STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035146	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Paradise Valley	4065 East Bell Road Phoenix, AZ 85032

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 facility observations, resident and staff interviews, and review of the clinical record and facility policy, the facility failed to ensure that medications were stored securely and were not left unattended at residents' bedsides for two of 28 sampled residents (#53 and #40) or on top of the medication cart. The deficient practice could result in unauthorized access to medications, medication errors, misuse, allergic reactions, adverse drug effects or other harm.Findings Include: -Regarding Resident #53: Resident #53 was admitted to the facility on [DATE], with a diagnosis including: chronic obstructive pulmonary disease with (acute) exacerbation, atrial fibrillation, and pneumonia. A Care Plan initiated on January 12, 2026, revealed a focus for a physician's order for unsupervised self-administration of the following medications: Ventolin HFA 2 puffs every(Q) 4hrs (hours) prn (as needed). The care plan was revised on February 17, 2026, to include a physician's order for Voltaren gel 2 grams TID (three times a day), and Breztri inhaler 2 puffs BID (two times a day), date initiated on January 27, 2026, and revised on February 17, 2026. A Medicare 5-day Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 11, indicating resident #53 had moderate cognitive impairment. Further review of the MDS revealed no indicators for mood or behaviors, debility, cardiorespiratory conditions, or oxygen therapy. Review of the Order Summary Report revealed a physician's order for self-administration with a start date of February 17, 2026, for Voltaren Arthritis Pain External Gel 1 % (Diclofenac Sodium (Topical) and Budeson-Glycopyrrol-Formoterol Inhalation Aerosol160-9-4.8 MCG/ACT (Budesonide-Glycopyrrolate-Formoterol Fumarate). A medication self-administration review dated February 17, 2026, revealed an assessment for self-administration for two medications: medication #1 was for Breztri 2 puffs BID and medication #2 was for Voltaren Gel, apply 2 grams TID to the shoulder and left knee. However, this review was completed after the surveyor brought medications left unattended at the resident's bedside to the facility's attention. On February 17, 2026, at 12:32 PM, an observation and concurrent interview were conducted with the Resident (#53). Upon entering the resident's room, one prescribed Breztri inhaler 160mcg 28 (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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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	inhalations, and one tube of Voltaren gel 100 gm, was observed on the resident's vanity sink area, and one albuterol inhaler at the bedside. Resident #53 stated the nurse must have forgotten to take the Breztri inhaler and Voltaren gel medications with her, and that the inhaler stays on his bedside table in case he needs it. On February 17, 2026, at 12:32 PM, Registered Nurse (RN/Staff/#125) was called to the room and verified the above findings. The RN stated that Resident #53 had an order for self-administration for the Ventolin rescue inhaler, but did not have a current physician's order for self-administration for the Breztri inhaler or the Voltaren gel. The RN stated medications should not be left at the resident's bedside, and the risks of having medications left in the resident's room place other residents at risk who may take them, or the resident can use the medications without authorization. -Regarding Resident #40: Resident #40 was admitted to the facility on [DATE], with Chronic Obstructive Pulmonary Disease, Abdominal Aortic Aneurysm, without rupture, unsteadiness on feet, difficulty in walking, not elsewhere classified, muscle weakness (generalized). A review of the provider orders revealed no evidence of prescribed Lidocaine roll-ons to be administered. A care plan, initiated February 5, 2026, revealed no evidence of a focus or interventions for Lidocaine roll-ons. Further review of the care plan revealed a focus for left hip pain. Interventions included pain meds as ordered. There were no interventions for Lidocaine roll-ons. The MDS assessment dated [DATE], revealed resident's #40 BIMS score of 15, indicating cognition intact. Further review of the MDS revealed no indicators for mood or behaviors. On February 17, 2026, at 1:52 PM, an observation and concurrent interview were conducted with the resident (#40). Upon entering the resident's room, two 2.5 Lidocaine roll-on bottles were observed on resident #40's vanity sink area. The resident stated he had brought them with him on admission, and he keeps the Lidocaine roll-ons at the sink area and has used them since admission to the facility, and that no staff have said anything about them. The resident stated he had asked staff to roll the Lidocaine on his hip for pain, but could not recall who administered the Lidocaine roll-ons. On February 17, 2026, at approximately 1:58 PM, RN (Staff #125) was called to the resident's room and verified the above findings. The RN stated that the medications were not prescribed, informing the resident she would be removing them from the resident's room and placing them in the medication cart. She further stated she would return the medications to the resident's spouse. An interview was conducted on February 19, 2026, at 11:22 AM with an RN (Staff#53). The RN stated that the facility's process for resident self-administration is making sure that the resident can do it safely, can follow directions, check with