STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035275	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Health Care of Glendale	16825 North 63rd Avenue Glendale, AZ 85306

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of clinical record, and review of facility policy and procedure, the facility failed to ensure Notice of Medicare Non-Coverage (NOMNC) regarding end of insurance coverage and discharge for one resident (#69) was provided timely according to regulation and facility policy. The deficient practice could lead to inadequate notice for a resident or resident representative to appeal the decision.Findings include:Resident #69 admitted to the facility on [DATE], with diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, dysphagia following cerebral infarction, metabolic encephalopathy, type 2 diabetes mellitus without complications, and other abnormalities of gait and mobility.Review of the clinical record revealed no evidence that a NOMNC was delivered to the beneficiary/representative at least two (2) days before the Medicare covered services ended.An admission Nursing Observation assessment dated [DATE], revealed Resident #69's preferred language was a language other than English, and the document revealed unable to determine whether the resident needed or wanted an interpreter to communicate with a doctor or health care staff. Additionally, the resident had unclear speech-slurred or mumbled words, was sometimes understood, and sometimes could understand others' verbal communication.A Brief Interview for Mental Status (BIMS) assessment dated [DATE], revealed a score of 1, indicating severe cognitive impairment.A baseline care plan dated January 9, 2026, revealed Resident #69 had an alteration in communication, with a goal that the resident's needs would be met daily. The care plan revealed that the resident had a language barrier, and had aphasic, disorganized, and slurred speech, with an intervention for a speech therapy consult. The care plan revealed that the check boxes for a communication board, written communication, and/or translation application were not checked.A Provider Notification progress note dated January 10, 2026, revealed Resident #69 would not take any medications or allow her blood sugar to be checked that morning. A language communication board was used but the resident pushed medications away from her and tried to wheel herself away from nursing staff with one arm. The note revealed that staff attempted to provide education on risks / benefits to the resident, but unable to verify understanding due to language barrier. There was no evidence of attempts to use an interpreter or a translator application.An Occupational Therapy (OT) Evaluation and Plan of Treatment dated January 10, 2026, revealed Resident #69 primarily spoke a foreign language other than English, and that the resident was pleasant, cooperative, and attentive. The document revealed Resident #69 required maximum assistance to perform lower body dressing and toileting, and required moderate assistance to perform upper body dressing and bathing. The goals of the plan of care included for the resident to reach an independent level of functioning in these tasks, and the frequency of the plan of care included 3-7 times per week for 4 weeks.An OT Service Log revealed on January 10, 2026, Resident #69 participated in 15 minutes of OT evaluation, 20 minutes of therapeutic activity, and 25 minutes of self-care management training.A Nursing note dated January 11, 2026, revealed Resident #69 was alert and (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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	uncooperative, and had an unwitnessed fall. The note revealed a certified nursing assistant (CNA) found the resident on the ground next to her bed sitting upright while holding her call light in her hand. The documentation revealed the resident was asked what happened but was unable to provide any information about the fall.An OT Service Log revealed on January 11, 2026, Resident #69 participated in 21 minutes of therapeutic activity. The Service Log included that the resident refused treatment on January 13, 14, and 15, 2026, with the same male therapist.A Physical Therapist (PT) Evaluation and Plan of Treatment dated January 12, 2026, revealed the reason for referral included that Resident #69 presented to the hospital with increased dizziness, confusion, and right sided weakness, and was diagnosed with a cerebral vascular accident (CVA / stroke). The evaluation revealed the resident's primary language was a foreign language other than English. The evaluation included that the resident required partial assistance to perform bed mobility and transfers with a hemiwalker, and required moderate assistance to be able to propel 30 feet in a wheelchair, with therapy goals to improve mobility to an independent level. The plan included for a frequency of 3 to 5 times per week, for 6 weeks.A PT Service Log included that on January 12, 2026, Resident #69 participated in 15 minutes of PT evaluation and 25 minutes of therapeutic activity.A Speech Therapy (ST) Evaluation and Plan of Treatment dated January 12, 2026, but signed January 16, 2026, revealed the resident predominantly spoke a foreign language other than English, was alert and oriented only to herself, and was pleasantly confused and impulsive. The evaluation revealed the resident had a diagnosis of dysphagia, and had goals for safe swallowing. The evaluation included it should be noted that (the resident) would not cooperate with attempts to assess her cognitive linguistic skills. The evaluation included no evidence of any attempts to