STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035302	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diamondback Healthcare Center	3000 N 91st 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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Keep residents' personal and medical records private and confidential. Based on clinical record review, staff interviews, observation, and policy review, the facility failed to ensure resident-identifiable information was maintained confidentially and protected from public view for one Resident (#29). This deficient practice resulted in the exposure of protected health information (PHI) to an unauthorized individual and could result in a violation of residents' rights to privacy and confidentiality. Findings include:An observation conducted on January 29, 2026, at 10:45 a.m. revealed an unattended computer workstation with resident records actively displayed on the monitor. No facility staff were present or monitoring the workstation at the time of the observation. The information displayed on the computer screen included personal and identifiable dietary information for Resident #29.At 10:46 a.m., a non-employee was observed walking down the hallway and passing directly by the computer monitor displaying Resident #29's personal information, with no attempt made by staff to shield or secure the information.At 10:47 a.m., the Director of Nursing (DON/Staff #85) approached the unattended workstation and immediately logged off the computer.An interview conducted on January 29, 2026, at 10:47 a.m. with Staff #85 who confirmed that the unattended computer contained private resident information. Staff #85 acknowledged that leaving resident information visible on an unattended workstation could constitute a violation of the Health Insurance Portability and Accountability Act (HIPAA) and failed to meet facility expectations for protecting resident confidentiality.On January 29, 2026, at 11:54 a.m., Staff #85 provided documentation of staff training titled, PHI (Protected Health Information), Close Screens - Do Not Leave Information Exposed, Confidentiality, Policy Review, HIPAA, and Resident and Family Notification. The documentation indicated that 31 staff members had signed, acknowledging their understanding of the confidentiality requirements.A review of the facility policy titled Resident Rights, revised January 1, 2025, revealed that residents have the right to secure and confidential personal and medical records and that the facility is responsible for safeguarding resident information from unauthorized access or disclosure.

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record review, staff interviews, review of facility process and policy, and the State Operations Manual the facility failed to ensure that all transfer/discharge notifications were made for two residents (#17 and #22). The deficient practice could lead to notifications and pertinent information regarding the discharge/transfer not being provided.Findings include:Regarding Resident #17 -Resident #17 was admitted to the facility on [DATE] with diagnoses of acute respiratory failure with hypoxia, fracture of the left femur, pulmonary hypertension, heart failure, and pneumonia. Review of the Ombudsman notification provided by the facility revealed no corresponding notification pertaining to the hospital transfer on September 5, 2024. The notification information provided was dated August 29, 2024 which was for a planned discharge. Review of the resident's face sheet revealed that the husband was listed as the responsible party while the daughter was listed as the emergency contact. The face sheet also listed the contact numbers for both the responsible party and the emergency contact. Additionally, the face sheet indicated that the resident was discharged to the hospital on September 5, 2024.A Physician Visit note dated September 5, 2024 revealed that the resident had a rapid decline in mental status and was sent to the hospital due to unresponsiveness. Review of the Order Summary Report did not reveal any order for the resident to be sent to the hospital. A discharge Minimum Data Set (MDS) assessment dated [DATE] revealed the reason for the assessment as discharge assessment-return anticipated. The MDS indicated that the resident was sent to the hospital. Review of the clinical record revealed no documentation of a transfer notice being provided to the resident or resident representative consisting of the required information. Regarding Resident #22 -Resident #22 was originally admitted to the facility on [DATE] with diagnoses of ventilator associated pneumonia, sepsis, respiratory failure with hypercapnia, type II neurofibromatosis, respirator dependence, visual loss, and pleural effusion. Review of the resident's face sheet revealed that the resident's mother was listed as her emergency contact. A contact number was listed for the mother was listed on the face sheet. An eINTERACT Transfer form dated June 24, 2025 revealed that the resident was transferred to the hospital due to hypotension. A Nursing Note dated June 24, 2025 documented that resident's blood pressure was 84/65. The POA (Power of Attorney) was at bedside and provider was notified. Per the note 911 was called for transport to emergency room per physician's orders. Review of the Order Summary Report revealed a physician's order dated June 24, 2025 which directed for resident to be transferred to the ER (emergency room) for hypotension. A discharge Minimum Data Set (MDS) assessment dated [DATE] revealed the reason for the assessment as discharge assessment-return anticipated. The MDS indicated that the resident was sent to the hospital on June 24, 2025. The assessment documented that the resident has severe cognitive impairment. Review of the clinical record revealed no documentation of a transfer notice being provided to the resident or resident representative consisting of the required information. An