was conducted on February 25, (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2026, at 1:46 PM, with a CNA (Staff #43), who stated that in a time of emergency, she will ask a nurse for the code staff of a resident if they are unsure of a resident's code status. The CNA also stated that there is a list of code statuses for all residents on their unit in the back of the nurses' stations, or they would also look at the electronic health record. The CNA stated that reviewing and understanding what a resident's code status is important because it will be against the resident's medical care plan if staff do not follow it. The CNA also stated that should the forms and the list located in the nurses' station not match the resident's health records, they would proceed with a full code status procedure until the correct code status is confirmed, despite the possibility that a resident can get hurt and receive care against their wishes.On February 25, 2026, at 2:26 PM, an interview was conducted with the ADON (Staff #67), who stated that the advance directive process can be completed by any floor nurse, and once an advance directive has been documented and signed by all parties, it will then be provided to the health information manager/medical records director. The ADON also stated that should the documents be completed incorrectly, they are given to her to complete. The ADON also stated that should a resident request to be a DNR/DNI, the required documentation per state guidelines for that request would be to have accurately filled out and attached to the prehospital medical care directive orange advance directive form so that in the event of an emergency, those documents can be provided to an EMT. The ADON stated that if both the prehospital medical care directive orange advance directive form and POLST were incorrectly completed, and not readily accessible, treatment may be performed against a resident's wishes. On February 25, 2026, an interview was conducted with the Director of Nursing (DON/Staff #15), who stated that the facility adopted a new advanced directive process that requires a POLST form to be completed accurately and thoroughly, which should be completed on fuchsia paper, as well as a prehospital medical care directive orange advance directive form. The DON, stated that a complete and accurate advance directive should include a POLST with sections A, B, D, E, and F, which should be completed, with the expectation that the staff who is assisting with the completion of the form include their name and signature, as well as the completion date on the second page of the POLST. Should a resident want a DNR/DNI status, then a prehospital medical care directive orange advance directive form, with the signatures of a health care provider, the resident, or a representative of the resident, a witness or notary, not both, is required on this form. The DON stated that, should there be no advance directive in place, then staff is to follow through with a full code status. She also stated that should there be conflicting information, staff are expected to follow the most current form within the resident's records. Regarding Resident #5, The DON stated that due to the resident's most recent POLST form stating DNR, staff is expected to follow through with that wish, despite not having an orange advance directive form, and an active order stating full code. The DON further stated that the conflicting documentation within Resident #5's records was not within the facility's expectations. Regarding Resident #22, the DON stated that due to the resident's active order of DNI and do not shock status, a POLST and a prehospital medical care directive orange advance directive form should have been completed and within their records. The DON further stated that not having any documentation to support the active order of DNI and to not to shock, within Resident #22's records, was not within the facility's expectations.The prehospital medical care directive (DNR) document, last updated in [DATE], revealed that this document must be on paper with an orange background and that it should be displayed as visibly as possible for first responders. The document further revealed that the prehospital medical care directive was to be signed by the patient and their doctor, which informs EMTs or hospital emergency personnel not to resuscitate the patient, and not use equipment, drugs, or devices to restart the heart or breathing, and not intervene with necessary medical interventions to provide comfort care or to alleviate pain, and must be signed by the patient, in front of a witness or notary. The document also revealed that a health care provider and a witness or notary must also sign this form. Under Arizona law, a prehospital medical care directive or DNR must be on letter-sized paper or wallet-sized paper on an orange background to be valid.A policy titled (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	?Advance Directives and Advance Care Planning', last reviewed on [DATE], revealed that Residents have the right to self-determination regarding their medical care. The policy also revealed that the patient's advance directives should be implemented if necessary, assuming those wishes are legally valid and permissible by State law. The policy also states that each time a resident is admitted to the facility, quarterly, and when a change in condition is noted in the resident condition, the facility should review the advance directive and advance care planning information, and, that the social services director or designee should document this conversion in the medical record and assist as needed with updating the documents that need revision in accordance with state and federal requirements. The policy also revealed that social services ensures that a copy of the advance directive is obtained for the resident's medical record and verifies that there is an appropriate physician's order in the resident's medical record as well. The policy also revealed that the information is reviewed or updated, as appropriate, at least quarterly or more frequently if there is a significant change in the resident's medical condition, and that each quarter, the care plan team should also review with the patient to ensure that they are still in line with the wishes of the resident, and that should at any time a DNR order be revoked, that discussion would need to be documented in the resident's chart as such with the consent of the resident or the resident's representative.