STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035299	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northpark Health and Rehabilitation of Cascadia	2020 North 95th Avenue Phoenix, AZ 85037

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 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, facility documentation, policy, and procedures the facility failed to ensure that Resident (#79) was administered only the medications ordered by the provider. The deficient practice resulted in the administration of medications that were not ordered for resident. -Findings include:Resident #79 was re-admitted to the facility on [DATE], with diagnoses of hypertension, chronic kidney disease, and type 2 diabetes.A Comprehensive MDS (Minimum Data Set) assessment dated [DATE], revealed a BIMS (Brief Interview for Mental Status) score of 15, indicating that the resident was cognitively intact.The care-plan initiated on January 05, 2026 revealed that Resident # 79 is on Anticoagulant therapy related to atrial fibrillation and at risk for abnormal bleeding; Interventions included -- Avoid use of aspirin; Resident #79 is on diuretic therapy related to fluid overload; Interventions included -- administer medication as ordered.Review of provider orders and the Medication Administration Record dated January 20, 2026 revealed that Resident #79 had the the following medication orders:Furosemide Oral Tablet 80 Milligram (mg); Start date 01/05/2026Spironolactone Oral Tablet 25 Milligram; Start date 01/06/2026Calcitriol Oral Capsule 0.25 Microgram; Start date 01/06/2026Guaifenesin Extended Release Oral Tablet Extended Release 12 Hour 600 Milligram; Start date 01/05/2026A Blood Pressure summary dated January 2026 revealed the following vital signs:1/11/2026 at 06:47 blood pressure reading was 122 / 62 mmHg1/11/2026 at 21:24 blood pressure reading was 105 / 40 mmHg1/11/2026 at 22:00 blood pressure reading was 88 / 40 mmHg Sitting r/arm1/11/2026 at 23:13 blood pressure reading was 104 / 44 mmHg Sitting r/arm1/12/2026 at 00:27 blood pressure reading was 78 / 38 mmHg Sitting r/arm1/12/20260 at 1:40 blood pressure reading was 83 / 49 mmHg Lying r/arm1/12/2026 at 02:52 blood pressure reading was 87 / 38 mmHg Lying r/arm1/12/2026 at 05:21 blood pressure reading was 80 / 40 mmHg Lying r/arm1/12/2026 at 06:59 blood pressure reading was 104 / 35 mmHg1/12/2026 at 07:03 blood pressure reading was 104 / 35 mmHg Lying r/arm1/12/2026 at 09:16 blood pressure reading was 97 / 48 mmHg OtherAn Order Summary Report dated January 11, 2026 - January 14, 2026, revealed the following: Change of condition for medication error every shift.A review of the clinical records, provider orders, and Medication Administration Record dated January 2026 revealed no active orders for the following medication:Aspirin 325 milligramCarvedilol 6.25 milligramLisinopril 40 milligramNifedipine Extended Release 90 milligramDespite Aspirin, Carvedilol, Lisinopril, and Nifedipine medications not being ordered by a provider, an incident Note dated January 11, 2026, at 17:36 revealed that Licensed Practical Nurse (LPN/Staff #69) had administered Aspirin 325 mg, Carvedilol 6.25 mg, Lisinopril 40 mg, and Nifedipine ER 90 mg instead of Furosemide 80 mg, Spironolactone 25 mg, Calcitriol 0.25 mcg, and Guaifenesin 600 mg. The incident note then revealed that Resident #79's vital signs were immediately assessed for a change in condition. The incident note additionally revealed that LPN /Staff #31), Director of Nursing (DON/Staff #64), and the provider were notified. The incident note also revealed that the provider ordered 10 mg Midodrine and a PIV (Peripheral Intravenous Line). The incident notes revealed that the nurse was advised to hold Furosemide and Spironolactone until further evaluation of the BP (Blood Pressure). The incident note then revealed that the resident and family were notified of the incident. The note then revealed that (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 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	the resident was frustrated about the incident.An email correspondence from a Clinical Consultant Pharmacist addressed the DON on January 12, 2026, revealed an adverse reaction of the following:Carvedilol: Hypotension, orthostatic hypotension, hyperglycemia, weight gain, diarrhea, asthenia, dizziness, and fatigue. Lisinopril: Hypotension, dizziness, acute kidney injury (AKI), angioedema, cough, and hyperkalemia. Nifedipine: Flushing, dizziness, heartburn, headache, and asthenia. Aspirin: perforation, gastrointestinal ulcer, hemorrhage, prolonged bleeding time, and hypotensionFurther review of the email correspondence from the Clinical Consultant Pharmacist addressed to the DON on January 12, 2026, revealed that the resident's vitals would be monitored, and the hypotensive medication would be fully eliminated from the resident's system in 2 to 3 days. The email also revealed that it's recommended to avoid the continuous use of the midodrine unless the resident develops orthostatic hypotension. A Health Status Note dated January 12, 2026, at 4:11 revealed that the resident's blood pressure was checked every hour. The health note then