

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035072	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/17/2025
NAME OF PROVIDER OR SUPPLIER Phoenix Mountain Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 13232 North Tatum Blvd Phoenix, AZ 85032	

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 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility assessment, facility documentation, staff interviews, personnel files, and facility policy, the facility failed to ensure that one staff member (#65) had the competencies and skill sets necessary to provide nursing and related services to safely meet one resident's (#166) transfer needs. The deficient practice regarding resident transfer equipment could increase the risk for accident-related injuries.</p> <p>Findings include:</p> <p>Resident #166 was admitted to the facility on [DATE] with the diagnosis type 2 diabetes and muscle weakness.</p> <p>A care plan focus of self-care performance deficit with the initiation dated of August 29, 2019 revealed that Resident #166 requires a Hoyer lift for transfers.</p> <p>A quarterly MDS (Minimum Data Set) assessment dated [DATE] revealed that Resident #166 had been dependent on helper assistance for chair to bed transfers, toilet transfers, and shower/tub transfers. Indicating that the resident relied on staff assistance to transfer in and out of their bed, and, into their wheelchair.</p> <p>A review of the facility's 2025 facility assessment revealed provided services include mobility and fall prevention with practices such as transfers. The assessment noted that in addition to required certification and licensure, all staff are oriented at the time of hire and receive all required training on an ongoing basis to meet the residents' needs, as identified, including the necessary competencies and skill sets. The assessment also revealed that the facility has identified competencies and trainings regarding transfers can include gait belts and mechanical lifting techniques. The assessment included factors that may affect the care provided by the facility, including staff competencies.</p> <p>On June 13, 2025 at 8:50AM, there was an observation of a CNA (certified nursing assistants/Staff #65) utilizing a Hoyer lift with Resident #166. There were no other staff members assisting Staff #65 with the usage of the Hoyer lift to transfer the resident.</p> <p>(continued on next page)</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 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with Staff #65 on June 13, 2025 at 10:48AM, where Staff #65 stated that the facility had provided training on Hoyer lift usage and the expectations regarding the utilization of mechanical lifts for transfers. Staff #65 stated that the usage of medical equipment is discussed during in-service trainings, and, as well as monthly meetings for CNAs. Staff #65 stated that the facility's expectation is to have two staff members present when utilizing a Hoyer lift. Staff #65 had also stated that they did not have a second staff present when utilizing the Hoyer lift with Resident #166 during the observation mentioned above.</p> <p>An interview was conducted with a CNA (Staff #17) on June 13, 2025 at 11:03AM, where Staff #17 stated that the usage of a Hoyer lift requires two staff to be utilized properly and to the facility's expectations. Staff #17 also advised that they facility had a recent training regarding how to utilize a Hoyer lift and that the requirement of two staff had been reiterated during that medical equipment training.</p> <p>An interview was conducted on June 13, 2025 at 11:20AM with an LPN (Licensed Practical Nurse/Staff #94), where Staff #94 stated that a Hoyer lift should not be used by any staff in the facility unless there are two staff present to utilize the mechanical lift. Staff #94 also stated that there should not be a problem to obtain a second staff member to complete a transfer with a Hoyer lift as CNA's are encouraged to ask staff such as a nurse or a therapy staff member.</p> <p>An interview was conducted with the DON (Director of Nursing/Staff #81) on June 13, 2025 at 1:08PM, where Staff #81 stated that the facility's expectations regarding the usage of a Hoyer lift requires two people to be able to utilize the equipment appropriately to meet the needs of a resident. Staff #81 also stated that the requirement of two staff members is important for the safety of the resident and as well as the staff members who utilize the equipment.</p> <p>Review of the facility policy, Resident Safety - Mechanical Lift, revealed that the policy is to help ensure the safety of the employees and the residents. The policy also revealed that the policy applies to all healthcare personnel involved in patient care and transfers within the facility. The policy also revealed that there should always be a minimum of two healthcare personnel during patient transfers with a mechanical lift, to ensure there is one person operating the equipment and one who assists the person operating the equipment.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, staff interviews, and review of policies and procedures, the facility failed to ensure clinical record documentation was accurately documented for one resident (#111) regarding medication administration. The deficient practice has the potential for clinical records to inaccurately and incompletely reflect the administration of medications to all residents.</p> <p>Findings include:</p> <p>Resident #111 was admitted to the facility on [DATE] with the diagnosis of Schizophrenia.</p> <p>An order dated November 28, 2023 revealed that a complete blood count with differential is to be completed every Monday for Clozapine monitoring, and, to fax the results to the pharmacy for review.</p> <p>An order dated December 6, 2023 an order of Clozapine 25 MG oral tablet one time a day for Schizophrenia. This ordered had been discontinued on February 20, 2024.