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, staff interviews, facility documentation, National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) guidance, and facility policy, the facility failed to ensure that physician insulin administration orders for notification of abnormal blood glucose results were followed for two of sampled residents (#4 and #36). This deficient practice placed residents at risk for delayed treatment or inadequate management of blood glucose levels. The universe was 68.Findings Include: -Regarding # 36 Resident # 36 was admitted to the facility on [DATE] with conditions that included Type 2 Diabetes Mellitus without complications, Stage 4 Chronic Kidney Disease (Severe), long-term (current) use of insulin, pressure ulcer of the right heel, and acute osteomyelitis of the right ankle and foot. An order dated October 20, 2025, directed the staff to notify the provider and administer 12 units of Humalog Solution 100 units/milliliters (ml), for glucose levels of 351 or greater. A Diabetes Mellitus care plan initiated October 21, 2025, instructed the staff to obtain blood sugar checks, and administer medications as ordered. However, the care plan did not reflect the sliding scale insulin orders, or the requirement to contact the provider when glucose exceeded 351. Review of a lab report, dated December 25, 2025, revealed the resident had a Hemoglobin A1C level of 7.8%. The report stated that the result exceeded the American Diabetes Association (ADA) guidelines recommended goal. The report also revealed the resident's average glucose was 177. Review of the December 2025 Medication Administration Record (MAR) revealed that blood glucose levels reached 351 mg/dL or greater, requiring 12 units of Humalog insulin per sliding scale orders; however, the clinical record did not document that the provider was contacted regarding these findings on the following dates: December 24, 2025 December 25, 2025 December 26, 2025 December 30, 2025 December 31, 2025 Review of the admission Minimum Data Set (MDS), dated [DATE], revealed the resident had a Brief Interview Mental Status (BIMS) score of 15 indicating he was cognitively intact. The assessment also indicated the resident received insulin therapy on a daily basis. Review of the January 2026 Medication Administration Record revealed that blood glucose levels reached 351 mg/dL or greater, requiring 12 units of Humalog insulin per sliding scale orders; however, (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the clinical record did not document that the provider was contacted regarding these findings on the following dates: January 4, 2026 January 5, 2026 January 7, 2026 January 16, 2026 January 17, 2026 January 22, 2026 Review of the February 2026 Medication Administration Record revealed that blood glucose levels reached 351 mg/dL or greater, requiring 12 units of Humalog insulin per sliding scale orders; however, the clinical record did not document that the provider was contacted regarding these findings on the following dates: -February 2, 2026 -February 18, 2026 -February 19, 2026 -February 23, 2026 An interview was conducted on February 27, 2026, at 8:10 a.m. with the Activities Director, who is also a qualified Certified Nursing Assistant (CNA/Staff #82). Staff #82 stated that CNAs are responsible for performing blood sugar monitoring and are instructed to report values of 60 mg/dL or lower and 170 mg/dL or higher to the nurse. The CNA explained that when a resident's blood sugar becomes too high, the resident may exhibit symptoms such as feeling hot, clammy, flushed, and experiencing altered mental status. The CNA further stated that she believes the nurse reports elevated blood glucose findings to the provider so that appropriate interventions can be implemented to prevent potential complications, including shock. An interview was conducted on February 27, 2026, at 8:55 a.m. with the Registered Dietitian (RD/Staff #111). The RD stated that symptoms of hyperglycemia (elevated blood sugar) can include confusion, syncope, and heart palpitations. The RD emphasized that if a resident is on a sliding scale and the provider is to be contacted for blood glucose levels that reach a specified threshold, this protocol must be followed. Failure to notify the provider can worsen symptoms and increase the risk of complications associated with diabetes. An interview was conducted on February 27, 2026, at 9:59 a.m. with Licensed Practical Nurse (LPN/Staff #95). The LPN stated that signs and symptoms of hyperglycemia can include excessive sweating, malaise, and coma. The LPN further stated that when a sliding scale is ordered for a resident, and the instructions specify that the provider should be contacted for certain blood glucose levels, the provider must be contacted, as per facility expectation. The LPN explained