use a language board, a translator application, or interpreter.An ST Service Log included that on January 12, 2026, Resident #69 participate in 10 minutes of ST evaluation, and 45 minutes of treatment of swallowing dysfunction and/or oral function for feeding.A Nursing note dated January 13, 2026, revealed the resident had a fall, and was found next to the bed on the floor, and was unable to describe the event. The note included that the provider was notified of the resident's fall.A PT Treatment Encounter Note dated January 13, 2026, revealed that resident #69 was refusing, pushing therapist away and holding onto a rail from her wheelchair, and refusing to leave her room. Regarding a pain assessment, the documentation included unable to communicate pain. The documentation included no evidence of attempts to use a language board, or translator application, or interpreter to communicate with the resident.An ST Service Log revealed that on January 13, 2026, Resident #69 participated in 55 minutes of treatment of swallowing dysfunction and/or oral function for feeding. The ST Treatment Encounter Note for January 13, 2026, included that Resident #69 was alert to herself only and confused, and required maximum verbal cues and gestures to increase her participation. The documentation included no evidence of attempts to use a language board, or translator application, or interpreter to communicate with the resident.An ST Service Log revealed on January 14, 2026, that Resident #69 participated in 57 minutes of treatment of swallowing dysfunction and / or oral function for feeding. The ST Treatment Encounter Note for January 14, 2026, included the resident was oriented only to herself and pleasantly confused, and willing to comply / cooperate with the treatment only if it took place in her room. The documentation included no evidence of attempts to use a language board, or translator application, or interpreter to communicate with the resident.A Nursing note dated January 14, 2026, revealed at 6:15 a.m., two CNAs attempted to change the resident, and the resident was observed screaming, kicking, scratching staff, and refusing medications and blood sugar checks at times. The documentation revealed the resident was redirected, and was changed. There was no evidence of notification to the provider of the resident's behaviors.A Nursing note dated (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medicare covered services end. The beneficiary must sign and date the NOMNC to demonstrate that they received the notice and understand the termination decision can be appealed or disputed. If the beneficiary refuses to sign the NOMNC, annotate the notice to that effect and indicate the date of refusal on the notice. The date of refusal is considered to be the date of notice receipt. The NOMNC may be delivered to a beneficiary authorized representative who has been appointed to act on behalf of the beneficiary during the appeal process. Whenever possible, delivery of the NOMNC should occur in person; however, the following alternative means of delivery are acceptable:TelephoneIf contact by telephone is necessary, the date you communicate the information is considered the NOMNC's receipt date.Annotate the NOMNC to document the telephone contact on the day that you make the telephone contact, reflecting that all of the required information was included in the communication.The annotation should include the name of that staff person initiating the contact, the name of the representative contacted by phone, the date and time of the telephone contact, and the telephone number called.Place a dated copy of the annotated NOMNC in the beneficiary's medical file and mail a NOMNC to the representative the day the telephone contact is made.Retain the original signed document in the beneficiary's file, and provide the beneficiary copies of all notices that include all of the required information such as the effective date and covered service at issue.

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Advanced Health Care of Glendale	16825 North 63rd Avenue Glendale, AZ 85306

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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 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 review of observations, staff interviews, and policy and procedures the facility failed to ensure that one resident (#78) had documentation and orders in place for dressings to the wrists and elbow. The universe was 52 and the sample size was 16. The deficient practice could impact the doctors available information on the resident, improper documentation/ communication among staff and potential for infection and worsening of the wound.Findings include:Resident #78 was admitted with pleural effusion, acute respiratory failure with hypoxia, syncope and collapse, atherosclerotic heart disease, hypertensive heart and chronic kidney disease with heart failure, type 2 diabetes mellitus, sick sinus syndrome, left bundle branch block, endocarditis, metabolic encephalopathy, acute embolism and thrombosis of the left peroneal vein, long term (current use) of anticoagulants and presence of a cardiac pacemaker.A review of the 5-day MDS (minimum data set) dated 01/31/2026 revealed no observed BIMS (brief interview of mental status) score.A review of the admission assessment dated [DATE] revealed that the resident was alert, cooperative and oriented to person, place, time and situation, and affirmed that the resident had clear comprehension. The admission assessment revealed no evidence of wounds to the wrists or elbow.A review of the care plan revealed no evidence of the presence of wounds to the wrists or