

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  035302	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2026
NAME OF PROVIDER OR SUPPLIER  Diamondback Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observations, staff interviews, and policy review, the facility failed to ensure that food is labeled and dated after opening in accordance with professional food safety standards. The deficient practice may result in practices of food storage that may not be in accordance with professional food safety standards. Findings include: An observation of the kitchen was conducted on January 4, 2026, at 8:40 AM with the facility's Dietary Manager (DM/Staff #152). The following food items were discovered without labels indicating what date they had been opened: Two liquid egg cartons did not have an opened date label. One bag of chicken tenders in the freezer without opened date label. One bag of tilapia in the freezer had no opened date label. One bag of hot dog buns had no opened date label. The dietary manager proceeded to remove these items from the refrigerator and freezer and disposed of the food with no open date labels. An interview was conducted on January 5, 2026, at 10:40 AM with the DM/Staff #152, who stated that the food should be labeled with the date that it is opened, and the expiration date. Staff #152 stated that if food had no opened date or expiration date label, the kitchen staff should dispose of it immediately because eating from open, undated food could pose a risk to the residents. An interview was conducted on January 5, 2026, at 1:43 PM with the registered dietitian (Staff #206) who stated that the expectation was that all food products are properly labeled and dated upon delivery and storage, as well as thereafter, once items have been opened. Staff #206 stated that the risk included not knowing when the food was received, stored, or opened. A review of the policy titled, Food Safety Requirements (dated 2014), revealed that food will be stored, prepared, distributed, and served in accordance with professional standards for food service safety. The policy further noted that all foods will be labeled, dated, and monitored refrigerated food, including, but not limited to leftovers, so that it is used by its use-by date.</p>

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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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review, observations, staff interviews, and review of policy and procedures, the facility failed to ensure proper infection prevention and control practices were implemented related to contact precautions for one resident of 5 residents (#117) and the facility failed to ensure that community infection control surveillance mapping was documented. The deficient practice could result in transmission of infection in the facility. Findings include: -Regarding Contact Precautions: Resident #117 was admitted to the facility on [DATE] with diagnoses that include enterocolitis due to clostridium difficile (C. Difficile), not specified as recurrent, urinary tract infection, site not specified, and other psychoactive substance abuse. Review of the comprehensive care plan dated February 3, 2026 revealed a focus for C. Difficile with interventions that included to use contact precautions such as: gowns and gloves during high-contact care activities, wear gowns and masks when changing contaminated linens, and use as much disposable equipment as possible. Review of a physician order with a start date of February 3, 2026, revealed single room contact precautions for C. Difficile (diagnosed), all cares, therapies and activities in room every shift until February 12, 2026. An observation was conducted on February 4, 2026 at 12:36 p.m. of Resident #117's room. Outside the room was a yellow signage which indicated the room was on contact precautions and required personal protective equipment (PPE), such as gowns and gloves, before entering the room. Additionally, a three-tiered isolation cart was positioned outside of Resident #117's room which contained disposable gowns, gloves, face masks, and sanitizing wipes. An observation was conducted on February 4, 2026 at 12:36 p.m. of a Certified Nursing Assistant (CNA/Staff #129) exiting Resident #117's room, a contact isolation room, without performing hand hygiene after delivering a meal tray. Upon exiting, the CNA was observed to grab another meal tray from the food cart then pushed the same tray back in the cart. There was no evidence that the meal tray the CNA touched and pushed back into the tray cart was discarded. Additionally, staff was observed to continue passing meal trays from the same food cart. Review of a Coaching and Feedback Form provided by the Administrator (Staff #62) revealed that the CNA (Staff #129) entered a contact isolation room without donning PPE and the course of action for this concern included providing education on proper PPE, isolation signage, and policies. An interview was conducted on February 4, 2026 at 12:43 p.m. with the CNA (Staff #129) who confirmed exiting the room of a resident that was on contact precautions without performing hand hygiene. The CNA stated that when a resident is on contact precautions, staff must don gowns and gloves when entering the room and doff gowns and gloves before exiting, provide disposable meal trays, perform hand hygiene, and disinfect any reusable items. The CNA stated that the signage and PPE outside of the room indicated what isolation precautions a resident requires. The CNA stated that the risks of not following contact precautions may result in the spread of the infection to staff and other residents. An interview was conducted on February 4, 2026 at 1:07 p.m. with a Licensed Practical Nurse (LPN/Staff #179), who stated that for a resident on contact precautions, staff need to use proper PPE which includes, mask, gowns, and gloves when entering the room. Staff #179 stated that the risks of not wearing the required PPE included spreading of the infection. An interview was conducted on February 4, 2026 at 1:26 p.m. with the Administrator (Staff #62), the Infection Preventionist (IP/Staff #140), with CNA (Staff #129) in attendance. The Administrator stated that due to an incident, involving CNA (Staff #129) not wearing contact isolation PPE when entering Resident #117's room to deliver a meal tray, and not performing hand hygiene upon exiting that the CNA would be placed on leave to minimize the potential spread of infection. The administrator stated that new scrubs were provided to the CNA (staff #129). The Administrator further stated that Resident #117 had C. Difficile which is highly contagious and is the reason why contact isolation precautions were required. The Administrator and Infection Preventionist stated that contact precautions must be followed even when delivering meal trays, and explained that there are (continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>serious risks if these isolation precautions are not followed. During the same interview as above, the CNA (staff #129), relayed stated that she knows it's a big deal and she has no idea why she didn't put on PPE, and that she has never worked on that unit. Review of the policy titled, Infection Prevention and Control Program (IPCP), last reviewed/ revised on January 1, 2025 revealed, the facility maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. Further review of the IPCP revealed hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures and all staff shall use personal protective equipment (PPE) according to established facility policy governing the use of PPE.</p>