that failure to (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notify the provider can place the resident at risk for hospitalization if blood glucose becomes too high and the resident becomes symptomatic. An interview was conducted on February 27, 2026, at 10:13 a.m. with the Director of Nursing (DON/Staff #15) in the presence of the Executive Director (ED/Staff #110). The DON stated that the resident's clinical record for December 2025 to February 2026, had been reviewed and a report listing occurrences where the provider was not notified for blood glucose levels ≥351 mg/dL had been emailed to the compliance officer. The DON confirmed that, according to provider orders, the provider should have been contacted in each instance, and the failure to do so did not meet facility expectations. The DON further stated that no documentation could be found showing that the provider had been contacted for these elevated readings for additional orders or instructions. The DON stated that some provider orders require notification only if the resident is symptomatic, however in this case, notification was required regardless of symptoms. The DON revealed that a failure to notify the provider, could result in the resident not receiving the best care for glucose control -Regarding Resident #4 Resident #4 was re-admitted to the facility on [DATE], with diagnoses that included type 2 diabetes mellitus, long term use of insulin, and acute kidney failure. A care plan revised on August 8, 2023, revealed that the Resident #4 has diabetes mellitus and the intervention included checking blood sugar as ordered. A physician order dated November 28, 2025 was written for Humalog solution 100 UNIT/ML (Insulin Lispro), to inject subcutaneously before meals and at bedtime for diabetes as per sliding scale: if 0 - 200 = 0 units; 201 - 250 = 2 units; 251 - 300 = 4 units; 301 - 350 = 8 units; 351+ = 10 units and call medical director. A December 2025, Medication Administration Records (MAR) revealed no evidence that the physician was notified when the blood sugar (BS) was above 351 on following dates: -December 1, 2025, at 4:30 p.m., BS was 454 and at 8 p.m., BS was 359 -December 2, 2025, at 11:30 a.m., BS was 524, at 4:30 p.m., BS was 490, and at 8 p.m., BS was 390 -December 3, 2025, at 4:30 p.m., BS was 510, and at 8 p.m., BS was 382 -December 4, 2025, at 8 p.m., BS was 351 -December 5, 2025, at 6 a.m., BS was 431 A quarterly MDS (minimum data set) dated December 4, 2025, revealed that the staff assessed Resident #4 for mental status that revealed short and long-term memory loss. A physician order dated December 5, 2025 was written for Humalog solution 100 UNIT/ML (Insulin Lispro), to inject subcutaneously before meals and at bedtime for diabetes as per sliding scale: if 0 - 200 = 0 units; 201 - 250 = 2 units; 251 - 300 = 4 units; 301 - 350 = 8 units; 351+ = 10 units and call medical director. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A February 2026, Medication Administration Records (MAR) revealed an order of Humalog solution 100 UNIT/ML (Insulin Lispro), and an order start date of December 5, 2025, noting to inject insulin subcutaneously before meals for diabetes as per sliding scale: if 0 - 200 = 0 units; 201 - 250 = 2 units; 251 - 300 = 4 units; 301 - 350 = 8 units; 351+ = 10 units and call medical director. Further review of the MAR revealed no evidence that the physician was notified when the blood sugar (BS) was 449 on February 10, 2026, at 4:30 p.m. Progress notes reviewed from December, 2025, through January, 2026, revealed no evidence that the provider was notified when the blood sugar was above 351. An interview was conducted on February 27, 2026, at 8:15 a.m. with the licensed practical nurse (LPN, staff # 95) who stated that she worked in the facility for about a year conducting medication administration and providing insulin shots to residents. The LPN further stated that a resident's insulin order would have parameters on the chart indicating whether the resident was on low dose sliding scale, regular sliding scale or high dose. If a resident's sugar level was out of parameters then the provider would be notified and may give an order for an extra dose of insulin or may change the order. The LPN then reviewed the the blood sugar levels in the MAR for Resident #4 for the month of December 2025, and February 2026, and stated that the resident's blood sugar was really high for December 1 through December 5, 2025, and for February 10, 2026 and that the provider was not notified. The LPN also stated that the director of nursing (DON) reviews resident's charts for assessment or any changes. The LPN further revealed that the risk of not notifying the provider when a resident's blood sugar is too high, could lead to a potential for hospitalization. An interview was conducted on February 27, 2026, at 9:22 a.m., with the DON (staff # 15) who stated that nursing staff will take a resident's blood sugar and if the blood sugar was above the parameter, then nurses follow the order and notify the provider. The DON then reviewed the blood sugar levels for Resident #4 in the MAR for the month of December 2025, and February 2026, and stated that the blood sugar levels were really high for December 1 through December 5, 2025, and for February 10, 2026. The DON also reviewed the nursing notes and stated that the provider was not notified when blood sugar levels were high. The DON then stated that the risk of not notifying the provider and following the orders, included a risk for hyperglycemia. The DON also stated that she will educate her nurses and notify providers regarding change in insulin parameters. Review of the facility policy