STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035154	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Place at Glencroft	8641 North 67th Ave Glendale, AZ 85302

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, facility documents, and policy review, the facility failed to ensure 2 residents (#458 and #16) were free from abuse. The deficient practice resulted in residents being abused. Findings include: Related to resident #458- Resident #458 was admitted to the facility on [DATE] with diagnoses that included epilepsy, dementia, psychosis, and anxiety disorder. A review of the quarterly Minimum Data Set (MDS), dated [DATE] revealed Resident #458 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated she had moderate cognitive impairment. The same MDS also noted resident #458 displayed verbal behaviors directed towards others during the assessment period. A review of a care plan, revised on January 22, 2024 indicated Resident #458 had cognitive/communication deficits due to the progression of her dementia diagnosis. The goal was for Resident #458 to remember who she was and to be able to recognize her name. Interventions included asking her closed ended questions and allow additional time for responses to be formulated, anticipate her needs, assist her with making safe choices, and to watch for signs that she is becoming upset or uncomfortable and redirect as needed. A review of progress notes, dated June 3, 2024, indicated Resident #458 was increasingly accusing others of stealing items from her room. The notes also revealed Resident #458 was calling other residents names and was unable to be redirected. A second progress note, dated June 4, 2024, indicated that activities staff had informed the Registered Nurse (RN/Staff #168) that Resident #458 was accusing other residents of stealing her things and calling them names. The note reveals that Staff #168 had asked Resident #458 questions regarding if she had seen anyone take items from her room. However, it also noted that Resident #458 denied seeing people in her room but continued to yell and scream at other residents in the dining room. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A third progress note, dated June 5, 2024, at 8:15 AM, indicated that the nurse (Staff #168) was overheard telling Resident #458, loudly, stop, shut up, you cannot disrespect others like that. The note also indicated that Staff #168 was suspended pending investigation and the police department was notified. An interview was conducted on May 9, 2025 with the MDS coordinator, Staff #25, at 11:11 AM. Staff #25 shared that she had overheard Staff #168 yelling and telling a resident to shut up and that she had no right to talk to people like she was. Staff #25 indicated that she separated Staff #168 from Resident #458 and told Staff #168 that she couldn't talk to residents like that. Staff #25 then reported the situation to her supervisor. Staff #25 also indicated that Certified Nursing Assistant (CNA/Staff #147) and CNA #72 had heard the commotion when it happened. A telephonic interview was attempted with Staff #147 on May 9, 2025 at 11:03 AM but was unsuccessful. An interview was conducted with Staff #72 on May 9, 2025 at 11:20 AM. Staff #72 recalled Staff #168 raising her voice at Resident #458. Staff #72 explained that she was in her office when she heard the yelling and she had left her office to investigate along with Staff #25. Staff #72 indicated that Staff #168 said something like shut up, you don't say that, and she, along with Staff #25, had separated Staff #168 and Resident #458. Staff #72 recalled Resident #458 was accusing other residents of stealing her hair brush and her white sweater which is what started the incident. Staff #72 indicated that Staff #168 attempted to intervene but had gone about it the wrong way. An interview was conducted with the Director of Nursing (DON/Staff #41) on May 9, 2025 at 11:36 AM. Staff #41 indicated that the facility trains staff on abuse annually in addition to frequent reviews during staff meetings. Staff #41 indicated that she recalled Staff #168 and didn't recall who the resident was. However, she did remember that Staff #168 was yelling at a resident and that they had terminated the staff because they felt it was abuse. She also added that Staff #168 should have spoken to the resident in a better way regardless of the resident's dementia diagnosis. There were other ways to address the situation. When asked if the way Staff #168 spoke to the resident was within her expectations, Staff #41 replied that it was not and that her expectation was for staff to treat residents with dignity and respect because that is what they deserved. Staff #41 also shared that the risks to the residents, who are being abused, are being affected emotionally and psychologically. Residents are towards the end of their lives and it could make them question why they were here. Related to Resident #16- Resident #16 was admitted to the facility on [DATE] with diagnoses of anxiety disorder, major depressive disorder, congestive heart failure, and type 2 diabetes. A review of the annual MDS, dated [DATE] revealed the resident had a BIMS score of 15, which indicated the resident was cognitively intact. A care plan, initiated on November 3, 2024, indicated that Resident #16 can be fearful at times due to bad experiences with a former caregiver. The goal was for her to feel safe and secure. Interventions included building a rapport with staff, allowing Resident to share her feelings and fears, and to make referrals to support services as needed. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a progress note, dated April 7, 2025 at 12:43 PM, indicated that Staff #41 spoke with Resident #16 about an incident that took place where another resident (Resident #458) had thrown a cup of warm coffee on her. It was noted that there were no injuries. An interview was conducted on May 7, 2025 at 11:19 AM with Resident #16 in her room. When asked if she was harmed by other residents in the facility, Resident #16 identified Resident #458 by her first name. She explained that Resident #458 was calling her names and accusing her of stealing her money and T.V. Resident #16 added that Resident #458 had thrown cool coffee on her. She also shared that she had no injuries from the coffee being thrown on her. Related to Resident #458- Resident #458 was admitted to the facility on [DATE] with diagnoses that included epilepsy, dementia, psychosis, and anxiety disorder. A review of the quarterly Minimum Data Set (MDS), dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 09, which indicated the resident had moderate cognitive impairment. The same MDS assessment also noted resident #458 displayed hallucinations and verbal behaviors directed towards others during the assessment period. Resident #458 also rejected care at times as well. Review of physician's orders for Resident #458 revealed she was taking desvenlafaxine 50 milligrams (mg) extended release once a day, Divalproex (mood stabilizer) 250 mg three times a day, and Seroquel (antipsychotic) 300 mg twice a day. Review of Resident #458's care plan, revised on February 4, 2025 indicated that the resident had a history of making false statements and accuses other residents of going into her room and messing with her things. The goal was for Resident #458 to not make false accusations through the next review period. Interventions included not entering the day room if another resident, that she does not get along with, is in there. Review of progress notes revealed no information about the coffee throwing incident. However, in the progress notes preceding the incident date, it was noted that the provider recommended a change in Resident #485's antipsychotic medication. The recommendation was to cross taper from Seroquel to Lurasidone due to Resident #485's increased hallucinations, paranoia, and delusions. Review of a second progress note, dated April 7, 2025, a note written by Staff #41 at 12:20 PM. The note indicated that Staff #41 spoke with Resident #458 about the incident that occurred and Resident #458 had communicated that people were going into her room to steal her belongings. The note also indicated that Staff #41 and told the resident that her belongings were still in her room and were not stolen. Furthermore, the note indicated that Resident #458 was alert and oriented x2 with dementia and bipolar in addition to experiencing delusions and hallucinations. Review of the facility's 5-day (investigative) report, indicated that the altercation was witnessed by CNA/Staff #3. The report also indicated that Resident #458 asked Staff #3 to wheel her closer to Resident #16 so she could speak with her. When Resident #458 was moved closer to Resident #16, Resident #458 then threw coffee from her coffee cup at Resident #16. Staff #3 then removed Resident #458 from the area. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on May 7, 2025 with Staff #3 at 12:05 PM. Staff #3 confirmed that she was familiar with both Residents. Staff #3 shared that Resident #458 was drinking coffee in the common area and the coffee was not hot as she had been drinking the same cup of coffee for a while. After some time had passed, Resident #458 had seen Resident #16 and asked Staff #3 to take her towards Resident #16 to talk to her. When they had gotten closer to Resident #16, Resident #458 then threw her cup of coffee at Resident #16. Staff #3 recalled that Resident #16 did not scream when the coffee was thrown at her, she indicated that she thought Resident #16 was in shock at what had just happened. Staff #3 then wheeled Resident #458 to the Nurses' station. Staff #3 acknowledged that Resident #458 was agitated in the morning before having coffee but she was not sure why. Staff #3 also added that Resident #16 did not have any injuries from the coffee. An interview was conducted, with Staff #41, on May 9, 2025 at 1:46 PM. When asked what Resident #458's baseline for her behaviors were, Staff #41 indicated that she experiences hallucinations, delusions, has paranoia, will say that she sees bugs and people are stealing things from her. Staff #41 also added that they had recently been working with the Psychiatric Nurse Practitioner to adjust her medications to addressed her symptoms and they had also tried to have Resident #458 admitted to the Psychiatric unit at an acute care facility, however, when the Resident would be at the acute care facility, the behaviors and symptoms would stop. Staff #41 described the incident as follows: both residents were having afternoon coffee and were seated at two different tables. Resident #458 told a staff member that she wanted to talk to Resident #16. When the staff member pushed Resident #458 towards Resident #16, she threw her cup of coffee at Resident #16. Staff #41 added that they do not serve hot coffee, only lukewarm coffee for resident safety. She also added that Resident #16 did not have any injuries as a result of the coffee being thrown at her. Staff #41 indicated that when residents are abused, they are at risk of suffering from injuries, emotional dysregulation, and they might not feel safe at the facility. Review of the facility's policy, titled Freedom from Abuse, Neglect, and Exploitation, indicates that it was last revised on May 13, 2024. The policy defines abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include . resident to resident altercations.