the doctor, and determine if there is any resident decline. The RN stated that resident #53 had a decline in the last 24 hours and will be evaluated by hospice. The RN further stated that in the last 24 hours, resident #53 is no longer a candidate for self-administration as of today. The RN stated the process for determining that a resident can no longer self-administer their medications is to notify the unit manager, case management, and the provider, and inform them of a difference in the resident's cognition. The RN stated to ensure compliance with medication administration policies and procedures for self-administration, the (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident would call the nurse before using their medication, and steps are taken to monitor a patient after they take their medication by checking that the resident does rinse his mouth following administration. The RN stated the process for documenting medication self-administration to ensure accuracy is documenting on the MAR for self-administration and will assist with their medication schedules by leaving a piece of paper at the bedside with the times for use. The RN stated the facility had safety measures to ensure other residents do not have access to medications in residents' rooms, such as keeping a close eye on the resident's medications, especially with a rescue inhaler on the bedside table. The RN also stated the risks of leaving medication at the bedside could result in the resident taking too much of the medication, and with inhalers, their breathing could worsen even further and increase their anxiety. An interview was conducted on February 19, 2026, at 11:22 AM with RN (Staff #53). The RN stated that a medication is anything that can alter the mind and can either help the resident or not, depending on the medication. She stated route of medications can be administered by mouth, intramuscular, subcutaneously, intravenously, rectally or topically, and that this would also include over-the-counter medications such as Tylenol, stool softeners, and that Lidocaine roll-ons would also be considered as medications. The RN stated the risks of having medications at a resident's bedside could result in the potential for a resident to take or use too much, another resident can gain access to the medications, and if they have any allergies, there could be allergies. An interview and concurrent record review were conducted on February 19, 2026, at 1:22 PM with the Director of Nursing (DON/Staff #85). The DON stated the facility's process for resident self-administration is an assessment that is completed for self-administration, and from that assessment, it is determined if it is safe for the resident. The DON stated that the criteria for a resident to administer medications depends on the medication, and if the resident is cognitively aware to administer and to make sure that the resident understands when to administer. The DON stated the facility has safety measures to ensure other residents do not have access to medications in residents' rooms by ensuring the medications are put away and that each resident has their own nightstand to put away their medications for self-administration. The DON reviewed the physician orders for resident #53 and confirmed that self-administration assessment for the Voltaren gel 2 grams 3 times a day and Breztri 2 puffs twice a day was not completed until February 17, 2026, at 12:40 PM. The DON stated that the risks of leaving access to medications in a resident's room can place the resident at risk for not knowing how to administer the medication properly, and the risk of another resident gaining access to the medication when the resident's door is open. - Regarding medications being left unattended on top of a medication cart: On February 19, 2026, at 1:23 PM, during a medication administration observation, a licensed practical nurse (staff #196) removed metronidazole (an antimicrobial) 500 milligrams from the medication cart, placed the medication in a medication cup, and left the cup unattended on top of the medication cart. The nurse then walked away from the medication cart down the hall toward a resident's room, with her back to the cart. No residents were observed passing the cart at that time. An interview was conducted on February 19, 2026, at 1:39 PM with staff #196 who stated that leaving the medications unattended created a risk that someone could access medications that were not theirs. She further stated identified additional risks, including a resident experiencing an allergic reaction or physical adverse reactions such as drop in blood pressure. An interview was conducted on February 20, 2026, at 11:41 AM with the Director of Nursing (DON/ (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staff #85), who stated the facility's expectation is that no medications should be left unattended. When a nurse needs to step away, the medication should be stored in a safe place or taken with the nurse. She confirmed that leaving medications on top of a medication cart unattended is not a safe practice. The DON further stated that possible risks would vary depending on medication ingested and there would be a risk of side effects. Review of the facility policy titled Administration of Medications, Reviewed September 9, 2025, states, The facility will ensure medications are administered safely and appropriately per physician order to address the resident's diagnosis and signs and symptoms. Review of the facility policy titled Self-Administration of Medication, Reviewed September 15, 2025, states, The facility will ensure that 