STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035297	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Surprise Health and Rehabilitation Center	14660 West Parkwood Drive Surprise, AZ 85374

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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 a clinical record review, staff interviews, facility documentation, and policy review, the facility failed to ensure that Specialized Durable Medical Equipment (DME) services were provided to one resident (#100). The census was 98. The deficient practice could result in immobility and isolation. Findings include: Resident #100 was re-admitted to the facility on [DATE], with diagnoses that included heart failure, anoxic brain damage, and chronic kidney disease. A comprehensive Minimum Data Set (MDS) assessment dated [DATE], revealed that the resident had several impairments in cognitive skills related to daily description-making. The MDS further revealed no use of a mobility device. A physician's order dated May 07, 2025, included a Physical Therapy (PT) / Occupational Therapy (OT) evaluation for a wheelchair. A Quarterly MDS assessment dated [DATE], revealed severe impairment in cognitive skills related to daily decision-making. The MDS also revealed that no mobility device or wheelchair was being used. A Nurse Practitioner (NP)/ Physician Assistant (PA) progress note dated November 06, 2025, indicates that the resident has mobility limitations that significantly impact his ability to participate in one or more MR Activities of Daily Living (ADLs) at home. The progress note also indicated that the resident would be a full-time wheelchair user and would require individualized fittings and adjustments. A facsimile Transmittal Sheet dated November 07, 2025, indicated that fax documentation was sent to the DME company. A care plan dated November 24, 2025, revealed an intervention for a Restorative Nursing Assistant (RNA) to transfer the resident to a wheelchair twice a week to improve posture and positioning. However, the Care Plan did not reference Durable Medical Equipment (DME). A Quarterly MDS assessment dated [DATE], revealed severe impairment in cognitive skills related to daily decision-making, and there was no indication of wheelchair use. A Nursing Home MDS assessment dated [DATE], revealed severe impairment in cognitive skills related to daily decision-making. The MDS further revealed no prior use of a wheelchair. A Therapy Progress Note dated March 26, 2026, indicated that the DME company was contacted regarding the status of the wheelchair order placed in November, and it was confirmed that the order was placed in November. The progress note then stated that the DME company attempted to contact the resident in January and March, but the writer clarified that the resident had been residing at the facility when the order was sent. The progress notes also indicated that the resident is unable to communicate independently. The Progress note then indicated that the facility and family attempted to obtain information, but due to HIPAA constraints, no information was provided. The progress note further indicated that, for April 13, 2026, the resident was scheduled for a wheelchair evaluation. Additionally, the Progress Note stated that writer would be the primary point of contact to ensure accurate coordination of care, appropriate location, and communication of patients' needs. The progress note also stated that the DME company was unable to reach the resident until January, when a home evaluation was scheduled for January 15, 2026. However, the resident was not present at that time, resulting in a reschedule. The progress note further revealed that the DME company was not advised that the resident was at the facility. The progress then stated that the writer will remain the primary point of contact to facilitate coordination and prevent further delays in equipment procurement. A call log dated March 26, 2026, to the DME company included a note that the Therapy Program Manager (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(Staff #167) had requested to speak with a representative and was given three different email addresses for the DME company. A second call log dated March 26, 2026, to the DME Company home care corporate notes that the Therapy Program Manager (Staff #167) called to follow up on the process and status. The representative for the DME company reported that the evaluation was attempted twice and that there was one scheduled for April 13th. The note further indicates that (Staff#167) called for an update/status but was told that a return call would be made to her. An interview was conducted on March 26, 2026, at 9: 35 AM with Resident # 100's daughter, who stated that they had spoken to the Therapy Department about a year ago to request a customizable wheelchair and were told it would take a long time to receive it. She then stated that, about five to six months into her father's admission to the facility, she contacted the Durable Medical Equipment (DME) company and was told that no order had been placed. She further stated that approximately three months ago, her father was reassessed for a custom wheelchair by the facility because the order had been lost. She also stated on March 28, 2026, she was told by rehab staff to call the DME company, and that the company told her there were no orders for it. An interview was conducted on March 26, 2026, at 11:04 AM with (Staff # 167), who stated that the facility's wheelchairs were not suitable for the resident, and they will rent or provide a customized wheelchair for the resident. She then stated that on November 06, 2025, an evaluation was completed for the customizable wheelchair for Resident 100. She then stated that the DME company prefers for the family to stay in contact with them. She also stated that the previous Director of Rehab had begun the process for the customizable wheelchair; however, after she stepped in as Director of Rehab, the process had to be restarted. She further stated that, with this particular company, it typically takes approximately 4 to 6 months to receive a response.A request was made on March 27, 2026, at 8:57 AM for any follow-up documentation with the DME company. The Clinical Resource (Staff #551) noted that there was no documentation of any follow-up with the DME company after November 