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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 interviews, and policy review, the facility failed to ensure that one of three sampled residents (#20) had a PASARR (preadmission Screening and Resident Review) completed . The deficient practice could result in specialized services not being provided for residents who need it. Regarding Resident #20 Resident #20 was re-admitted to the facility on [DATE] with diagnoses that included bipolar disorder, anxiety, and heart failure. A care plan revised on May 04, 2025 revealed that the resident is being considered for a Level II PASARR, and that the paperwork has been submitted for review/determination. Further review revealed an approach dated February 10, 2023 for social services to review the PASARR as needed and during the annual review and recommendation of the level II will be followed- E.G routine psychological counseling. A Physicians order dated September 10, 2024 revealed an order for Trileptal tablet 150 mg for bipolar disorder. The quarterly Minimum Data Set (MDS) dated [DATE] revealed that a Brief Interview for Mental Status (BIMS) of 11, which indicated moderately impaired cognition. A review of the medical record revealed that the resident had a diagnosis of Bipolar disorder and that there was no evidence that the Level 1 PASRR had been updated/completed, despite the resident continuing to reside in the facility over 30 days. An interview was conducted on May 09, 2025 at 1:07 P.M with the Director of Social Services (SSD/#87) along with Social Worker (#68), and Director of Nursing (DON/ #41) present . Staff # 87 stated that for all residents upon admission they would review the residents PASARR and if there is no PASARR done for the resident one will be created for them. The Social Service Director stated that they would use the list of diagnoses on the PASARR to identify diagnoses relating to mental illness and intellectual disability. (SSD/#87) When a resident is at the facility for more than 30 days a PASARR level two will be completed. The Social Service Director further stated that social services will review with the interdisciplinary team (IDT) if the resident presents with behaviors like wandering out of the unit, aggression, combative, throwing items. She stated that for resident #20 based on the resident diagnosis there is no need for a PASARR to be completed. (SSD/#87) stated the clinical records will have notes about bipolar disorder behavior if the residents showed signs. She further stated that there is no need for a high level of care based on the psychology providers council. An interview was conducted with Director of Nursing (DON/ #41) who stated that the resident was diagnosed with bipolar disorder in 2021. She further stated that a PASARR was done for resident #20 on July 07, 2018, July 26, 2018, September 13, 2024, August 08, 2024, and September 10, 2024. (DON/#41) stated that the risk of not doing a PASARR is that if the resident does not have the correct diagnoses then that resident would not be medicated correctly. She also stated that in order for a resident to have a diagnosis the resident needs to present symptoms. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy titled Preadmission Screening and Resident Review (PASRR) revealed the facility to complete the level one Preadmission Screening and Resident Review (PASRR) before or at the time admission, and to request a level two PASRR in a timely fashion when indicated.

