

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035275	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Advanced Health Care of Glendale		STREET ADDRESS, CITY, STATE, ZIP CODE 16825 North 63rd Avenue Glendale, AZ 85306	
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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 observations, staff and Resident interviews, review of facility documentation, facility policies and procedures, and the State Agency complaint portal, the facility failed to ensure one resident (#1) was free from neglect by failing to provide a safe transfer using a manually operated mechanical lift device. The deficient practice resulted to a physical harm and could place other residents' safety at risk. Findings include: Resident #1 was admitted to the facility on [DATE], with diagnoses that included metabolic encephalopathy, pyelonephritis, encounter for fitting and adjustment of urinary device, and hypertensive heart disease with heart failure. The Resident's Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview of Mental Status (BIMS) score of 9.0, indicating that the Resident's cognition was moderately impaired. A review of the care plan dated June 3, 2026, revealed that the Resident was identified as at increased risk for verbal abuse, physical abuse, sexual abuse, and or exploitation related to her physical, cognitive, or psychosocial deficits. The interventions included to encourage the Resident and/or her family to report suspected or potential abuse issues promptly to the charge nurse and validate the Resident's concerns and fears. A review of the nursing progress notes dated June 16, 2026, revealed that at approximately 6:20 PM, the nurse was made aware of a new skin tear and the nurse entered the Resident's room and observed the Certified Nursing Assistant (CNA/Staff #91 and CNA/Staff #49) at the Resident's bedside. The progress note described the resident having a large laceration to right lateral anterior leg. The note relayed that the nurse instructed the CNA (Staff #91) and CNA (Staff #49) to reapply pressure while she gets more supplies. The progress note further revealed that an image and description of the wound were sent to the Nurse Practitioner (NP) per the Nurse Practitioner's request, and a pressure dressing was applied to the wound. The note relayed that 911 was called, and the Resident was sent to the emergency room (ER) for further evaluation and treatment, and that the Director of Nursing (DON/Staff #13) and the Resident's family member were notified of the laceration to Resident #1's right leg during a mechanical lift transfer, and the resident's injury required a higher level of treatment. The note included that the resident stated that she was being transferred from her wheelchair to her bed via the mechanical lift device when the device fell sideways onto her leg. The note also revealed that CNA (Staff #91) and CNA (Staff #49) stated that after Resident #1 had been lifted over the bed, the mechanical lift device fell sideways onto the resident's leg. Another nursing progress note dated June 16, 2026 revealed that the resident sustained a laceration to the leg during a mechanical lift device transfer and that the injury resulted in active bleeding which required nursing intervention and emergency medical services (EMS) transport to the ER. On June 16, 2026, the resident's care plan was updated and revealed that the resident sustained a laceration to her leg while using a manually operated mechanical lift device for transfer. The care plan also revealed that the resident was sent to the ER and returned to the facility on the same day with sutures. The interventions included to monitor the Resident's skin for signs and symptoms of infection. A physician's order dated June 17, 2026, revealed an order for suture removal from the right lower extremity, cleanse with iodine, remove every other suture at a time, and notify the provider of any (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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On June 18, 2026, at 10:22 AM, a CNA (Staff #32) was observed pushing a battery-operated mechanical transfer lift device from one hall to another hall. An interview was conducted with Staff #32 who stated that he was on his way to use the mechanical transfer lift device on a resident sitting in a shower chair. He also stated that he needed 2 people to use the battery-operated mechanical transfer lift device during a resident transfer. While interviewing Staff #32, another CNA (Staff #78) joined the interview and she stated that she would be assisting Staff #32 with the transfer using the battery-operated mechanical transfer lift device. On June 18, 2026, at 10:39 AM, a battery-operated mechanical transfer lift device transfer observation was conducted with two CNAs (Staff #32 and Staff #78) for Resident #2. During the observation, Staff #78 was pushing the battery-operated mechanical transfer lift device towards Resident #2's bed. The battery-operated mechanical transfer lift device that holds the sling was raised up so it can go over the bed and the base of the device was pushed under Resident #2's bed. CNA (Staff #32) was on the opposite side of the bed guiding the device. While Resident #2 was lying in her bed with the sling under her, CNA (Staff #32) assisted with placing the straps of the sling in the hooks of the battery-operated mechanical transfer lift device. Once the straps of the sling were placed in the hooks, the