2025. A review of a document received on March 27, 2026, regarding a call log to the DME company with the date of November 07, with a note written by an Occupational Therapist (OT/Staff# 166) that the DME company inquired about the process and confirmed the fax number, and that the DME company was asked if the facility or therapy would be contacted, and was told no. However, there was no additional documentation confirming that this information was provided or that a follow-up discussion occurred.Review of a document received on March 27, 2026, revealed that (Staff #167) had reached out to three different DME companies on March 26, 2026, regarding Resident 100's DME order for the wheelchair. Further review of the document revealed that two out of three companies did not receive any orders for the resident. Also, one of the companies returned the call and indicated that they had received the resident's facesheet in April 2025 and reported that they were not contracted with the resident's insurance. An interview was conducted on March 27, 2026, at 9:54 AM with Clinical Resource (Staff #551), who stated that there had been follow-ups regarding the wheelchair; however, there was no documentation to support these actions. She then stated that the Director of Rehab had made phone calls to the company a few times, but there is no documentation of this. She further stated that, based on the information gathered, the delay in completing the evaluation is due to a leadership transition in the Director of Rehabilitation. She also stated that they had reached out to the former Rehab Director, who did not recall working with any specific company, particularly regarding the customized wheelchair for this resident. She stated that the former Director of Rehabilitation had identified three possible wheelchair companies, and this information had been used to guide follow-up efforts. She then stated that they had instructed the current Rehab Manager to contact the 3 possible companies and that the resident's insurance covered only one of the DME companies. One of the three companies not covered by the resident's insurance stated that it had received the evaluation for the custom wheelchair in April 2025 or May 2025, but there is no documentation to support this. Staff #551 also stated that any follow-up regarding resident services should have been documented. She then stated that the current Rehab Director stated that follow-ups with the wheelchair company had (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	occurred on March 11 and March 19, but these interactions had not been documented. She also stated that there is no documentation regarding follow-up for the customizable wheelchair. She further stated that the facility reviews other residents who are pending evaluations to identify similar issues. She then stated that it would take six to nine months to receive the customizable wheelchair. She further stated that there should have been communication with the family regarding the wheelchair process. An email dated March 27, 2026, at 11:23 AM from DME company to (Staff#167) revealed that DME company was unable to reach out to the resident in January, and they had scheduled a home eval on January 15, 2026, but unfortunately, the resident was not home, and they had to reschedule for March 11, 2026. The email further revealed that the DME company was not informed that the resident was residing at the facility until the family advised them. The email also revealed that the resident was scheduled for an evaluation on April 13. The email further revealed that there needs to be a therapist eval signed by the same prescribing doctor, and a signed written order. An interview was conducted on March 27, 2026, at 11:17 AM with a Service Representative for the DME Company (Staff #777) who processes the customizable wheelchair is that an order needs to be placed. She then stated that the facility's PT and OT departments will conduct an evaluation and send over that information to the provider for approval. She then stated that once that information is in their system, they would send out a specialist for evaluation. She then stated that once they have completed their evaluation, they will get a price range, enter that information into the system, and the provider will sign off on it as approval. She then stated that the resident's insurance company would decide whether to process. She further stated that residents would call, but they would expect the facility to call them as well. She then stated that if a resident is not able to communicate due to their disease, they would expect a caregiver or nurse to call for an update. She also stated that she received a call from (Staff # 167) on March 26, 2026, regarding the customized wheelchair, but there had been no prior communication from the facility about it. She further stated that the only order on file for the resident was dated November 13, 2025. She then stated that because the order was valid for only 6 months, the facility would need a new prescription, OT, and PT evaluation, as well as a charting note. A further interview was conducted on March 27, 2026, at 11: 38 AM with (Staff #167), who stated that she had gotten the Director position in August 2025 and was informed in October 2025 that Resident #100 had not received the custom wheelchair. She then stated that she had contacted the wheelchair company and was told there was no documentation on file for the wheelchair evaluation that was submitted to them. Staff #167 stated that in May 2025, an evaluation was completed, but the necessary paperwork had not been submitted to the customized wheelchair company. She also stated that on October 17, 2025, (Staff #166) had conducted an evaluation to determine whether the resident was appropriate for rehabilitation services. Staff #167further stated that on November 07, 2025, Resident #100 was evaluated for a customized wheelchair, and a call was placed to the wheelchair company; however, there was no documentation to support this. She also stated that it takes about 3 to 6 months for a response from the customized wheelchair company. She then stated that she had verbally told the resident's family to reach out to the DME company, and the resident's daughter attempted to make contact with the DME Company back on March 19, 2026, but t there is no documentation of this. She