titled Administration of Medications, with a review date of September 9, 2025, revealed that every drug administered must have an order from the provider. The policy further revealed that it compares the order with the electronic medication administration record (eMAR) for accuracy. Per the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK)guidance, persistent blood glucose readings above the ordered sliding scale should be communicated to the provider so the treatment plan, medications, or sliding scale orders can be reviewed and adjusted as needed to maintain safe, effective diabetes management The facility's Nursing Documentation policy, facility reviewed August 29, 2025, revealed the facility will ensure nursing documentation is consistent with professional standards of practice, the state nurse practice act, and any state laws governing the scope of nursing practice

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, staff interviews, and policy review, the facility failed to implement their policy regarding reporting allegations of abuse and neglect and to ensure that allegations of neglect were reported within a timely manner to the state agency for one of one sampled resident (Resident #32). The deficient practice could result in further instances of allegations of neglect not being reported and investigated promptly, and in accordance with professional standards. The universe was 68.Findings include:Resident #32 was admitted on [DATE], with the diagnosis that included type 2 diabetes mellitus; depression; retention of urine; benign prostatic hyperplasia without lower urinary tract symptoms; muscle spasm; and morbid obesity due to excess calories.A care plan initiated on February 23, 2024, revealed a focus for risk of change in mood or behavior due to medical condition. Interventions included medications as ordered, initiated February 24, 2024.The care plan for risk of change in mood and behavior was revised on February 13, 2025 to include that the resident makes statements of untruths related to receiving medications on time. A review of a quarterly MDS (Medicare Minimum Data Set) assessment dated [DATE], revealed a BIMS (Brief Interview for Mental Status) score of 15 out of 15, which indicated intact cognition. The assessment also revealed that within the last 7 days before the assessment, Resident #32 felt down for two to six days; verbal behavioral symptoms and other behavioral symptoms not directed towards others occurred one to three days.On February 13, 2026, a behavior progress note revealed that the Resident told a medication technician, that he was being neglected and wanted to speak to a nurse right now. The progress note also revealed that the allegation was reported to the DON, who spoke to the resident and instructed staff to have 2 people in the room for care. however, there was no evidence that the allegation had been reported to the state agency.A care plan for risk of change in mood or behavior was revised on February 18, 2026 to include interventions for 2-person cares and medication pass.On February 20, 2026, a behavior progress note revealed that Resident #32 complained that he was not receiving his medications at night, and the resident stated that it is your fault. The nurse wrote that the ADON (assistant director of nursing) was notified that the resident accused staff of abusing and neglecting him. The nurse also relayed that the resident's medications were administered according to physician orders. Another behavior progress note dated February 20, 2026 revealed that cares in pairs was continuing.An interview was conducted on February 24, 2026, at 11:23 AM, with Resident #32, who stated that he felt that an LPN (licensed practical nurse/Staff # 32) had inflicted mental abuse on him, as evidenced by previous interactions that made Resident #32 feel less than a man. The resident also stated that he had increased anxiety when he was aware that the LPN would be on the upcoming shift, and that he had experienced anxiety attacks due to being scared of the LPN. Resident #32 further stated that he felt that he had been abused and neglected due to his race and did not understand why the staff would treat him that way. The resident stated that he had told the DON (director of nursing), but felt that the facility did not do anything about it. An interview was conducted on February 25, 2026, at 10:06 AM, with a CNA (certified nursing assistant/Staff #76) who stated that allegations of abuse and neglect, such as physically harming a resident, utilizing mean words towards a resident, taking the money of a resident, not listening to a resident's needs, and ignoring call lights and walking way to not provide care to a resident, such as closing the door; are examples of instances of abuse and neglect that are expected to be reported to their charge nurse The nurse is expected to report allegations shared by the aides to DON and up the chain of command. Regarding Resident #32, the CNA stated that the resident had reported alleged abuse and neglect to her, and had also reported the allegations to nurses; however, the CNA stated that the nurses told her that they were aware of the allegations and to let them handle the allegations, which she stated she did.An interview was conducted on February 25, 2026, at 10:47 AM, with an LPN (Staff #95) who (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated allegations of abuse and neglect, such as pushing, kicking, hitting someone, intimidation, verbal abuse such as comments made to make residents feel demeaned such as mocking a resident for their beliefs, how they look, racist comments, or not taking care of someone and or withholding care