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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 clinical record review, interviews, facility documentation, and policy review, the facility failed to ensure one resident (#465) received lab services as ordered by a physician. The deficient practice could lead to delayed diagnosis or treatment or potential deterioration in the resident's condition placing the resident at risk for harm. Findings include- Resident #465 was admitted to the facility on [DATE] with diagnoses that include dementia, acute kidney failure, Encephalopathy, and cerebrovascular disease. The quarterly Minimum Data Set (MDS), dated [DATE] revealed Resident #465 was not able to complete a Brief Interview for Mental Status (BIMS) assessment. However, it was noted that staff assessed her cognitive skills for daily decision making as severely impaired. Review of the physician's orders revealed a lab order, dated March 6, 2024, for Complete Blood Count (CBC) test that also includes a differential count of white blood cells and a platelet count. This was to be done on the 1st and 3rd Monday of the month. The order was discontinued on July 30, 2024. Review of Resident #465's laboratory results revealed testing was completed on the following dates: -March 6, 2024 (1st Wednesday) -March 26, 2024 (4th Tuesday) -May 15, 2024 (3rd Wednesday) -May 22, 2024 (4th Wednesday) -July 1, 2024 (1st Monday) -July 15, 2024 (3rd Monday) Review of Resident #465's admission/discharge history revealed she was discharged from the facility on June 11, 2024 and returned on June 18, 2024. Review of Resident #465's Medication Administration Record (MAR) for the months of March, April, May, and June 2024 found the following entries: -CBC with Plt/Diff; Comprehensive Metabolic Panel (CMP) marked as being completed on Monday, March 4, 2024. -CBC with Plt/Diff; Comprehensive Metabolic Panel (CMP) marked as being completed on Monday, March 18, 2024 -CBC labs marked as being completed on Monday, April 1, 2024. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-CBC labs marked as being completed on Monday, April 15, 2024. -CBC labs marked as being completed on Monday, May 20, 2024. -CBC labs marked as being completed on Monday, June 3, 2024. -CBC labs marked as being completed on Thursday, June 11, 2024. A request was made to the facility on March 9, 2025 at 8:30 AM for a copy of all lab results for Resident #465 conducted between March 1, 2024 through August 15, 2024. On March 9, 2025 at 9:20 AM, surveyor was provided a copy of lab results performed on the following dates: -May 10, 2024 (CMP) -May 15, 2024 (CBC w/diff and CMP) -May 22, 2024 (CBC w/diff and CMP) -June 20, 2024 (CBC w/diff and CMP) -July 11, 2024 Basic Metabolic Panel (BMP) -July 14, 2024 (BMP) An interview was conducted on May 9, 2025 at 10:20 AM with Licensed Practical Nurse (LPN/Staff #151). Staff #151 explained that usually labs are ordered by a provider when there is a change of condition. If for some reason labs are not done as ordered, there would be documentation on a progress notes as to why the lab was not done. Some examples are a resident refuse or if they struggle to find a vein. Staff #151 added that they will talk with the resident about the importance of doing lab work to help them treat residents. Staff #151 shared that all lab results are kept in the residents' clinical records in the Electronic Medical Record (EHR) and that the Medical Records department also kept copies of the results as well. An interview was conducted with LPN/Staff #17 on May 9, 2025 at 10:53 AM. Staff #17 was asked to review Resident #465's clinical record for lab work. She confirmed that she was not able to find evidence that Resident #465 had labs done in April of 2024. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Director of Nursing (DON/Staff #41) on May 9, 2025 at 11:45 AM. Staff #41 explained that when lab work is needed, there is an order for it and the order will show up in the MAR. Staff #41 confirmed in the EHR that Resident #465 had an order, with a start date of March 6, 2024 and end date of July 30, 2024, for labs to be done on the 1st and 3rd Monday of the month. Staff #41 added that blood is usually drawn in the early morning hours and will show up on the MAR for the Nocturnal (NOC) shift. Staff #41 was asked to confirm if there was evidence of lab work done during the month of April and the beginning of June. After reviewing facility lab work results on her computer, she confirmed that it was not done during those time frames and was unable to provide a rationale for why it was not done. When asked what were some potential risks to residents when lab services are not provided as ordered, Staff #41 shared that they could have an infection, dehydration, and it would delay treatment to them. Review of the facility's policy, titled, Physician's Orders, indicated that it was last revised on September 11, 2024. The policy explained that the physician's orders must be monitored for completion.