revealed that the order for the 10 mg of midodrine was carried out, and the follow-up BP was 83/49 mmHg with a pulse of 69. The Health note also revealed that an on-call provider's order for Resident #79 to be sent out to the Emergency room, but the resident wanted to wait it out. The Health note then revealed that there were orders for CBC (Complete Blood Count) and CMP (comprehensive Metabolic Panel). The Health note further revealed that Resident #79 was informed that she will be sent out to the emergency room if Hypotension continues. Review of provider orders documentation dated January 20, 2026 revealed that Resident #79 had 2 new medication orders: Midodrine hydrochloride Oral Tablet 10 MG (midodrine hydrochloride) give 1 tablet by mouth one time only for hypotension for 1 day; order date 01/12/2026; start date 01/12/2026; end date 01/13/2026; order status completed. Review of MAR revealed that Midodrine was administered at 0630 by Staff #83 and again at 0045 by Staff #58 on 01/12/2026. Additionally, review of provider orders documentation dated January 20, 2026 revealed that Resident #79 had a new medication order: Albumin Human Intravenous Solution 25% (Albumin Human) Use 12.5 gram intravenously one time only for hypotension for 1 Day May repeat one additional dose if SBP remains below 100.Review of MAR revealed that Albumin Human Intravenous Solution 25% was administered at 1730 by Staff #83 on 01/12/2026. An Internal Investigation Report dated January 13, 2026, revealed that Resident #79 had a history of acute chronic diastolic heart failure, hypertension, and is at high risk for hypotension. The internal investigation then revealed that on January 11, 2026, (LPN/Staff # 69) administered medications to Resident #79 that were intended for another resident. Resident #79 was scheduled to receive Calcitriol, Furosemide, and Spironolactone, but instead was administered Carvedilol 6.25 mg, Lisinopril 40 mg, Aspirin 325 mg, and Nifedipine 90 mg. The report also revealed that the immediate actions taken were: a change in condition, vital signs obtained, and BP was 127/54 with a heart rate of 82, monitoring for adverse effects, and medication administration stopped immediately. The investigation then revealed that Resident #79's creatinine elevated to 2.9; eGFR 15, and no hypotension or bradycardia was noted at the time. The investigation then revealed that the IV dislodged overnight, and the resident declined IV replacement. The report then revealed a plan to continue monitoring BP, and resident #79 was determined to be medically unable for discharge due to rising creatinine and subtherapeutic INR. The note further stated that continued monitoring due to the high clotting risk associated with the mechanical valve. The investigation then revealed education and corrective actions for in-service, the five rights of Medication administration, and individual education and counseling were provided to (LPN/Staff #79), including reinforcement of patient identification, medication verification, and adherence to facility policy. An interview was conducted on January 21, 2026, at 12:32 PM with a Certified Nurse Assistant (CNA/Staff #130), who stated that CNAs check residents' Blood Pressure (BP); and that, a normal BP would be 120/80mmHg. She then stated that the blood pressure range depends on the resident's health condition. She further stated that nurses are the ones who do medication administration, but that it is important for nurses to verify who the resident is prior to giving out the medication. An interview was conducted on January 21, 2026, at 12:47 PM with (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Licensed Practical Nurse (LPN/Staff #5), who stated that CNAs are the ones who obtain the baseline BP (Blood Pressure). She then stated that if a resident's BP is elevated or too low, then they will use a manual machine to verify BP. She further stated that if BP is elevated, then BP medication would be administered and provider will be notified. She then stated that a normal BP systolic range is 120 mmHG to 140 mmHG, and to be considered low, it would need to be under 100 mmHG. She stated that when the BP diastolic range is in the 40's, they would notify the provider. She then stated that the process for administering medication is to get the medication cart key, count the narcotics tablets, and ensure that Over the Counter (OTC) medications are up to date. She will then attend to the residents with high BP, the resident who asked for pain medication, and move on to those who are awake. She also stated that staff would verify the resident receiving the medication she would compare the MAR (Medication admission Record) and medication on hand in order to verify the resident. She then stated that when the residents have given her consent to come into the room, and then she will verify with the resident their name and birthday. She then stated she would wait in the room to make the resident take their medication. Staff #5 confirmed that an incident note dated January 11, 2026, Resident #79 was administered aspirin 325 mg, Carvedilol 6.25 mg, lisinopril 40 mg, and nifedipine ER 90 mg instead of Furosemide 80 