from a resident, are instances of abuse and neglect that are to be reported to the state agency within a two hour timeframe. The LPN also stated that if a resident were to report an allegation of abuse and neglect, she would ensure the safety of the resident and then ensure that the ADON, DON, or the Administrator are made aware of the allegation so that an investigation can be conducted. Regarding Resident #32, the LPN stated that the resident had reported allegations of abuse and neglect regarding his water restrictions and not receiving his medications as ordered by a specific staff member. The LPN stated that she reported the allegations to the ADON, DON, and the Administrator; however, they did not communicate to her what the facility intended to do with the allegation. An interview was conducted on February 25, 2026, at 1:46 PM, with a CNA (Staff #43) who stated that allegations of abuse, such as hitting, mental abuse, emotional abuse, verbal abuse, expressions of anger, and mean words, that could result in a resident feeling scared, would be required to be reported to the nurses. The CNA stated that that she had reported the comments made by Resident #32 to the nurses on the shift, and had been met with responses that indicated that they are aware of the comments and that they have already spoken to Resident #32. The CNA stated that she was unsure what was done regarding the concerns. A phone call interview was attempted on February 26, 2026, at 10:09 AM with the alleged perpetrator (AP/Staff #32); however, it was unsuccessful, and a voicemail could not be left as there were no identifiers within the voicemail.An interview was conducted on February 26, 2026, at 1:15 PM, with the DON (Staff #15), who stated that all allegations of abuse and neglect, including verbal abuse, are expected to be reported to the abuse coordinator to determine next steps. Regarding the progress note from June 21, 2024, regarding the allegation of neglect, the DON stated that she was not notified of the allegation, indicating that the allegation had not been reported to the state agency and had not been reported per their facility policy and regulatory requirements. The DON also stated that should this allegation have been reported to her, it would have been reported to the state agency per the facility policy and regulatory requirements. The DON also stated that allegations of abuse and neglect are expected to be reported per facility policy for the safety of the residents, with the risk of the alleged abuse and neglect not being followed through on. Regarding the progress note on February 13, 2026, the DON stated that the allegation of neglect had been reported to her, and although a discussion may have occurred, she acknowledged that she did not complete documentation of any discussions she had with Resident #32. The DON requested the support of the ADON (Staff #67), Social Services (Staff #14), and the Administrator (Staff #110). The DON, ADON, and Social Services stated that there had been a conversation regarding the allegations; however, they confirmed that documentation of the conversation had not been completed and had not met the facility's expectations. The DON then further stated that the conversation included the determination that the allegation did not meet their understanding of what abuse and neglect were, and decided that it did not require further action, which included reporting it to the state agency, as stated per their facility policy and regulatory requirements. Social Services stated that the resident had exhibited behaviors of increased depression and anxiety, and stated that they did not make the correlation between the allegations of abuse and neglect and the resident's increased behaviors of anxiety and depression. Social Services further stated that following the most recent allegation of abuse and neglect made by Resident #32 during the annual re-certification, law enforcement shared with the facility that Resident #32 reported the comparison of his ex-wife resembling the alleged perpetrator, which Social Services stated may have been a potential trigger. It had also been discussed that there had been an attempt to interview the alleged perpetrator, but it had been unsuccessful. A phone interview was conducted on February 26, 2026, at 2:53 PM, with an LPN (Staff #32), who stated the allegations of abuse and neglect would require understanding of who has made the allegation, and stated that, depending on the person, she (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would only then report that information to the DON and indicating that she will report or not report allegations and will determine what is reported, depending on the rapport built with the resident. The LPN also stated that she could not recall that the Resident had disclosed any allegations of abuse or neglect to her or against her, and denied that any allegations of abuse and neglect against her had been untrue due to her character. The LPN did not state what actions or behaviors of abuse and neglect could look like.A policy titled ?Abuse - Identification of Types', last reviewed May 6, 2025, revealed that it is the policy of the facility to identify abuse, neglect, and exploitation of residents, and misappropriation of resident property. The policy also revealed that abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, painful or mental anguish, which included verbal abuse. The policy also revealed that the facility will apply the following definitions to identify abuse, neglect, and exploitation, and that facility staff should report any suspected abuse, neglect, or exploitation to the Executive Director or Director of Nursing.A