sling with the Resident on it was lifted up from her bed, and the Resident was transferred from her bed to her wheelchair. After the observation of transferring Resident #2 using a mechanical transfer lift device, an additional interview was conducted with CNA (Staff #32) and CNA (Staff #78). The CNA (Staff #78) stated that for her to know how a resident should be transferred, the physical therapist or the occupational therapist would write on the whiteboard in the resident's room, which would include how a Resident should be transferred. The CNA (Staff #78) stated that she would ask the resident how he/she want to be transferred, either by using their wheelchair or a mechanical transfer lift device. The CNA (Staff #78) stated that she would ask for help or get a partner to assist with the use of a mechanical transfer lift device. The CNA (Staff #78) stated that the other person who would be assisting with the transfer would grab the resident's wheelchair, while the other CNA would be operating the mechanical transfer lift device. The CNA (Staff #78) further stated that she would open the lift device's legs using the lift control device so that the Resident's wheelchair could go in between the mechanical transfer lift device's legs, and that after the mechanical transfer leg device was in between the wheelchair, the resident could then be lowered on the wheelchair. The CNA (Staff #78) stated that a mechanical transfer lift device would work when the battery was charged. The CNA (Staff #78) also stated that the other department in the facility would also check the mechanical transfer lift device to make sure that it was operating properly. The CNA (Staff #78) stated that when a mechanical transfer lift device was not working properly, she would notify the maintenance department or she would go directly to the administrator. The CNA (Staff #78) also stated that if the maintenance staff was not available, she would write the work order in the maintenance work order binder located at the nurses' station. Further, the CNA (Staff #78) stated that she was trained using a mechanical transfer lift device during her CNA training program, from her previous job, and that she did not remember receiving mechanical transfer lift device training when she started at the facility because she already knew how to use it. Further interview was conducted on June 18, 2026, at 10:39 AM with CNA (Staff #32) in conjunction with CNA (Staff #78). The CNA (Staff #32) stated that he heard about an incident involving a resident that occurred while using a manually operated mechanical transfer lift device but was not aware of the specifics of the incident. (continued on next page)		

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The CNA further stated that she did not want to continue with the interview because she did not know who she was talking to. On June 18, 2026, at 11:15 AM, a phone interview was conducted with CNA (Staff #49), who stated that right after dinner, Resident #1 requested to be put back in bed. The CNA (Staff #49) stated that on June 16, 2026, she and another CNA (Staff #91) assisted Resident #1 back in bed using the manually operated mechanical transfer lift device, and that during the transfer, the device tilted to the side. The CNA further stated that she un-tilted the device, removed the sling, and then she noticed a skin tear on Resident #1's right leg after the transfer. The CNA (Staff #49) stated that she called for the night nurse to inform her of the incident. The CNA (Staff #49) stated that she believed that a part of the manually operated mechanical transfer lift device touched the Resident, but she could not tell how it happened because it happened so fast. The CNA (Staff #49) also stated that she was told not to come to work the next day while the investigation of the incident was happening. Further, CNA (Staff #49) stated that she knows how to use a manually operated mechanical transfer lift device. A review of the CNAs' June 14, 2026 through June 20, 2026, staff schedule revealed that CNA (Staff #91) and CNA (Staff #49) were scheduled on June 16, 2026, from 7:00 AM to 7:00 PM. During an interview with Resident #1 on June 18, 2026, at 11:44 AM, the resident stated that the staff used an old hand pump mechanical transfer lift device, that the CNAs put her on it and pushed her over the bed while on the transfer lift, but the transfer lift would not go over the bed. Resident #1 stated that the mechanical transfer lift device tilted, and one of the CNAs assisting with the transfer went to the other side of her bed and pulled or touched the mechanical transfer lift device to move it, because the mechanical transfer lift device's legs did not want to go under the bed, and that's when the handle of the manually operated mechanical transfer lift device hit her leg. Resident #1 stated that it was the CNAs' first time to use the manually operated mechanical transfer lift device for transfer. Resident #1 stated that since she had been in the facility, the CNAs had been using the battery operated mechanical transfer lift device for her transfers. During the interview, Resident #1's representative was at bedside, and stated that staff called 911 because it was gushing blood. Further, Resident #1 stated that she was sent out to the hospital, and the hospital told her that she received 23 stitches. During the interview, Resident #1 was observed to have her lower right leg above the ankle wrapped in white bandage. On June 18, 