elbow or corresponding wound care.An observation was conducted on February 3, 2026 at 9:13 AM which revealed the resident seated in his wheelchair with his daughter present in the room. The resident was further observed with bandages/ dressings to both the left and right wrist as well as the left elbow. None of the bandages were dated or initialed by staff. The daughter stated that the bandage to the right wrist was coming off, but that the resident was getting ready to leave for a medical appointment. The staff #2, RN (registered nurse) was advised of the lose bandage to the right wrist.A review of the physician's orders on February 3, 2026 at 9:20 AM revealed no evidence of documented wound care orders to the left wrist and elbow or the right wrist. A subsequent physician order entry revealed an initial order of wound care to the right wrist on February 3, 2026.A review of the progress notes on February 3, 2026 revealed no documentation regarding any wounds to the wrist(s) or left elbow.An observation was conducted on February 4, 2026 at 8:12 AM. Resident #78 was observed seated in his wheelchair. The dressing to his right wrist was observed to be securely in place with a date and initial displayed on the bandaging; however, the dressing to the left wrist and elbow showed no evidence of a date or staff initial.A follow-up review of the physician orders revealed an order dated February 4, 2026 noting wound care to the right wrist, left elbow and left wrist area. Indicating that the areas should be cleaned with wound cleanser, patted dry and a foam dressing applied twice a day as needed.An interview was conducted on February 4, 2026 at 8:01 AM with staff #43 RN (registered nurse). Staff #43 stated that the wound team rounds every Wednesday and that orders outside of Wednesday, regarding wound care, are addressed by the nursing staff. Staff #43 stated that post ordered wound care, all bandages are required to be dated and initialed. Staff #43 stated that if they are not dated and initialed, you would not know when the dressing was last changed or who changed it. Staff #43 stated that for each wound site an order needs to be in place. The RN stated that if wound care is conducted during an outside appointment, nursing staff review the documentation from the appointment and conduct a head to toe assessment when the resident returns from the appointment. The RN stated that that if orders for wound care were not in place for each wound, the risk could include a wound not being cared for and a potential for infection.An interview was conducted on February 4, 2026 at 8:30 AM with staff #2 RN. Staff #2 stated that wound care orders are required for each wound. Staff #2 stated that if orders were not in place for each wound, that there could be a chance for (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	infection, since the wound care would not be addressed. Staff #2 stated that all wounds need to be looked at, including those that a resident may have been admitted with. Staff #2 further stated that all dressings should have a date and the initial of the nurse who conducted the wound care. Staff #2 pulled up the electronic health record for resident #78 and stated that she had asked the doctor yesterday for wound care orders for the right wrist, after she was notified of the lose bandage. She stated that she did not know why the dressing was not dated or initialed, but stated that it should have been. Staff #2 further stated that this morning she had noticed a few more areas, but stated that she wasn't sure how long these dressings had been in place. Staff #2 reviewed the record again and stated that there were no orders in place for the left wrist or left elbow. Staff #2 stated that the risk for not having orders in place can include the doctor not being aware of the wound, improper monitoring of the wound and the risk of infection.A telephone call was placed on February 4, 2026 at 8:45 AM to staff #73 LPN (licensed practical nurse), who conducted the initial admission assessment. A message was left on the voicemail, but no return call was received.An interview was conducted on February 4, 2026 at 9:09 AM with staff #85 ADON (assistance director of nursing). Staff #85 stated that if a resident has a wound on admission, then it would be identified in the admission assessment and orders would need to be put in place. Staff #85 stated that if wound care was conducted during an offsite appointment, then nursing staff would confirm that orders were put in place. Staff #85 stated that any bandaging/ dressings have to be documented in the electronic health record and have corresponding orders. Staff #85 further stated that per facility policy all dressings are required to have a date and initial of the staff who completed the wound care or observation. The ADON stated that if dates and initials on the dressing were not in place that the risk could include a worsening of the wound, progression or regression of the wound and or infection. Staff #85 pulled up resident #78 in the electronic health record and confirmed the new orders for the right wrist but stated that she did not see any orders for the left wrist and elbow. She further reviewed the electronic health record and stated that she did not see any entries indicating when the dressings were applied and by who. Staff #85 stated that this did not meet her expectations and stated that the risks wound include the wound(s) not being monitored, not healing and the risk for infection. Staff #85 further stated that orders always need to be in place to provide treatment/ services. An interview was conducted on February 4, 2026 at 10:00 AM with staff #75 (Wound Care Nurse). Staff #75 stated that she was not aware when the injuries to the wrist(s) and elbow occurred. She stated that the nurse, staff #2, had made her aware of the missing orders, dates and initials and that she was in the process of creating education for staff regarding wound dressings. She stated that the expectation would be to have orders in place, documentation of the wound and that dressings are dated and initialed. She stated that the risk would include not knowing what happened, who provided the care and what was done.A review of the facility policy titled Documentation of Wounds, version F1008, revealed that the licensed nurse assigned to each individual patient will be responsible for completing all daily monitoring, treatments and weekly skin assessments on the day and shift indicated. The policy further noted that eh licensed nurse will sign that he/ she has completed the assigned daily monitoring and treatment. A review of the facility policy titled Standards of Professional Nursing Practice, version A0717, revealed the American Nurses Association standards of practice documented as 1-16, noting that registered nurses collect comprehensive data pertinent to the healthcare consumer's health or situation, implements coordination of care, evaluates progress towards attainment of outcomes, contributes to quality of nursing practice.A review of the facility policy titled Charting Requirements, version E0325, revealed that all new admits will be charted on every shift for the first 72 hours and daily (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of clinical record, and review of facility policy and procedure, the facility failed to ensure sufficient staffing regarding provision of a caregiver / sitter to meet a resident's (#69) needs. The deficient practice could place the resident at risk for physical or psychosocial harm, or place a resident at risk of undue financial burden of having to provide the staffing out-of-pocket for themselves.Findings include:Resident #69 admitted to the facility on [DATE], with diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, dysphagia following cerebral infarction, metabolic encephalopathy, type 2 diabetes mellitus without complications, and other abnormalities of gait and mobility.An admission Nursing Observation assessment dated [DATE], revealed Resident #69's preferred language was a language other than English, and the document revealed unable to determine whether the resident needed or wanted an interpreter to communicate with a doctor or health care staff. Additionally, the resident had unclear speech-slurred or mumbled words, was sometimes understood, and sometimes could understand others' verbal communication.A Brief Interview for Mental Status (BIMS) assessment dated [DATE], revealed a score of 1, indicating severe cognitive impairment.A baseline care plan dated January 9, 2026, revealed Resident #69 had an alteration in communication, with a goal that the resident's needs would be met daily. The care plan revealed that the resident had a language barrier, and had aphasic, disorganized, and slurred speech, with an intervention for a speech therapy consult. The care plan revealed that the check boxes for a communication board, written communication, and/or translation application were not checked.A Provider Notification progress note dated January 10, 2026, revealed Resident #69 would not take any medications or allow her blood sugar to be checked that morning. A language communication board was used but the resident pushed medications away from her and tried to wheel herself away from nursing staff with one arm. The note revealed that staff attempted to provide education on risks / benefits to the resident, but unable to verify understanding due to language barrier. There was no evidence of attempts to use an interpreter or a translator application.A Nursing note dated January 11, 2026, revealed Resident #69 was alert and uncooperative, and had an unwitnessed fall. The note revealed a certified nursing assistant (CNA) found the resident on the ground next to her bed sitting upright while holding her call light in her hand. The documentation revealed the resident was asked what happened but was unable to provide any information about the fall.The care plan revealed no evidence of updates or added interventions to address the resident's fall on January 11, 2026.A Nursing note dated January 13, 2026, revealed the resident had a fall, and was found next to the bed on the floor, and was unable to describe the event. The note included that the provider was notified of the resident's fall.The care plan revealed no evidence of updates or added interventions to address the resident's fall on January 13, 2026.A Nursing note dated January 14, 2026, revealed at 6:15 a.m., two CNAs attempted to change the resident, and the resident was observed screaming, kicking, scratching staff, and refusing medications and blood sugar checks at times. The documentation revealed the resident was redirected, and was changed. There was no evidence of notification to the provider of the resident's behaviors.A Nursing note dated January 14, 2026, at 12:10 p.m., revealed Resident #69 was observed attempting to get out of bed and stand by herself without assistance, and when staff tried to assist the resident, the resident smacked staff's arm and gestured with her hand to move and get out. The note revealed that additional staff were able to assist the resident into the wheelchair. The note included that the resident started throwing things onto the floor and into the trash, including the resident's leg brace, sensor pad, and wheelchair pad. There was