STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035072	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Phoenix Mountain Post Acute	13232 North Tatum Blvd Phoenix, AZ 85032

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observations, record review, and interviews, the facility failed to ensure that menus provided alternate meal options for residents who refused the food offered. The census was 110, and the sample size was 22. The deficient practice had the potential to affect all residents in the facility by limiting resident choice and failing to meet individual nutritional preferences and needs. Findings include:An initial screening interview was conducted with Resident #106 on September 16, 2025 at 8:55 AM who stated that the facility had not provided other meal options for breakfast, lunch, and dinner. Resident #106 showed this surveyor their breakfast meal tray, which was still present on the resident's bedside table during the interview and appeared untouched. Resident #106 also stated that the facility menu had not always been limited. Resident #106 stated that about 6 months ago, the menus had changed and that they no longer included alternate options. Resident #106 stated that she had been able to request food items such as quesadillas and beef burgers if they did not prefer the meal options provided. Resident #106 stated that they were unsure of what options were available, as the provided menu did not state any other available options.An initial screening interview was conducted with Resident #10 on September 16, 2025 at 9:09 AM who stated that the facility had not provided other meal options for breakfast, lunch, and dinner. Resident #10 stated that they understand that their options could be limited due to an ordered weight loss diet. However, they stated that before the change in diet, they had shared their concerns regarding the alternative food options available and within their preferences for weight management. Resident #10 stated that the prepared meals would have included chicken, and had been chicken for days in a row.An interview was conducted on September 17, 2025, at 11:54 AM with the Dietary Supervisor (Staff #89) who stated that residents are given a menu on Friday's that will include the meal for the upcoming seven days and the residents can choose between two main entree items, and, then expected to return them to the dietary staff by the ed of the day Saturday so that their choice is accommodated. Staff #89 also stated that residents are able to choose a peanut butter and jelly sandwich or a grilled cheese sandwich upon request. Staff #89 stated that as dietary staff, they will rely on the resident's individual meal ticket as a tool to advocate preferences and advise the dietary staff if they do not want what is provided, so that an accommodation can be made. Staff #89 also stated that a count of residents who request an alternate meal is not documented, as the dietary staff who participate in the tray assembly line review the meal ticket during tray line assembly and will be able to confirm what meal is agreed on by the resident and their assigned meal ticket.At the time of the above interview, this surveyor completed an observation of the lunch tray assembly on September 17, 2025. During this observation, it revealed that a resident's individual meal ticket provided each resident with two entree items to pick, baked creamy garlic chicken or bot ties with Italian sausage, tomato, and cream; with a baked potato and sour cream, buttered corn, apple crisp, dinner roll, and a beverage. There were no other options or substitutions on a resident's individual meal ticket to choose from.Additional interviews were conducted with residents following this observation of the lunch tray assembly on September 17, 2025, and the following were stated:An interview with Resident #103 on September 17, 2025, at 2:30 PM, who stated that they did not eat their lunch. Resident #103 stated that they do not (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	enjoy eating heavy starches such as potatoes and pasta. Resident #103 also stated that within the last seven days, they did not eat lunch for 5 of those days due to heavy starches such as potatoes and pasta. Resident #103 also stated that they were unaware of an alternate menu with other food options and had chosen not to eat due to the lack of meal options for lunch.An interview was conducted on September 17, 2025, with Resident #71 at 2:46 PM, who stated that there are never any options provided in their meal ticket. Resident #71 stated that their meal ticket provided two options for every meal and stated they do not know how to order any other meal options.An interview was conducted on September 17, 2025, with Resident #1 at 2:54 PPMM, who stated that they did not know there were other meal options provided and would pick and choose what to eat off the plate that is provided. Resident #1 stated that there are certain food items that he has to be mindful of due to receiving outside dialysis services, so if the facility provides food items, such as potatoes, he will not eat the food item and eat what he can eat from the provided meal tray.An interview was conducted with Staff #89 on September 18, 2025, at 2:31 PM, who stated that the alternate menu process begins on Fridays, where printed out menus of the upcoming week, Sunday through Saturday, are provided to each resident for individual review by Saturday's dinner so that the dietary staff is aware of which residents would prefer the alternate entree. If a resident does not like the two offered entrees, they are able to request a peanut butter and jelly sandwich or a grilled cheese sandwich. Staff #89 stated that residents are not able to write any other food option on their menu requests and meal tickets, and that they are only able to choose from the two alternate entree options or the two sandwich options. Staff #89 acknowledged that not providing residents with all of their options for meals could pose difficulty in respecting the preferences of residents. Staff #89 stated that the expectations regarding the two sandwich alternative meals were to advise the resident upon admission, and by staff throughout the day-to-day, should a resident question their meal options. Staff #89 also stated that if the meal tools provided to the residents for meal preferences and meal selections are not prepared in a way that benefits the residents, or do not provide preferences or options that they are agreeable with, the risk could be that