also stated that there is no documentation of the facility staff contacting the wheelchair company. She further stated that the facility should have documented any phone calls to the wheelchair company. She then stated that on March 26, 2026, she had called the wheelchair company and was told that in January 2026, a home visit was made to evaluate the resident, but the resident resides at the facility. Staff # 167 then stated that the morning of April 13, 2026, the resident is scheduled to be evaluated by the customized wheelchair company. She further stated that the expectation is for the evaluations to be submitted to the customized wheelchair company, and physician orders should be followed. She also stated that when they receive orders, they will complete them on the day they receive them or within 3 days. Staff #167 stated that the risk of not following through with physician orders results in noncompliance with provider directives and does (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not meet the expectations of the resident's family. Staff #167 also stated that the risk of not following through with a physician's order is that they are not being compliant with the provider's orders and with the family. She then stated that the importance of the customizable wheelchair was to provide leisure and allow him to be out of the room. She further stated that the risk of not following through with physician orders results in noncompliance with provider directives and does not meet the expectations of the resident's family. An interview was conducted on March 27, 2026, at 12:03 PM with (Staff #166), who stated that in November 2025, she had completed a wheelchair evaluation, and that a prior evaluation had been conducted for the resident in May 2025. She also stated that they would typically maintain documentation for any communication with the wheelchair company. Staff #166 stated that on November 07, 2025, she completed the wheelchair evaluation and sent over the face sheet, fax sheet, and face-to-face note to the company. However, she was unable to recall the date she attempted to contact the company and noted that this was not documented, which it should be. She also stated that a CNA had notified her that the family had asked about the customized wheelchair, and she had provided the company's phone number for the family to contact the company. She also stated that she was unsure if this incident was even documented. (Staff #166) stated that, for some time, they were using a geri-chair for the resident, but at some point, the family did not want to get up in the geri-chair due to discomfort. She stated that although there were several loner wheelchairs, the geri-chair was the safest for the resident, but he would need to be supervised. She then stated that they did not have a suitable wheelchair for the resident because of his height, weight, and size. She also stated that when the customized wheelchair arrives, they would have to assess its safety. She also stated that the risk of not communicating with family regarding the status of the wheelchair process could result in them becoming upset. A request was made on March 27, 2026, at 1:40 PM for a Durable Medical Equipment (DME) policy and a Quality of Care (QofC) Policy. Facility staff had noted on the request form that there were no specific policies for this request on March 27, 2026. An interview was conducted on March 27, 2026, at 1:41 PM with a Certified Nursing Assistant (CNA/Staff # 527), who stated that Resident #100 is totally dependent on care and is nonverbal. He then stated that the family never brought any concerns regarding the customer's wheelchair to his attention, but there were times when he had helped the resident up onto a recliner. He also stated that the Restorative Nursing Assistant (RNA) staff was working with the Resident on his range of motion. He further stated that the resident is bedbound and that he had not seen the resident outside his room. He then stated that, as humans, we are social beings and need interaction and time outside. He added that, as humans, individuals require social interaction and time outside of their rooms for overall well-being.An interview was conducted at 1:53 PM with a Licensed Practical Nurse (LPN/Staff #69) who stated that she manages the staff, ensures they know what they are doing, and addresses resident requests. She then stated that the resident is totally dependent on care, and she had never seen him with a wheelchair. She then stated that the nursing staff would work on changing, repositioning, and bathing the resident. She then stated that the risk of a resident constantly being in their rooms depends on their condition. She further stated that they should try to get the resident out of the room for activities like bathing, getting sunlight, and socializing. She then stated that if a resident is in their room constantly and is bed-bound, then it can affect their mood depending on the resident. An interview was conducted on March 27, 2026, at 2:29 PM with the Director of Nursing (DON/Staff #63), with the Clinical Resource (Staff #552) present. DON stated that when there is a physician's order, it is confirmed and communicated through all departments. DON then stated that, for this resident, the only note she had seen regarding the customizable wheelchair dated back to November 2025, with no additional documents. DON then stated that the purpose of the customizable wheelchair is to provide the resident with leisure and to allow the resident to leave the room. DON then stated that she would have expected the therapist to follow up on the wheelchair customization and communicate updates to the family. DON also stated that she would have expected the information regarding the customizable wheelchair to have been brought up during the stand-up (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	meeting since the nursing staff would not have access to therapy notes. Clinical Resource (Staff #552) stated that there were two additional residents that have been identified as not being provided continuous care for rehab services. A review of the titled policy Accommodation of Needs, reviewed August 2025, revealed that facility to assure that a resident has the right to reside and receive services in the facility with reasonable accommodation of individual needs and preferences.