mg, Spironolactone 25mg, Calcitriol 0.25 mg, and Guaifenesin 600mg. She added that after the medications were administered resident's BP dropped significantly, and the provider was notified. She further stated that there was orders added to administer 10 mg midodrine, CBC (completed Blood Count), and CMP (Comprehensive Metabolic Panel) to check kidney function. She also confirmed that Resident #79 had no orders for Aspirin 325 mg, Carvedilol 6.25 mg, Lisinopril 40 mg, and Nifedipine ER 90 mg. She stated that Aspirin is an anti-coagulant, which means that staff would monitor for bleeding, bruises, and nosebleeds. She also stated that Carvedilol is a beta blocker that lowers blood pressure and heart rate and can cause fainting, dizziness, and falls. She further stated that Lisinopril is a BP medication, and they will monitor the resident for dizziness and fainting. She then stated that Resident #79 had orders for Furosemide 80mg, Guaifenesin 600mg, Calcitriol 0.25 mcg, and Spironolactone 25 mg. She then stated that the impact with taking those medication not ordered but administered was that it could harm the kidney, return to the hospital, cause fainting, and possibly result in death. A telephonic interview was conducted on January 21, 2026, at approximately 2:59 PM with (LPN/Staff # 69), who stated that when performing medication administration, she uses the MAR and medication in hand to verify that it was the correct resident. She stated that then asks a resident for name to make sure that she has the right medication on hand. Staff # 69 stated that on the date of the incident, instead of entering the intended resident's room for the medication administration she entered Resident #79's room. She further stated Resident #79 had questioned the Enoxaparin Injection after she had administered the oral medication. She then stated that she had taken the Enoxaparin Injection from the resident and went out of the room to review the MAR. She also stated that she realized that she had administered the wrong medication because the MAR she had up was for a different resident. She then stated she notified the charge nurse (LPN/Staff #31) at the time about the incident, and he did verified that the wrong medication was administered. She then stated (LPN/Staff #31) spoke with the provider, the resident's vitals were reassessed, and resident BP continued decreasing. She then stated that they had attempted to evaluate the BP the resident by having her head close to the head of the bed, raising her legs up, and repositioning her. She also stated that the provider ordered midodrine to increase BP. She further stated that when Resident #79 was informed about the medication error, she was frustrated. She then stated that the risk of this is that the BP went down, and if the resident did not improve, she would be sent out to the hospital. An interview was conducted on January 22, 2026, at 8:24 AM with (LPN/Staff #32), who stated that she provides training to the facility's staff about medication safety, verification of medication, and proper infection control. She stated staff should examine the resident's MAR and medication on hand to verify the correct resident. She stated that when entering the resident's room to administer medication, they should make sure that it is the right (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	resident, by asking for the resident's name and looking at their arm band. She further stated that she will describe the intent of the medication to the resident. She also confirmed that the incident note dated January 11, 2026, Resident #79 was administered Carvedilol 6.25 mg, Lisinopril 40 mg, Nifedipine ER 90 mg, and aspirin 3.25 mg, and none of these medications were part of her orders. Staff #32 stated that it was reported to her that Staff # 69 had administered incorrect medication to Resident #79. She further stated that when Resident #79 had questioned Staff #69 about the Enoxaparin Injection medication, Staff #69 reviewed the MAR and realized that she had the wrong medication. She then stated that the provider and charge nurse at the time were notified, and the provider wanted the resident to be on IV to help increase the BP for Resident #79. She further stated that overnight, the resident was hypotensive, but the resident consented to the IV treatment later on in the day. She stated that the adverse reaction was that the resident's BP went down. She also stated that the risk is that the resident may be hypotensive, and the use of aspirin may lead to internal bleeding. An interview was conducted on January 22, 2026, at 11:04 AM with Resident #79, who stated that the nurse came into her room and accidentally administered the wrong medication. She then stated that the nurse did not ask for her name and told her the medication that would be administered was for high blood pressure. She also stated that the nurse told her that her MAR was right next to the other resident, who was supposed to receive those medication instead. She then stated that the nurse apologized to her about administering the wrong medication, but she was not happy about that. Resident #79 stated that she knew something was not