no evidence of (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notification to the provider of the resident's behaviors.A Nursing note dated January 14, 2026, at 9:38 p.m., revealed Resident #26 remained combative and refused all care and medications. There was no evidence of notification to the provider of the resident's continued behaviors.A Nursing note dated January 14, 2026, at 9:52 p.m. revealed Resident #60 had 3 unwitnessed fall events that evening alone. The note revealed that the resident would not allow any staff to touch her and continued to be very distressed and seemed unable to be safe at that time, and that the provider was notified.The care plan was reviewed and revealed no evidence of updates to the care plan regarding communication with the resident whose primary language was a foreign language other than English, and no evidence of any interventions to include attempts to use a translator application or interpreter.A Nursing note dated January 14, 2026, at 9:59 p.m. revealed that a psychiatric consult was ordered for Resident #69. The note included that the resident's family was contacted and urged to sit bedside with her or hire someone to sit bedside with her 24/7 for the resident's safety. The note revealed that the resident's family stated that they were located out of town and unable to hire someone that evening. The note included that the family was informed to speak with management tomorrow for a plan of action. Additionally, the note revealed that the resident was refusing all medications that evening, was sitting on the floor and refusing to get back in bed, refusing staff to come near her, was not receptive to redirection, and appeared comfortable at that time. The documentation revealed no evidence of attempts to use a language communication board, or an interpreter, or a translator application.The care plan was reviewed and revealed no evidence of a revision or added intervention specifying the need for 1 to 1 sitter or caregiver 24/7.A Nursing note dated January 14, 2026, at 10:10 p.m. revealed that the physician ordered to send the resident to the hospital.A Nursing note dated January 14, 2026, at 10:26 p.m. revealed Resident #69 had barricaded herself in the room, and that staff were attempting to get into the room in order to check on her, and that the physician was aware. There was no evidence that the facility had provided a sitter or caregiver as was previously recommended 24/7.A physician order dated January 14, 2026, included for a psychiatric consult, and to discharge the order when completed.A Nursing note dated January 15, 2026, at 1:05 a.m., revealed transportation arrived to take the resident to the hospital at 10:45 p.m., and that due to it being an all male crew, it was requested per their supervisor to wait to exchange care with a female crew, and that an all female crew arrived at 12:05 p.m.An Acute Care Transfer nursing progress note dated January 15, 2026, at 1:05 a.m., revealed the resident was transferred to the hospital due to having 3 unwitnessed fall events on evening shift, and the resident was unable to answer questions.A Nursing progress note dated January 15, 2026, at 4:27 a.m. revealed Resident #69 returned to the facility with no findings per the hospital Emergency Department (ED), and had no injury and no evidence of urinary tract infection (UTI) or other abnormal lab results. Additionally, the documentation revealed the resident was resting comfortably in bed.A Social Services progress note dated January 15, 2026, at 9:48 a.m., signed by the administrator (Staff #81), revealed that the administrator spoke with the resident's son and stated concerns about the resident's safety and need for a caregiver with her from 4:00 p.m. to 6:00 a.m. The note revealed that the son stated he will plan to take her home with him or have her stay with her brother for safety reasons, but revealed no evidence of a timeframe for a planned discharge. The note revealed that the administrator shared with the resident's son information for a private caregiver company for hire in case the son needed it for that night. The note revealed that the son stated at worst, he would be at the facility by tomorrow to take Resident #69 home.The care plan was reviewed and revealed no evidence of a revision or added intervention specifying the need for 1 to 1 sitter or caregiver between the hours of 4:00 p.m. to 6:00 a.m.A Nursing progress note dated (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	January 15, 2026, at 9:54 p.m., revealed Resident #69 had direct 1 to 1 supervision with a private sitter, and that the resident refused medications, blood glucose checks, and a skin check. The note revealed that the resident was calm and not calling out. The note included no evidence of attempts to use a language communication board, or an interpreter, or a translator application.A Discharge BIMS assessment dated [DATE], revealed the Resident had a score of 4, indicating severe cognitive impairment.A Notice of Transfer or Discharge document, revealed the reason for discharge was the resident's needs cannot be met in the facility.The clinical record was reviewed, and revealed no evidence of a physician note stating that the resident was not safe to remain in the facility or that the resident's needs could not be met in the facility.A Discharge progress note dated January 16, 2026, revealed Resident #69 left the facility at 11:20 a.m. to discharge home and that transportation was provided by the resident's son, and the resident's family was made aware of the resident's continued refusal of medications.A telephonic interview was conducted with Resident #69's son on