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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. Based on observation, staff interviews, and the facility policy and procedures, the facility failed to ensure one medication cart was secured when left unattended. The deficient practice could result in residents, visitors and/or staff members having unrestricted access to medications. The census was 98.Findings include:An observation was conducted on March 26, 2026 at 11:10 a.m. on the C Wing on the first floor, a staff member was preparing medications at the medication cart. The staff member (Registered Nurse (RN), Staff #165) collected the medication cup with the prepared medications and walked around the cart and into the resident room that was located next to the medication cart. The medication cart was left facing out into the hallway, was left unattended and unlocked.Assistant Director of Nursing (ADON) Staff #69 was then observed walking up to the medication cart, and locking the cart.An interview was conducted on March 26, 2026 at 11:11 a.m. with ADON Staff #69. Staff #69 stated that the policy is to lock the carts when you walk away and if you don't, patients or anyone can get into the medications. An interview was conducted on March 26, 2026 at 11:13 a.m. with RN, Staff #165. Staff #165 stated that she thought she had locked her medication cart but it must not have happened and the policy is to lock medication cart. RN Staff #165 concluded the interview by stating the risk for not locking the medication cart, is that someone can get into it.An interview was conducted on March 26, 2026 at 11:15 a.m. with director of nursing (DON) Staff #63 who stated that the policy is to lock medication cart when a nurse walks away. The DON stated that the medication cart can only be open when a nurse is present and stated the risk for leaving a medication cart unlocked and unattended is that anyone can get into it.A review of the facility policy titled, Medication Access and Storage, E kit access, revised July 2023 and reviewed July 2025, revealed that it is the policy of the facility to store all drugs and biologicals in locked compartments.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interviews, and policy review, the facility failed to ensure that the food item was stored in accordance with professional standards for food service safety. The deficient practice could increase the risk of foodborne illness.Findings Include: During an initial walk-through of the kitchen dry storage on March 24, 2026, at 8:26 a.m., with the Kitchen Dietary Manager (staff #65), a gallon-sized container of Pace Chunky Salsa was observed to have approximately 1/10 of its contents used and stored in non-refrigerated dry storage with two different labels dated as February 2, 2026 and March 2, 2026. Then, the Kitchen Dietary Manager opened the lid of the Pace Chunky Salsa, noting that the safety seal had been opened and a portion of the salsa had been used. The Kitchen Dietary Manager immediately discarded the opened container of Pace Chunky Salsa in the trash located in the kitchen. An interview was conducted on March 24, 2026, at approximately 8:28 a.m., with the Kitchen Dietary Manager (Staff #65), who stated that the gallon of opened Pace Chunky Salsa should be in the walk-in refrigerator by the salad dressing area on the top shelf and expressed not knowing what those differing dates indicated. The Kitchen Dietary Manager stated that having an open gallon of Pace Chunky Salsa not properly dated and refrigerated after opening for use does not meet his expectations because it can cause foodborne illness. An interview was conducted on March 26, 2026, at 09:32 a.m., with the [NAME] (Staff #411), who stated that the facility's process for storing open salsa is that it should be dated and refrigerated after it is opened. He stated that, on the morning of March 24, 2026, he opened a new gallon-sized container of Pace Chunky Salsa to fill two little cups of salsa for a resident. The [NAME] stated he ran, back to hustle on the line. He then stated he should have refrigerated the Pace Chunky Salsa after opening. He stated that the risk associated with not refrigerating the salsa after opening is that someone can get sick. A follow-up interview was conducted on March 27, 2026, at 08:25 a.m., with the Kitchen Dietary Manager (Staff #65), who stated that the facility's process for storing open salsa is to first date when the salsa is opened, then put into the walk-in refrigerator. Then he stated that if open salsa is not refrigerated, it can cause foodborne illness, which would not meet his expectation or the facilities' expectations. An Interview was conducted on March 27, 2026, at 08:44 a.m., with the Chief Executive Officer (CEO/staff #264), who stated that the expectation is that opened salsa is refrigerated. He then stated that if there is a risk, it would be that the food would change after being left open in the dry storage. The facility policy titled Food Storage, last revised in 2014, revealed that food should be stored at appropriate temperatures and by methods to prevent contamination or cross-contamination. It also revealed that TCS (Time/Temperature Control for Safety) foods must be maintained at or below 41 degrees Fahrenheit.