right because the nurse was informing her that she had permission to administer Enozaprin Injection, and she informed the nurse that she does not get Enozaprin Injection. She further stated that the wrong medication that was administered to her - took about two to three days to clear out of her system, and the staff were having a hard time keeping her BP at a normal range. An interview was conducted on January 22, 2026, at 12:42 PM with (LPN/Staff #31) via phone, who stated that he will review blood sugar before meal time and BP before administering medications. Staff #31 stated that the BP will be reassessed if it is too low or too high. He further stated that when administering medications, he would utilize the 5 rights: right resident, right dosage, right medication, right route, right reason, and right time. He then states that to verify the 5 rights, he would look at the MAR and the medication card. He further stated that he would also ask the resident for their date of birth , and check their arm band to verify that it is the right resident. He confirmed that (LPN/#69) had administered the wrong medication to a resident. He stated that a new order for Midodrine to help bring the bp up was administered by the nurse. He then stated that the impact of this risk is that the resident's BP dropped and that she needed medication to help bring it up. An interview was conducted on January 23, 2026, at 1: 52 PM with the DON, who stated that (LPN/Staff #31) had told her that (LPN/Staff # 69) had administered the wrong medication to Resident #79, and a change of condition order for 3 days. She then stated that the provider and family were notified of the incident. DON stated that when Staff #69 was trying to give the Enoxaparin Injection medication, the resident told her that it was not a medication. She then stated to the Staff #69, look at the MAR she had up, she realized that she had a different resident. She then stated Carvedilol 6.25 mg, Lisinopril 40 mg, and Nifedipine ER 90 mg were administered instead of Calcitriol 0.25 mcg, Spironolactone 25 mg, and furosemide 80 mg. The DON also stated that as a result of this, Resident #79 had low blood pressure and they had offered her IV fluid, but Resident #79 did not consent till later. The DON also stated that before the medication error, the resident's BP was 110/58, and within 24 hours, the resident's BP dropped to 88/40 mm HG.A policy title Medication Administration revealed that staff are responsible for following the 20 rights of medication: right medication, right resident, right dose, right route, and right time and frequency.

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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 observations, staff interviews, and a review of facility policy, the facility failed to ensure medications were not stored past their expiration date. The deficient practice could result in expired drugs stored in the facility available to be used for the residents. Findings include:An observation of a medication storage room was conducted on January 23, 2026, at 9:07 am, in the presence of the Assistant Chief Nursing Officer (ACNO/Staff #21). The following medications were found to be stored past expiration:- 1 bottle of Geri-Dryl (Diphenhydramine Hydrochloride), expiration date of 07/2025During a observation of a second medication storage room on January 23, 2026 at 9:17 am, in the presence of Staff #21, the following medications were found to be stored past expiration:- 2 bottles of Melatonin 3 milligrams, expiration date of 11/2025An interview was conducted on January 23, 2026 at 9:10 am, with the Assistant Chief Nursing Officer (ACNO/Staff #21) who confirmed that the medications were expired. Staff #21 stated that the expectation was that whoever is stocking the medication rooms also goes through the medications to ensure that they are not expired. She further stated that the risk associated with storing expired medications is that the medications are less effective. An interview was conducted on January 23, 2026, at 12:12 pm, with the Chief Nursing Officer (CNO/staff # 64). Staff #64 stated that both central supply and nursing leadership are responsible for inventorying the medication storage rooms and disposing of expired medications. She further stated that the expectation is that medications are checked for expiration before the medication leaves the medication storage room. Staff #64 stated that the risk associated with storing expired medications is that there could be adverse reactions. Review of the policy titled, Medication Storage and Labeling, released October 13, 2025, revealed that facility policy is that, . medications are stored and labeled in accordance with CMS regulations, state law, and acceptable professional principles to ensure safety, efficacy, and compliance. Further review revealed that facility policy also states, 4. Inspection and Monitoring a. Nursing leadership inspects medications carts and storage rooms for: . ii. Expired or damaged medications, and 5. Disposal a. Expired or discontinued medications must be removed promptly and disposed of per facility policy and DEA guidelines to prevent diversion.