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, policy review, and observation of current practice, the facility failed to ensure that resident drinks were transported from the kitchen to the residents' rooms in accordance with professional standards. The sample size was 22. The deficient practice could result in contamination of the resident's drinks. Findings include: An observation was conducted on May 7, 2025 at 12:00 P.M., with a Certified Nursing Assistant (CNA/Staff #39) who was carrying a drink tray with 5 uncovered drinks down the hall, approximately 50 steps. Continued observation on May 7, 2025 at 12:05 P.M. revealed another CNA (Staff #30) carrying a tray with an uncovered drink into room [ROOM NUMBER]; approximately 50 steps. An interview was conducted on May 7, 2025 at 12:11 P.M. with a Licensed Practical Nurse (LPN/Staff #169), who stated that food is delivered first and then drinks are delivered after, and the process is the same for residents eating in their room. The LPN stated drinks should be covered when delivered to the residents' room. She further stated that she had not observed whether the drinks were covered or not when they were being delivered. However, the LPN stated that she had to issue some reminders to staff in the past to cover drinks. The LPN further stated that the expectation is all drinks are covered until they reach the patient. The LPN also stated that the risk of transferring uncovered drinks from the kitchen to the residents' rooms could result in contamination of the drinks. An interview was conducted on May 7, 2025 at 12:18 P.M. with a CNA (Staff #39), who stated that drink glasses should have been covered prior to delivery, but they weren't. The CNA also stated that in the morning, the drinks they receive from the kitchen are usually covered, but not during lunch time. Staff #39 also revealed that the risk of transferring uncovered liquids could result in contamination. An interview was conducted on May 7, 2025 at 12:20 P.M. with a CNA (Staff #30), who stated that when drinks are transported to resident rooms, they should be covered. The CNA said that the drinks were not covered when they were delivered, and the risk could result in contamination. An interview was conducted on May 9, 2025 at 09:05 A.M. with the Director of Nursing (DON/Staff #41), who stated that stated that the expectation is for drinks to be covered in the kitchen. The DON also stated covering drinks when transporting them decreases chances of infection and spills. A facility policy entitled, Food Safety and Sanitation, dated 2017, revealed that all local, state and federal standards and regulations will be followed in order to assure a safe and sanitary department of food and nutrition services. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a lunch observation on May 7, 2025 at 11:15 AM on the 3rd floor of the facility, Certified Nursing Assistant (CNA/staff # 99) was observed to remove a plastic wrap covering from a pitcher of juice. The CNA was then observed to pour juice into approximately 8 plastic cups. The CNA was not observed to cover the cups with any type of covering. The CNA (staff #99), along with another CNA (staff #52), were then observed to put the uncovered cups of juice on residents' meal trays and walk down the hall to deliver the trays to the residents in their rooms. The cups of juice remained uncovered as they walked down the hallways.

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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 observations, interviews, and facility documentation and policy, the facility failed to ensure one shower room was kept in clean and sanitary conditions. The deificient practice could result in the spread of disease and infection. On March 6, 2024 observed with Certified Nurse Assistants # 7 and 12, feces in the shower stall next to the shower chair and near the drain. During initial pool screeing, on March 6, 2025 at 10:27 a.m. a resdient revealed that receiving showers at the facility are hit and miss. The resident recalled wanting a shower the other night, but was tired of seeing feces on the floor, so she elected to have bed baths instead. An interview was conducted with Certified Nurse Assistants # 7 and # 12 on March 6, 2025 at 11:22 revealed that both parties were in agreement that the feces present on the floor is not a facility expectation. Both parties stated it will be cleaned up immediately and appropriately. CNA # 7 revealed being pulled away earlier and but was immediately planning to return to clean it up, which he realizes was not according to facility expectation. An interview with the Infection Preventionist (IP/Staff #) on March 7, 2025 at approxomately 11:30 a.m., revealed that feces in the shower is an infection control issue, and is not a facility expectation. The expectation is for the shower stalls to be cleaned as per protocol to ensure a clean and sanitary environment. The facility's Cleaning Rooms and Bathrooms policy, reviewed May 21, 2024 revealed showers are cleaned and sanitized up to 2 times a day. The facility's Infection Prevention and Conrol Program, revised May 30, 2024 revealed all staff shall demonstrate competence in relevant infection control practices. Based on staff interviews and policy reviews, the facility failed to ensure that reporting guidelines were adhered to for reporting a Legionella outbreak following national standards for communicable diseases. This deficient practice could result in an outbreak not being reported to the State Agency. Findings include: A review of Maricopa County email correspondence with the facility revealed that the facility was positive for Legionella Urine Ag on December 31, 2024. Subsequent email correspondence with the Maricopa County Department of Public Health revealed that, post negative test results, the investigation was closed as completed on April 29, 2025. Review of the internal complaint tracking system revealed no evidence that the state agency had been notified of the Legionella outbreak. (continued on next page)