February 4, 2026, at 8:45 a.m. who stated that he was called by facility staff on January 15, 2026, informing him that Resident #69 could no longer stay at the facility because she was resisting staff and was difficult at night. The son stated that the facility staff stated that the only condition that the resident could stay in the facility the night of January 15, 2026, was if the resident had a family member who could stay overnight with the resident or if the resident's family hired a private sitter to come to the facility overnight with the resident. The son stated he was panicking because he lived out of town and could not be there, and stated that he did not want the facility to kick her out to the curb, so he hired a private caregiver / sitter to stay with the resident overnight on the night of January 15, 2026. The son stated that he had to pay for the sitter out of pocket, because the facility staff had told him that the facility could not provide that level of one to one care. The son stated he found out about Resident #69's discharge on [DATE], and had to come to the facility the morning of January 16, 2026, to pick her up.An interview was conducted on February 5, 2026, at 9:59 a.m. with a licensed practical nurse / discharge nurse (LPN / Staff #88) who stated that Resident #69 had met her therapy goals, and completed her skilled stay. The clinical record was reviewed, and Staff #88 then stated that Resident #69 was given notice of discharge on [DATE], and that the resident was alert, of sound mind, and could make her own decisions. Additionally, Staff #88 stated that Resident #69 had a rushed discharge because of safety concerns, because the resident was combative, was refusing therapy, and the resident needed a caregiver/sitter between the hours of 4:00 p.m. to 6:00 a.m. Staff #88 stated that the facility administrator (Staff #81) had informed the resident's son that there needed to be a sitter in the facility with the resident from 4:00 p.m. to 6:00 a.m., and that there was not a facility staff who could sit with the resident then, and that the resident's son could not provide the sitter in order for the resident to stay longer in the facility.An interview was conducted with a licensed practical nurse (LPN / Staff #10) who stated that he had cared for Resident #69, and that the resident could understand very basic things, but did not speak English, and would have bouts of confusion and was impulsive and very forgetful. Staff #10 stated that from his experience, the resident's behaviors never became too much for staff to handle, and that she was able to calm down with staff interventions.An interview was conducted with the Rehab Service Manager and Activities Director (Staff #5) on February 5, 2026, at 9:24 a.m., who stated that Resident #69 primarily spoke a foreign language other than English, and that he did not know of a language interpreter service or translator service that the facility had.An interview was conducted with the administrator (Staff #81) on February 5, 2026, at 10:17 a.m. who stated that the facility is equipped to care for residents with cognitive impairments, dementia, and/or behaviors by first pre-screening residents (continued on next page)

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Health Care of Glendale	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 review of observations, staff interviews, and policy and procedures the facility failed to ensure that one resident's (#86) medication/treatments were not left at bedside. The universe was 52 and the sample was 16. The deficient practice could result in residents not receiving medications as ordered by the physician. Findings include:An observation of Resident #86's room was conducted on February 3, 2026 at 11:45 AM. Two containers of ZAL cream were observed on the counter next to the sink, in the resident's room. The containers were observed with pharmacy label attached. When interviewed the resident stated that she applied the ZAL cream herself on her buttocks and labia. The resident stated that she had been cleared to use the cream, and that staff knew that she was using the cream since her admission. The resident also stated that one of the containers was empty. There was no evidence of a lockbox for medications at the bedside.Resident #86 was admitted on [DATE] with diagnoses that included Sjogren syndrome, urinary tract infection, Type 2 diabetes mellitus.An admission Observation assessment form dated January 28, 2026 revealed that the resident was alert/oriented to person, place, time, situation.Orders dated January 28, 2026 through February 3, 2026 revealed no evidence of provider orders regarding medication/treatment self-administration.Further review of provider orders revealed no evidence of an order for ZAL cream from January 28, 2026 through February 3, 2026.Review of the clinical record revealed that the admission Minimum Data Set assessment had been submitted, and was still in process. However, a Brief Interview of Mental Status (BIMS) form dated January 28, 2026 revealed a score of 13, which indicated that the resident was cognitively intact.A care plan revealed evidence of the following areas of focus:Altered skin integrityIndwelling catheterThe care plan revealed no evidence of a focus or interventions regarding self-administration of medication/treatments.Provider orders dated February 4, 2026 were written for:4 ounces of equal parts topical lidocaine 3%, zinc oxide 20% ointment, Vitamin A/D ointment; sparingly topical, 1 application twice a day; preventative per patient request.ZAL topical cream (zinc oxide/A&D/Lidocaine), twice a day.Another observation of the resident's