policy titled ?Abuse - Reporting and Response - No Crime Suspected', last reviewed May 7, 2025, revealed that the facility will report alleged violations related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source and misappropriation of resident property, and report the results of all investigations to the proper authorities within prescribed timeframes. The policy also revealed that the facility will ensure that all staff are aware of reporting requirements and support an environment in which staff and others report all alleged violations of mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of the resident's property. The policy also revealed that alp associates are mandated to immediately report suspected abuse and/or neglect to their immediate supervisor and/or facility representative, and must be reported to the supervisor regardless of the time lapse since the incident occurred. The policy also revealed that all alleged violations, whether oral or in writing, must be reported to the facility and to other officials in accordance with State law through established procedures.

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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 the interview, review of the clinical record, and review of facility policy and procedure, the facility failed to ensure PASARR (Preadmission Screening and Resident Review) screening and referral were accurate, completed, and submitted per professional standards for 2 of 5 sampled residents (Residents #36, #2). The deficient practice could result in residents' medically related social and emotional needs not being met. The sample size was 5 and the census was 68.-Regarding Resident # 36 Resident # 36 was admitted to the facility on [DATE] with diagnoses that include long term (current) use of insulin, Type 2 Diabetes Mellitus without complications, Stage 4 (Severe) Chronic Kidney disease, and unspecified protein-calorie malnutrition. Review of the Pre-admission Screening and Resident Review (PASRR) Level 1 Screening tool, dated October 20, 2025, submitted by the referring hospital, revealed no evidence reflecting the resident's history of anxiety or substance use disorder. The clinical record also revealed no evidence to reflect a PASSR Level 1 screening, generated by the facility. A care plan initiated on October 20, 2025, identified the resident as being at risk for elopement and negative health outcomes related to continued substance use while in the facility. Interventions included administering medications as ordered and monitoring for side effects and potential drug interactions related to medication-assisted treatment (MAT). Review of the elopement risk evaluation, dated October 20, 2025, revealed the resident had a history of Substance Use Disorder. A mood or behavior care plan, dated October 21, 2025, revealed the resident was to take medications as ordered due to risk for change in mood or behavior due to medical condition. The clinical record revealed no evidence to reflect direct care planning for anxiety. Review of the admission MDS (Minimum Data Set) dated October 23, 2025, revealed the resident had a BIMS (Brief Interview for Mental Status) score of 12, which indicated moderately impaired cognition. The assessment revealed no evidence reflecting the resident's history of anxiety, or use of antianxiety medications. An order was written for Hydroxyzine HCL (antianxiety) 10 mg, dated January 1, 2026, to be given 1 tablet as needed every 6 hours for anxiety. Review of the quarterly MDS, dated [DATE], revealed the resident had an active diagnosis of anxiety disorder, but did not take any anti-anxiety medications during the lookback period. An interview was conducted on February 27, 2026, at 8:10 a.m. with the Activities Director (Staff #82). The Activities Director stated that a correct PASSR helps staff develop appropriate interventions when a new resident is admitted . However, the Activities Director also indicated that even if the PASSR is not completely accurate, she believed she had the ability to figure out residents and their needs as they relate to the activities department. An interview was conducted on February 27, 2026, at 9:21 a.m. with the Social Services Director (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	responsibility to ensure that the process of submission and interventions is being monitored. Regarding Resident #2, the SSD stated that the diagnosis of bipolar disorder had been active at admission and that a PASARR level II should have been submitted. She further stated that there was no evidence in the resident's clinical record of a PASARR level II screening once it was determined that Resident #2 would have exceeded a stay of 30 days. The SSD also stated that an accurate and completed submission of a PASARR screening is important to ensure that, as a facility, staff understand the care a resident may need to be provided while at the facility. The SSD further stated that should a screening not be accurately completed and submitted for determination, the facility would fail to make sure a resident is in the right facility and receiving the appropriate placement and interventions. An interview with the DON (Staff #15) was conducted on February 26, 2026, at 11:53 AM. The DON stated that social services is responsible for ensuring that the PASARR is completed upon admission, and that the forms are typically obtained at the time of admission. The DON stated that discussions regarding PASARR completion generally occur when the auditor reviews the forms and brings any concerns to the team's attention. During the interview, the PASARR form was examined in detail, including the sections