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	035154	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Place at Glencroft	8641 North 67th Ave Glendale, AZ 85302

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted on May 6, 2025 at 10:27 A.M. the surveyor was notified by the social worker (Staff #87) that approximately a week ago there was an outbreak of Legionella, which had been resolved. An interview was conducted on May 6 at 10:40 A.M. with the Director of Nursing (DON/Staff #41) who stated the facility recently had an outbreak of Legionella, approximately a month ago. The DON further stated that as of May 5, 2025, tests showed the water supply clear. The DON stated they were in contact with Maricopa County Health Department. She stated that one resident became ill with pneumonia with Legionella and that it had not been reported to the state agency. An additional interview was conducted on May 6, 2025 at 11:08 A.M. with the DON and the Infection Preventionist (IP/Staff #96). Both stated that the facility was not aware of a Legionella outbreak until they were notified by the County, post hospitalization of a resident. The DON stated on December 30, 2025, a resident was sent to the hospital with lowered blood pressure, altered mental status, hypoxic respiratory failure. On January 2, 2025, the IP (Staff #96) was contacted by Maricopa County to let all staff and residents know not to drink the water. The DON stated the expectation is that these types of outbreaks would be reported to the state. She also stated that the risk for not reporting could result in is the potential for all residents being affected, and the state not being aware. An interview was conducted on May 8, 2025 at 12:53 P.M. with the IP (Staff #96), who stated that families, staff, and residents were notified of the outbreak. An interview conducted on May 9, 2025 at 10:00 A.M. with the Executive Director (ED/Staff #172), who stated that a few years back they were told by the state they were reporting too much. The ED stated they were working with the County and thought that was sufficient. The ED expressed that their parent company, as well as the facility, did not know Legionella was reportable to the state. Staff #172 identified no risk by not reporting to the state as they worked closely with the County and did what needed to be done. The ED stated his expectations going forward will be to report whether they are sure or not; and to also ask the SOD (surveyor of the day) for guidance. A facility policy titled, Event Reporting of a Resident, effective date of November 8, 2019 revealed that all resident events be reported, investigated and documented adequately. A facility policy titled, Infection Prevention & Control Program, effective date of September 13, 2019, revealed that the facility failed to follow their guidelines for reporting of communicable disease and infections. -Regarding meal delivery: Findings include: During a lunch observation on May 7, 2025 at 11:15 AM on the 3rd floor of the facility, Certified Nursing Assistant (CNA/staff #99) and CNA (staff #52) were observed to deliver meal trays to all of the residents on the 3rd floor. The CNAs were not observed to sanitize their hands before meal delivery, nor in between delivering each tray. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the same observation, at 11:30 AM, CNA (staff #52) was observed to don gloves. The CNA was not observed to sanitize her hands before she donned the gloves. The CNA was then observed to pick up a piece of pizza from a resident's plate, broke the pizza into pieces with her gloved hands and handed the broken pieces of pizza to the resident. The resident was observed to put the pizza into his mouth and swallowed it. An interview was conducted with Staff #52 following the lunch observation. Staff #52 acknowledged she did not sanitize her hands before donning gloves and acknowledged that she and the other aides did not sanitize their hands in between meal delivery to residents. She stated the risk of this could be passing germs to residents. -Regarding a dressing change for Resident #63: Findings include: Resident #63 was admitted to the facility on [DATE], with diagnoses that included metabolic encephalopathy, epilepsy, dementia, type 2 diabetes and morbid obesity. A Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 1, indicating the resident had severe cognitive impairment. The same MDS also indicated that Resident #63 was at risk of developing pressure ulcers and had one stage 2 pressure ulcer (partial thickness loss of dermis; may also present as an intact or open blister). A care plan initiated on April 30, 2025, revealed that Resident #63 had a blood blister to his left 1st toe and a dried scab from a blister to his right big toe that required treatment as ordered. A progress note, titled Surgical Wound Care Consult, dated May 6, 2025, was reviewed. The note revealed that Resident #63's right 1st toe had been debrided (removal of tissue) to the level of the subcutaneous layer. Review of the order summary revealed an order dated May 6, 2025. The order prescribed to clean the resident's right toe with wound cleanser, pat it dry and apply medihoney and calcium alginate. Then, secure with kerlix (gauze wrap) until healed. The order also indicated to continue to apply iodine to the left toe. The dressing changes were ordered to be performed once daily. A dressing change was observed for Resident #63, on