room was conducted on February 5, 2026 at 7:45 AM. A container of ZAL ointment was observed on the counter next to the sink, along with a box of Baqsimi (glucagon), and there was no evidence of a lockbox for medication storage at the bedside. An interview was conducted on February 2, 2026 at 3:53 PM with a Certified Nursing Assistant (CNA/staff #57), who stated that it is not ok for medications or treatments (creams/ointments) to be left in the resident's room at bedside, and if she observed this she would immediately tell the nurse. The CNA further stated that residents are not supposed to have any medications/creams unattended at the bedside, and staff should also report to the nurse when a family member/visitor/resident brings any medications/creams/ointments into the facility. An interview was conducted on February 5, 2026 at 8:08 AM with a Licensed Practical Nurse (LPN/staff #10), who stated that residents can have ointments left unattended at the bedside, but a nurse would apply the ointment, unless there was a provider order that the resident may self-administer. He reviewed the resident's clinical record and stated that there were no orders for medication/treatment self-administration. The LPN entered the resident's room along with the surveyor and stated that there was a box of Baqsimi nasal spray (glucagon) sitting on the counter, next to the sink, unattended. The LPN stated that this is generally kept in the medication cart and should not have been left in the resident's room unattended. He also stated that he observed a container of ZAL (zinc oxide, vitamin A & D cream, topical BID (twice a day), and the label on the container was from the acute care hospital. The LPN stated that he did (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not know that these medications were in the resident's room, and that neither of the medications should have been left unattended in the resident's room without a provider order. The nurse stated he talked to provider about the ZAL cream yesterday, February 4, 2026, and received an order for 4% lidocaine, zinc oxide and A & D ointment. The LPN reviewed the resident's provider order and stated that there was no evidence of a physician order for ZAL ointment, and that 4% lidocaine was ordered by the provider on February 4, 2026, or orders for Baqsimi nasal spray or [NAME] cream to be self-administered. The LPN stated that leaving medication/ointments unattended at the bedside did not meet the facility standard, and the risk could result in medication error.An interview was conducted on February 5, 2026 at 8:25 AM with the Director of Nursing (DON/staff #86), who stated that when residents request to self-administer medications/ointments, nurses are expected to conduct an observation to determine if the resident knows how to administer the mediation, the medication/ointment needs to be kept in a lock box. The DON stated that the observation would be documented on a form that is found the observation tab on a form titled AHC Self Medication Administration observation. The DON also stated that a provider order would be required prior leaving any medications/creams/ointments in a resident's room for medication self-administration. The DON reviewed the resident's clinical record and stated that there was no evidence of a nursing administration observation form for medication self-administration at the bedside. The DON stated that there was a standing order to administer glucagon, but there was no order to store the medications/cream at bedside, and there was evidence of a provider order for ZAL cream dated February 4, 2026. However, the DON stated that there was no provider order for ZAL cream to be left at the bedside. The DON stated that she would have expected that staff would have noticed the Baqsimi and ZAL cream unattended in the resident's room. She stated that this did not meet her expectations and could result in another resident taking the medications.An interview was conducted on February 5, 2026 at 8:44 AM with CNA (staff #38), who stated that the resident was assigned to him for care today, but he had not observed any medications on the residents sink counter when he was providing care this morning.A policy titled, Administration of Medication, Version F0505, revealed that licensed personnel, in accordance with professional standards of practice, will appropriately administer prescribed medications. A Policy titled, Self-Medication Administration, version A1014, revealed that patients may self-administer medications if it is determined that they are capable of doing so in a safe and consistent manner. As part of their overall evaluation, staff will assess each patient's mental and physical abilities to determine whether a patient is capable of self-administering medications. In addition to general evaluation of decision-making capacity, staff will perform a more specific skill assessment utilizing the Self-Medication Administration Assessment form which includes the patient's ability to read and understand medications labels, comprehension of the purpose/proper dosage and administration time for his/her medications. the Self-Medication Administration Assessment form will be maintained in the medical record. Patients requesting to self-administer medications will be assessed as above. Staff shall identify and remove any medications found at the bedside that are not authorized for bedside storage, for proper storage or return to the family or responsible party.A policy titled, Medication Orders, Version B0113, revealed that medications are administered only upon the clear, complete, and signed order of a person lawfully authorized to prescribe.