</p> <p>A Minimum Data Set (MDS) assessment dated [DATE], revealed the resident had a Brief Interview for Mental Status score of 14, which indicated the resident was cognitively intact.</p> <p>A medication administration record for February 2024 revealed that the resident had been administered Clozapine 25 MG on February 9, 2024; February 14, 2024; and February 18, 2024. Indicating that from February 1, 2024 to February 20, 2024, Resident #111 did not receive Clozapine 25 MG on the days not listed above.</p> <p>An interview was conducted on June 11, 2025 at 11:19AM an LPN (Licensed Practical Nurse/Staff #12, where staff #12 stated what the facility's expectations are regarding the medication process. Staff #12 stated that if a medication is not available for a resident in their designated medication cart, that they will refer to the facility's additional medication storages to locate additional supply. Staff #12 also stated that if the medication is not present, they are to reach out to the provider and the pharmacy as soon as possible to determine the status of the order. Staff #12 also stated that a detailed description of what was done, who was contacted, and any directives given by either the provider or the pharmacy, and to notate that description into the progress notes of the resident's electronic health records. Although Staff #12 did not provide care to Resident #111, Staff #12 also stated that the completion of this process, in regards to Clozapine, is to prevent the risk of increased symptoms of anxiety, restlessness, confusion and behaviors. Staff #12 also stated that although medications can take time to get to the facility, there can be times where the medication may not be available for a few days and having accurate documentation of what was done to obtain a status is important.</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Another interview was conducted on June 11, 2025 at 12:01PM with an LPN (Staff #11), where Staff #11 stated that if a medication is not available that there is an emergency box where medications can be located. Staff #11 also stated that the pharmacy and as well as the provider would be contacted to determine where the medication is and the status of the order. Staff #11 also stated that they are to seek guidance from the provider as well to determine what to do for the resident. Staff #11 also stated that a progress note in the resident's electronic health record would be completed with the information of any updates and that the medication was not administered due to not being available. Staff #11 also stated that there may be times where family notification will need to be done and that is expected to be documented in the progress note as well. Staff #11 had been familiar to the behaviors Resident #11 exhibited, however did not provide direct care with the resident and did not directly administer medication to the resident. Staff #11 also stated that the completion of accurate administration and documentation of medications, in regards to Clozapine, can prevent to risk of signs and symptoms worsening.</p> <p>There was an attempted interview with the contracted Psychiatric Provider (Staff #158) who had been the provider at the time of the review of Resident #11 on June 12, 2025 at 11:12AM, who had been the Psychiatric Provider at the time of the review. However, it was unsuccessful.</p> <p>An interview had been conducted on June 12, 2025 at 1:04PM with the current contracted Psychiatric Provider (Staff #159) where Staff #159 stated that if a medication is unavailable for a resident, the facility can reach out to her to determine the status of the order. Staff #159 also stated that a delay in available medications would require adjustments and changes and with her role. Staff #159 stated that they were familiar to the care of Resident #111's psychiatric interventions. Staff #159 advised that when they had transitioned into their role, had been around the time where Resident #111 had been experiencing medication delays for Clozapine 25 MG. Staff #159 also stated that Resident #111 grew non-compliant with care and refused to completed lab work that had been required for the pharmacy to dispense the medications. Staff #159 also stated that although they do not see the documentation left by staff following conversations of unavailable medications or updates with medication status', that the expectation is to ensure there is documentation of any interaction pertaining to the unavailable medications and any recommendations that may be provided.</p> <p>An interview had been conducted on June 12, 2025 at 2:35PM with the DON (Director of Nursing/Staff #81) where correspondences to attempt to obtain updates on the status of the medications had been initiated. Staff #81 provided documentation that a new order of Clozapine 25 MG had been sent on February 20, 2024 with a new request for lab work. Staff #81 also stated that the administration of Clozapine 25 MG resumed on February 21, 2024. Staff #81 also reviewed medication administration record and the progress notes for February 1, 2024 to February 20, 2024, and stated that the only explanation for February 9, 14, and 18 of 2024 was that they were incorrect charting of the administration of the medication, as the medication had not been available at all. Staff #81 also stated that there can be times where medication is completely unavailable and if s situation were to arise, the expectation is that documentation is completed. Staff #81 stated that accurate documentation is crucial as the risk can include incorrect statements and documentation that do not accurately depict the resident's care.</p> <p>A facility policy titled, 'Documentation and Charting', revealed that the purpose of the policy is to provide a complete account of the resident's care and treatment, and, a source of guidance for providers when prescribing appropriate medications and treatments.</p>		