indicating that a new PASARR must be completed if a resident's stay is expected to exceed 30 days. The process for submitting the PASARR was also reviewed, including where the document must be sent and the required components of the submission. The DON also stated that staff were not previously aware of these requirements and advised that they would review this information with the SSD. The Arizona Health Care Cost Containment System (AHCCCS) Medical Policy Manual, regarding the PASARR level I screening tool, revealed that the nursing facility must update the level I at such time that it appears the individual's stay will exceed 30 days. A facility policy titled 'Pre-admission Screening and Resident Review (PASARR), last reviewed September 26, 2025, revealed that the facility will ensure that potential admissions are screened for possible serious mental disorders or intellectual disabilities and related conditions. The facility also revealed that a negative Level I screen permits admission to proceed and ends the PASARR process unless a possible serious mental disorder or intellectual disability arises later. The policy revealed that a positive Level 1 screen necessitates an in-depth evaluation of the individual by the state-designated authority, known as PASARR Level II, which must be conducted before admission to a nursing facility. The policy also revealed that facilities should look to their state PASARR program requirements for specific procedures, PASARR contact information for the SMH/ID authorities, and the State Medicaid Agency. There is no evidence within the policy that addresses any updates to a level I at such a time that it appears that the individual's stay will exceed 30 days.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interviews, and policy review, the facility failed to ensure that food was stored in accordance with professional standards for food safety. The deficient practice has the potential to place residents at risk for consumption of expired or unsafe food. The census was 68.Findings include:On February 24, 2026, at 9:20 AM, an initial observation of the facility kitchen was conducted with the Food Services Director (Staff #44) and Dietary Manager & Director (Staff #111). At 9:21 AM, a walk-through of Refrigerator #1 revealed an original packaging of what the Food Services Director identified as grapes, with no evidence of a received date, opened date, or used-by date. At 9:26 AM, a walk-through of Freezer #1 revealed an original packaging that the Food Services Director identified as pepperoni, with a received date of September 5, 2025, with no evidence of an opened date, or a used-by date. A box containing an opened original packaging was identified by the Food Services Director as vegan burger patties, received on January 7, 2026, with no evidence of an open date or used-by date. In the same box was an opened original packaging identified as a cod fish patty by the Food Services Director, with no evidence of a received date, opened date, or use-by date. At 9:31 AM, a walk-through of the dry storage revealed the original box potatoes identified by the Food Services Director, with no evidence of a received date. The Food Services Director identified a box of bananas, with no evidence of a received date and an original bag of tortilla chips with no evidence of a received date, an opened date, or a used-by date.Following the initial observation on February 24, 2026, at 9:37 AM, an interview was conducted with The Food Services Director (Staff #44) and Dietary Manager & Director (Staff #111). The Food Services Director stated that items stored in the refrigerator, freezer, and dry storage, are expected to have a label displaying the received date, open date, and, as applicable, a used-by date, in accessible view to staff, per the facility policy. The Food Services Director further stated that should a food item be kept opened in its original packaging, staff are expected to place the food item in a sealable container or package with the received date, an opened date, and a used-by date, per facility policy. During the same interview conducted on February 24, 2026 at 9:37 AM the Dietary Manager & Director (Staff #111) stated that staff are expected to maintain the received date on the original box/packaging that contain fresh produce, and to check for wholesomeness on a daily basis, and are expected to discard food items when determined to do so. The Dietary Manager & Director stated that the risk of not maintaining the food labeling expectations within the facility policy could result in serving perished foods, foodborne illness outbreaks, and inconsistency with the longevity, quality, or safety of food items.A policy titled ?Food Safety', last reviewed May 1, 2025, revealed that food is stored and maintained in a clean, safe, and sanitary manner following federal, state, and local guidelines to minimize contamination and bacterial growth. The policy also revealed that pre-packaged food is placed in a leak-proof, pest-proof, non-absorbent, sanitary container with a tight-fitting lid; and labeled with the name of the contents and date, when the item is transferred to the new container. The facility policy also revealed that a ?Use by Date' is noted on the label or product when applicable. The policy further documented that received food is labeled with the date received if not already indicated on the item, and, if multiple items are packaged in one box, each item will be individually dated with the receipt date. The policy also revealed that opened packages of food are resealed tightly to prevent contamination of the food item, and the ' use by date' will be used when applicable.