

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  035205	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/13/2026
NAME OF PROVIDER OR SUPPLIER  Suncrest Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2211 East Southern Avenue Phoenix, AZ 85040	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review, interviews, facility documentation and policy, the facility failed to ensure that one resident (#2) received physician-ordered testosterone therapy per physician's order. This deficient practice could result in the worsening of a resident's underlying condition. The sample size was five. The universe was 50. Findings include: Resident # 2 was re-admitted to the facility on [DATE] with diagnoses that included testicular dysfunction. The quarterly Minimum Data Set (MDS) assessment, dated January 6, 2026, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating he was cognitively intact. On March 7, 2026, a complaint was received through the Arizona Online Complaint Portal alleging that the resident, who had been prescribed testosterone injections every two weeks by a urologist for low testosterone levels, did not receive the medication as scheduled, against accordance with the provider's orders. An order for Testosterone Cypionate Intramuscular (IM) solution 200 mg, dated January 15, 2026, revealed the resident was to receive the injection in the afternoon every 14 days for supplementation. The January 2026 Medication Administration Record (MAR) revealed the resident received the injection on January 15, 2026. The MAR failed to reflect the resident receiving the medication on January 29, 2026. A nursing note, dated February 8, 2026, revealed the resident received the Testosterone IM injection on that date, which was well tolerated by the resident. The clinical record failed to reflect supporting documentation allowing the facility to administer the IM injection exceeding the ordered 14 days. An interview was conducted on March 12, 2026, at 7:08 a.m. with a Registered Nurse (RN/Staff #33). The RN stated that testosterone therapy is important for maintaining the resident's mood and overall well-being. The RN indicated that if the medication is not available, the provider should be contacted, and staff should document notification of the pharmacy. The RN further explained that some medications may be obtained from the automatic medication dispensing cabinet; however, if the medication is not available, the Director of Nursing (DON) can contact the pharmacy to expedite delivery. The RN stated it is important to inform the resident when a medication is not available and to educate them on potential signs and symptoms that may occur if a dose is missed. The RN identified possible effects of missed testosterone injections as including mood swings and fatigue. An interview was conducted on March 13, 2026, at 11:30 a.m. with the Assistant Director of Nursing (ADON/Staff #67). The ADON reviewed the resident's clinical record and stated that an order was written on January 13, 2026, for testosterone 200 mg injection to be administered every two weeks. The ADON reported that the resident previously received the injections at a urology office; however, the resident expressed a preference to receive the injections at the facility. The ADON explained that testosterone therapy is intended to maintain appropriate hormone levels and treat the resident's testicular hypofunction. The ADON further stated that failure to administer the hormone injections as ordered could result in worsening of the resident's condition, including exacerbation of testicular hypofunction, mood swings, and irregularities in vital signs. The ADON stated that the facility expectation was for the provider to have been notified of the missed or delayed doses, in order to allow the provider to evaluate the resident's hormone levels and determine whether any dosage adjustments were necessary. The ADON stated that the expectation is for staff to follow physician (continued on next page)</p>

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>orders as written, and if the medication is unavailable or cannot be administered as ordered, the provider should be notified promptly for further direction. An interview was conducted with the resident on March 13, 2026, at 12:20 p.m. The resident stated that he had recently informed his urology clinic of his decision to resume receiving his testosterone injections at the clinic, citing concerns that the facility had not been reliable in administering the injections as scheduled. The resident further stated that the medication is important to his health and expressed concern that his condition could worsen due to inconsistent administration by facility staff. An interview was conducted on March 13, 2026, at 1:11 p.m. with the Interim Director of Nursing (IDON) (Staff #76). During the interview, the IDON reviewed the clinical record and confirmed that a prescribed testosterone injection, ordered on January 13, 2026, was not administered on January 29, 2026, and that there was no supporting documentation indicating that the provider was notified of the missed dose. The IDON also stated that the resident did not receive his next dose of Testosterone until February 8, 2026, which exceeded the 14-day order. The IDON stated that the facility's expectation is that when a medication is unavailable, nursing staff are to notify the provider to receive further instructions. The IDON acknowledged that facility protocol was not followed regarding the missed testosterone dose in January 2026, and confirmed that the expectation for medication administration and provider notification was not met. The facility's Pharmacy Services policy, revised October 1, 2025, revealed the pharmacist is responsible for helping the facility obtain and maintain timely and appropriate pharmaceutical services that supports resident's healthcare needs, goals and quality of life that are consistent with current standards of practice and meet state and federal requirements.</p>		