interview with a Social Worker (SW/staff #61) was conducted on January 29, 2026 at 3:13 p.m. Staff #61 stated that Social Services/Case Management is not involved with transfer/discharge notifications. Per Staff #61, it is Medical Records that oversees transfer/discharge notifications. An interview with the Medical Records Director (Med Rec Dir/staff #56) was conducted on January 29, 2026 at 3:17 p.m. Staff #56 stated that she just started tracking transfer/discharge notification around October 2025. She indicated that a form for transfer/discharge was created October 2025. This was also around the time that she took over ombudsman notification. Staff #56 said that the facility's liaison (staff #120) visits the residents transferred to the hospital and provides them the transfer/discharge notification. Otherwise, it is mailed out. However, she (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	noted that she is not involved in the bed hold briefing as it is done during admission. Staff #56 noted that she is unsure of how mailed out notification is tracked. Completed transfer/discharge notifications are normally scanned into the residents' clinical records. However, the form can only be uploaded if provided to her. If she does receive the completed transfer/discharge form then it cannot be uploaded. Staff #56 said that transfer/discharge notification is important so that the resident/resident representative has information regarding the transfer/discharge, and their appeals rights. Per the Medical Records Director, the ombudsman is the resident's advocate and therefore should be aware of the resident's status. The resident needs the ombudsman's info because that is their advocate. Staff #56 said that it is important that they are able to provide documentation regarding the transfer/discharge notification since it shows that they are taking care of their residents and document the information that was provided to them. Without that documentation there is no paper trail of what information was passed on. A copy of the facility's transfer/discharge notification form was reviewed with Staff #56. It was noted that the information for the appeals was wrong. Additionally, the information for the ombudsman was also incorrect. Staff #56 stated that she is unsure of where that information was obtained. A review of residents #17 and #22 was conducted with staff #56. Staff #56 confirmed that there was not transfer/discharge notification in either residents' record. During an interview with the Admissions Coordinator/Clinical Liaison (staff #120) conducted on January 29, 2026 at 4:50 p.m., staff #120 stated that he visits the hospital where the residents were transferred to provide a means of contact between the facility and the residents. Staff #120 stated that he does not provide any transfer/discharge form or packet to the resident or resident representative during the visit. Additionally, he stated that he is unfamiliar with the form. Staff #120 said that it is important for the residents to be provided a transfer/discharge notification since most residents have never been in this circumstance before and would need information regarding resources and their rights. It is good to have that information that way they would want to come back. The impact of residents/resident representative not receiving that information is that they would not want to come back, might get the perception that they cannot come back, and lack information that they might need. An interview with the Administrator (staff #107) was conducted on January 29, 2026 at 6:02 p.m. The Administrator stated that a transfer notice is provided to the resident/resident representative 3-days prior to discharge. The Administrator said that there is a transfer/discharge notification for each level and each one has a checklist. The responsible party is called if not in the building during a change in condition. Per the Administrator, it is important that the transfer/discharge notification is provided since it is required per regulation, policy, continuity of care, and so that the resident/resident representative knows their rights and actions to take. The potential impact of not providing a transfer/discharge notification to the resident/resident representative is that resident might not receive the care needed and not know how to exercise their rights. The facility's transfer/discharge notification form was reviewed with the Administrator and she noted that it did not look like the one she approved and was unaware her team was utilizing the form. The Administrator stated that she is unaware of where the contact information for the appeals was obtained. The Administrator was informed that contact information for the appeals portion was erroneous. Review of the facility policy titled Discharge/Transfer of a Resident implemented January 1, 2025 stated that for unplanned discharge such as emergent transfer to an acute care setting, the facility will review the bed hold policy with the POA within 24 hours of transfer. Further review of the facility's policy for discharge/transfer did not reveal that it addressed transfer/discharge notification to resident/resident representative. Additionally, the policy did not indicate what the required information are that (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	is to be provided to the resident/resident representative. Per the State Operations Manual Appendix PP, revision 232, the facility must notify in writing the resident and the resident's representative of the transfer/discharge which includes the following items: The reason for the transfer or discharge;The effective date of the transfer or discharge;The location to which the resident is transferred or discharged A statement of the resident's appeal rights including the name, address and telephone number of the entity which receives the request, and information on how to obtain an appeal form and assistance I completing the form and