2026, employee records for Staff #49 and Staff #91 were requested for review. Regarding Staff #49's employee record, the document revealed that Staff #49 received a mechanical transfer lift device competency skill check on November 2024 and December 2025. Per the November 2024 Nursing Assistant Competency Checklist, the mechanical transfer lift device checklist contained the following return demonstration: weight limit, 2-staff members at all times, sling placement under the resident, sling placement on attachment points, base legs and positioning, locking of the wheels, and remote-control use and the moving of the resident. Regarding Staff #91's employee record, the document revealed that Staff #91 received a mechanical transfer lift device competency skill check on December 2025. An interview was conducted on June 18, 2026, at 1:02 PM with the Maintenance/Housekeeping Supervisor (Staff #10), who stated that her responsibilities included life safety, housekeeping, maintaining the building, handling of work orders such as call light issues, air condition issues, bathroom plumbing, bed or bed controls not working, and any mechanical transfer lift device issues, which she stated that mechanical transfer lift device issues were rarely a problem. (continued on next page)		

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The DON also stated that the CNAs were trying to put the Resident #1 quickly in bed. The DON also stated that the CNAs knew exactly what they were supposed to be doing, it was just that the CNAs did not take their time. Further, the DON stated that she expects her staff to spread the mechanical transfer lift device legs. She also stated that she would clarify what the mechanical transfer lift device manual relayed about spreading the mechanical transfer lift device legs. An interview was conducted on June 18, 2026, at 2:40 PM with the Director of Rehabilitation (Staff #76), who stated that he facilitates the in-services for the new hire on transfer training, gait belt and the use of mechanical transfer lift device. The Director of Rehabilitation stated that the training of the mechanical transfer lift device involved the use of visuals, handouts, watching videos, and the trainings were conducted quarterly and during monthly meetings. The Director of Rehabilitation stated that during the mechanical transfer lift device training, the base legs of the mechanical transfer lift device would be wide open as possible to have a nice base of support, to keep the resident steady and safe so that the weight would be distributed safely. He stated that if not widely open, he would not know what would happen, but the best way was to have the legs opened widely to distribute the weight evenly. He also stated that he could not tell how a mechanical transfer lift device would tilt during a transfer. The Director of Rehabilitation provided a copy of a handout that he uses when training the staff, titled How to Safely Lift A Patient Into A Patient Lift/Hoyer Lift, Tri-State Nursing Professionals with Pride. A request was made to observe a demonstration using the manually operated mechanical lift device on a similar bed frame that Resident #1 used at the time of the incident. At 3:03 PM on June 18, 2026, an unoccupied room was used, and the unoccupied room had the same bed frame used by Resident #1. At 3:11 PM, the manually operated mechanical device was brought inside the unoccupied room by the Administrator (Staff #55) and the DON (Staff #13) to conduct a transfer demonstration using the manually operated mechanical lift device. During the observation, the manually operated mechanical device was being operated by the DON while the Administrator was at the other side of the bed. During the observation, the manually operated mechanical lift device's base legs could not go under the bed because it was hitting the horizontal base of the bed. The manually operated mechanical device stayed side by side parallel with the bed, and the hook part of the lift device could not go over the surface of the bed. The DON stated that she would not use the manually operated lift because it would be unsafe for transfer, the hook for the sling was not over the bed, the hook could not be moved, and she was not sure how to move the resident on the bed while the mechanical lift device sling was not over the bed. The DON stated that she would not recommend anybody using it if the sling did not go over the bed. The Medline Hydraulic Patient Lift Low Base User Manual with a revised date of May 12, 2017, revealed on page 9 of the manual on how to use a patient lifter during a Transfer to Bed: Raise the lifter until the patient's gluteus maximus (butt area) is above the surface of the bed. You may need to lower the height of the bed. If the patient cannot be lifted above the bed, do not push or pull the patient onto the bed. This can cause in a tip over and serious injury to the patient and assistant! Move the lifter so that the open end of the U-base is safe as far under the bed as possible. After the patient has been centered on the bed, rotate the patient so that the patient faces the foot of the bed. Carefully lower the patient onto the bed. Remove the chains or straps from the sling. The instructions from the Hydraulic Patient Lift Low Base User Manual were to raise the lifter until the patient's butt area was above the surface of (continued on next page)		

Department of Health & Human Services
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