May 7, 2025 at 9:29 AM, with a Registered Nurse (RN/staff #60). The RN was observed to sanitize her hands with alcohol-based hand rub (ABHR) upon entering the resident's room. The RN placed a plastic bag of wound care supplies onto the bedside table. Resident's belongings were observed on the table. There was no barrier observed on the bedside table. The RN (staff #60) donned gloves, sprayed wound cleanser onto a piece of gauze and cleaned the resident's left great toe. The RN then put the used gauze onto the bedside table, without a barrier present. Then, the RN picked up the used gauze and placed a tissue under it. The RN then got another tissue and wiped her gloves. She left the toe open to air. She threw the used gauze and tissues into the garbage can. She was not observed to sanitize her hands or change her gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The RN (staff #60) was then observed to spray wound cleanser onto another piece of gauze. She proceeded to clean the right 1st toe with the gauze, placed the used gauze onto a tissue on the bedside table. She was not observed to sanitize or change her gloves. She then applied medihoney to a piece of calcium alginate. She was observed to wrap the right 1st toe with the calcium alginate, secured it with kerlix and tape, and wrote her initials and the date on the tape. She gathered her used supplies and threw them into the garbage can. The RN was observed to doff her gloves and through them into the garbage can. She was then observed to wash her hands with soap and water. A wet, clear liquid was observed on the resident's bedside table, where the RN had initially placed the used gauze. The RN was not observed to clean the bedside table before leaving the resident's room. The RN was not observed to wear a gown during the dressing change. Further, there was not an Enhanced Barrier Precautions (EBP) sign next to the resident's door and an EBP order was not located in the resident's record. An interview was conducted with the RN (staff #60) on May 7, 2025, following the dressing change. The RN acknowledged that she did not change her gloves during the dressing change, and only sanitized her hands upon entrance and exit of the resident's room. She further acknowledged that she did not wear a gown during the dressing change. The RN stated that she only used EBP for Foley catheters and tube feeds. Further, she stated she did not change gloves or sanitize her hands during the dressing change because the wounds were small and were only on the resident's toes. An interview was conducted with a Licensed Practical Nurse (LPN/staff #151) on May 9, 2025 at 8:38 AM. The LPN stated EBP should be used if a resident had a wound, a Foley catheter or was on isolation. The LPN explained that EBP would involve putting on a gown and gloves and washing hands before entering and exiting the resident's room. The LPN stated that Resident #63 was not currently on EBP, but should be since he had an open wound on his toe. She further stated that she had not been following EBP for Resident #63 because there was not a sign next to his door and it had not been reported to her that he was on EBP. An interview was conducted with a Certified Nurse Assistant (CNA/staff #163) on May 9, 2025 at 8:44 AM. The CNA indicated that if a resident was on EBP, there was typically a cart next to the door that contains gloves, gowns and masks. The CNA indicated that she understood that EBP was for residents with open wounds and catheters. The CNA stated she was unaware that Resident 63's toe wound was now open and that she would tell somebody to get the EBP equipment in place. She was observed to report the need for EBP for Resident #63 to the staffing coordinator. An interview was then conducted with the Director of Nursing (DON/staff #41) on May 9, 2025 at 11:29 AM. The DON stated that if a resident has an open wound, they should be on EBP. She stated she did not think Resident 9 needed EBP in place due to his wound being small and barely open. Further the DON acknowledged that RN (staff #60) should have changed her gloves and sanitized her hands during the dressing change on Resident 9's toes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy titled, Alcohol-Based Hand Rubs & Hygiene, revised on September 20, 2023, revealed that the use of gloves does not replace hand hygiene and that if a task requires gloves, staff are to perform hand hygiene prior to donning gloves and immediately after removing gloves. The policy further indicated on a Hand Hygiene Table, that hands should be sanitized before and after handling clean or soiled dressings, as well as after handing items potentially contaminated with blood, body fluids, secretions or excretions. Additionally, during resident care, when moving from a contaminated body site to a clean body site. A policy titled, Enhanced Barrier Precautions, effective June 5, 2024, revealed an order for enhanced barrier precautions would be obtained for residents with pressure ulcers, unhealed surgical wounds, etc., even if the resident is not known to be infected or colonized with a MDRO. The policy also indicates that gowns and gloves should be immediately available near or outside the resident's room, and that the PPE was necessary when performing high-contact care activities, to include wound care: any skin opening requiring a dressing. On Table 1 of the policy, it indicates that EBP should be used when a resident has a wound, without secretions or excretions and are not known to be infected.