submitting the appeal hearing requestThe name, address and telephone number of the Office of the State Long-Term Care OmbudsmanThe contact information for the agency responsible for the protection and advocacy of individual with developmental disabilities (if applicable)The contact information for the agency responsible for the protection and advocacy of individual with mental disorder (if applicable)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to accurately document that a medication was discontinued and rationale thereof for one (#28) of three sampled residents. The deficient practice could result in negatively impacting continuity of care documentation. Findings include:Review of Resident #28's hospital records prior to admission revealed that she was admitted to the hospital on [DATE]. Upon discharge from the hospital, the medication list indicated no medication changes, and included olanzapine 2.5 mg by mouth once daily.Resident #28 was admitted to the facility on [DATE], with diagnoses including: urinary tract infection, resistance to multiple antibiotics, noninfective gastroenteritis and colitis, cerebral palsy, muscle weakness, abnormalities of gait and mobility, and depression.Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 9, indicating moderate cognitive impairment. The MDS further revealed that Resident #28 had exhibited no verbal or physical behavioral symptoms directed toward others during the assessment period.Review of physician orders revealed an order initiated on November 6, 2025, for olanzapine oral tablet, 2.5 mg by mouth once daily, with an indefinite end date.Review of the Medication Administration Record/Treatment Administration Record (MAR/TAR) revealed that olanzapine 2.5 mg was administered to Resident #28 on November 6, 7, 8, 9, 10, and 11, 2025. The MAR documented that olanzapine was discontinued on November 11, 2025, at 11:41 a.m.Further review of the MAR/TAR revealed an order for behavioral monitoring related to the use of the antipsychotic medication olanzapine, initiated on November 5, 2025, at 6:00 p.m. This monitoring order remained active and continued through Resident #28's discharge on [DATE], despite the discontinuation of olanzapine on November 11, 2025. No behavioral symptoms were documented during this period.Review of a physician history and physical progress note dated November 5, 2025, indicated that Resident #28 was recommended to continue olanzapine and benztropine for psychosis.On November 11, 2025, a psychiatry progress note was entered into the clinical record for Resident #28 and signed by the physician assistant (PA/Staff #224). The note documented that this was the initial psychiatric visit and stated that, from a psychiatric standpoint, no medication changes were recommended. The note did not document the discontinuation of olanzapine, despite the medication being discontinued later that same day. The note further directed staff to refer to the MAR for non-pharmacologic interventions.On November 11, 2025, a discontinue order for olanzapine was entered into the clinical record, noted as a telephone order given by PA/Staff #224 and entered by LPN/Staff #170. Review of the MAR confirmed that olanzapine was not administered after November 11, 2025; however, the associated behavioral monitoring order remained active.On November 13, 2025, a nurse practitioner progress note documented that Resident #28 would continue olanzapine and benztropine for psychosis.On November 17, 2025, a subsequent nurse practitioner progress note again documented that Resident #28 would continue olanzapine and benztropine for psychosis.Census records revealed that Resident #28 was discharged from the facility on November 19, 2025. Review of discharge records revealed that Resident #28 was discharged without a prescription for olanzapine.On January 29, 2026, at 11:09 a.m., an interview was conducted with LPN/Staff #170, who stated that physician orders are frequently entered into the electronic medical record by nurses and may be received via telephone, text message, or in person.On January 29, 2026, at 2:48 p.m., an interview was conducted with the nursing unit manager/LPN (Staff #211). Staff #211 stated that when an antipsychotic medication is discontinued, a black box warning alerts the user. Upon review of the clinical record, Staff #211 identified that although olanzapine was discontinued on November 11, 2025, provider documentation indicated that (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	no medication changes were made. Staff #211 further stated that no changes were made to alert charting or behavioral monitoring following the discontinuation of olanzapine.On January 29, 2026, at 3:38 p.m., a telephone interview was conducted with the facility pharmacy consultant (Staff #228). Staff #228 stated that newly admitted residents are reviewed for diagnoses, behaviors, and medications. Staff #228 further stated that olanzapine 2.5 mg is commonly prescribed during hospitalizations for short-term behavioral control and that discontinuation typically does not require continued monitoring when the medication is no longer prescribed.On January 29, 2026, at 4:09 p.m., a telephone interview was conducted with PA/Staff #224. Staff #224 stated that he evaluated Resident #28 on November 11, 2025, at approximately 10:00-11:00 a.m. and subsequently discontinued olanzapine at 11:41 a.m. Upon review of his progress note, Staff #224 acknowledged that documentation of the discontinuation of olanzapine was omitted.Review of the facility policy titled Nursing Documentation, implemented October 1, 2025, revealed that nursing documentation is intended to accurately communicate changes in a resident's condition, treatment, and orders.Review of the facility policy titled Provision of Physician Ordered Services, implemented January 1, 2025, revealed that documentation of physician consultations and orders must be maintained accurately in the resident's clinical record.