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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, and staff interviews, the facility failed to ensure appropriate infection control practices were implemented for 1 of 5 sampled residents (#136) regarding following contact precautions. The universe was 28 residents. The deficient practice could result in a spread of preventable illness to residents and staff. Findings include: -Resident #136 was admitted to the facility on [DATE], with diagnoses that included prosthesis, subsequent encounter, aftercare following joint replacement surgery, systemic inflammatory response syndrome (SIRS) of non-infectious origin without acute organ dysfunction.The physician order dated February 11, 2026 included usage of contact isolation precautions over and above standard precautions, related to ESBL- E. coli hip wound infection every shift.The care plan initiated on February 12, 2026 revealed a focus that the resident was on intravenous medications related to ESBL-E. coli (Escherichia coli producing extended-spectrum beta-lactamase) hip wound infection. Interventions in place for this focus included the use of Contact Isolation.The admission Minimum Data Set (MDS), dated [DATE], revealed that Resident #136 had an active diagnosis for infection/inflammatory reaction due to internal hip prosthesis, subsequent encounter.An observation of the room tray pass was conducted on February 17, 2026, at 12:41 PM for Resident #136's lunch tray. Observation revealed a certified nursing assistant (CNA/Staff# 60) entered a contact precaution room belonging to resident #136 without sanitizing hands or donning personal protective equipment (PPE) that was located at the entrance of the resident's room, as well as the signage on the wall indicating the room had contact precautions before entering the resident's room. The CNA was observed taking the room tray off the cart, entering the resident's room, and placing the resident's room tray on the bedside table. Further observation revealed that the CNA leaned to place the tray on the bedside table, his clothing came into contact with the resident's bed linen. The CNA exited the resident's room and was in the process of reaching for another tray when he was questioned regarding the observation.An interview was immediately conducted on February 17, 2026, at 12:44 PM with Staff#60 who stated that PPE for contact isolation should have been used when he entered Resident #136's room. The CNA stated that he got confused and he usually worked the other hall. He stated that he was helping pass out the room trays and he wasn't thinking when he went into the room. The CNA also stated he had received infection control training, and the risks of not donning PPE when entering a room with contact precautions is that he can transfer the germs to other residents. An interview was conducted on February 19, 2026, at 11:32 AM with CNA (Staff#69) who stated that staff are made aware of residents with precautions from the nursing report and signage on the residents' doors. The CNA also stated the process when entering a resident's room with contact precautions is to clean your hands, gown up before entering, and remove the PPE before leaving the room, then immediately wash your hands. The CNA further stated that staff are provided with infection control meetings and online training twice per month. The CNA stated that the risk of not using proper infection control precautions can cause the spread of infection and the risk of the resident's infection not getting better. An interview was conducted on February 19, 2026, at 2:43 PM with Infection Control Preventionist (IP/Staff #61) who stated that all staff are provided with training regarding infection control prevention through the Healthcare Academy, new hire orientation that discusses trends, and residents. The IP stated all staff are made aware of resident's on precautions when signage is placed, and their nurse will keep them informed. The IP also stated it is expected that all staff utilize infection control precautions when providing care and passing their room trays and to cleanse their hands, don the PPE outside of the room, doff the PPE before exiting the room, and sanitize or handwash their hands when they have exited the room. The IP stated that the risks of not following contact isolation precautions are spreading the infection to other residents or staff. The IP further stated We want to make sure it is contained. The IP also stated that she was aware of the incident (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and provided an immediate in-service to all staff working that floor, and also provided CNA #69 with individual training, and also discussed the concerns with not following infection control precautions. An interview was conducted on February 19, 2026, at 3:29 PM with the Director of Nursing (DON/Staff #85), who stated that staff should don PPE any time they are in residents' rooms or providing direct care for residents with orders for contact precaution. The DON identified the purpose of contact precautions as to decrease the risk for infection, especially for residents and staff.Review of the facility policy titled Contact Precautions revised December 30, 2025 states Contact precautions should be used when a resident develops signs and symptoms of a transmissible infection or has a laboratory confirmed infections that requires the use of contact precautions to prevent transmission of pathogens that are spread by direct (e.g., person-to-person) or indirect contact with the resident or environment (e.g., MRSA, scabies), and requires the use of appropriate PPE, including a gown and gloves.