residents choose not to eat, and can experience unmanaged and excessive weight loss. Staff #89 stated that if a resident refuses to eat what is provided, whether one of the two alternate entrees or one of the two alternate sandwich options, staff are encouraged to let the dietary staff know of the lack of meal intake so that a proper conversation with the resident can take place. Staff #89 also advised that another tool to determine if a resident chose to not eat the meal provided, floor staff is encouraged to rip the meal ticket in half as an indication to the dietary staff that that meal tray had been refused by that assigned resident in which the meal ticket had been placed on. However, Staff #89 stated that there is no set tool for residents to view when determining their meal options and alternatives, other than the weekly review of menus that takes place from Friday to Saturday.A facility policy titled ?Menu Planning', last edited in 2022, revealed that regular and therapeutic menus would be written to provide a variety of foods served on different days of the week. The policy also revealed that the facility's efforts should reflect the religious, cultural, and ethnic needs of the population served, as well as the input received from individuals and groups.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, interviews, and policy review, the facility failed to ensure that proper infection control practices were implemented according to professional standards for five residents (#6,11, 25, 67 and 99). This deficient practice could lead to the spread of infection.Based on observation, clinical record review, interviews and a review of policies and procedures, the facility failed to ensure Enhanced Barrier Precautions (EBP) were in place for four residents (#99, #6, #25, and #11). This deficient practice could result in an increased risk of pathogen transmission. Findings include: Based on the resident matrix and a review of resident records, Residents #25, #6, #99, and #11 were receiving catheter care. However, EBP signage was not present outside these residents' rooms on two consecutive days—September 16 and 17, 2025. In an interview with Infection Preventionist Staff #91 regarding this issue, Staff #91 stated that sometimes the signs fall off or are removed by residents. However, the staff member also noted that signage is only routinely checked every Friday. Staff #91 further explained that current facility practice requires nursing staff to wear gowns and gloves during high-contact care (e.g., brief changes, bathing, changing bed linens) for residents with EBP signage. Staff #91 also confirmed that residents with long-term intravenous (IV) use, indwelling devices such as catheters, nephrostomy tubes, peripherally inserted central catheters (PICC lines), or open wounds for 90 days or more with drainage are required to have EBP signage posted on their doors. Additionally, Staff #91 stated it is the expectation of the facility to adhere to this infection control policy. However, EBP signage was only observed outside the doors of the residents' doors starting on the third day of the survey and remained in place through the final day. Findings include: -Regarding Resident #67 Resident #67 was admitted to the facility on [DATE], with diagnoses that included aphasia, hydrocephalus, dysphagia, and contractures. A physician's order, dated April 6, 2024, instructed staff to employ Enhanced Barrier Precaution (EBP) every shift for the G-tube (gastrostomy tube). Medication administration was observed for Resident #67 on September 17, 2025, at 7:20 AM with a Licensed Practical Nurse (LPN/Staff #58). The LPN (Staff #58) explained that Resident #67 had a G-tube and would receive her medication through the tube. The LPN was observed sanitizing his hands, donning gloves, and preparing Resident #67's medicines at the medication cart. He was not observed to don a gown. An Enhanced Barrier Precaution (EBP) sign was observed next to Resident #67's room. The sign (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	instructed staff to don gloves and a gown when performing care involving the resident's G-tube. Two unopened packages of gowns were observed in the resident's room above her sink. Staff #58 was observed to enter the Resident 67's room with his gloves on, set the resident's medications on a table next to the resident, and begin administering the following medications through the G-tube: - Water flush - Amlodipine 10 mg, one tablet crushed and mixed with water - Famotidine 2.5 milliliters (ml) and - Lactulose 10 ml - Water flush Staff member #58 was not observed wearing a gown during the administration of the medications through the G-tube. Following the administration, an interview was conducted with Staff #58, who stated that the EBP sign by Resident #67's door was used to inform people that the resident had a G-tube. The LPN (Staff #58) stated he did not need to wear a gown when manipulating Resident #67's G-tube. He stated gowns were only for residents who were on contact isolation. The LPN continued to explain that if staff needed to wear gowns, supplies would be available outside the resident's room. Staff #58 was asked to review the EBP sign by Resident #67's door. The nurse reviewed the sign and continued to state that gowns were not necessary when providing care to Resident #67's G-tube. An interview was conducted with the Director of Nursing (DON/Staff #200) on September 19, 2025, at 10:16 AM. The DON stated that she expected her staff to follow the EBP postings located outside the resident rooms. She explained that EBP would be used for residents who had indwelling catheters, wounds, feeding tubes, and other similar conditions. She stated that for feeding tubes in particular, she expected staff to wear gloves and gowns when starting or stopping the feeding, or manipulating the tube in any way, including administering medications. The DON stated that the risk of not following the EBP guidelines could be the spread of infection. A facility policy titled IPCP Precautions Policy and Procedure, revised and reviewed on April 2025, provides guidance on implementing infection control measures to prevent the spread of communicable diseases and conditions, states that EBP must be initiated for residents with: (i) wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers); and/or (ii) indwelling or implanted medical devices (e.g., central lines, ports, urinary catheters, feeding tubes, tracheostomy or ventilator tubes), even if the resident is not known to be infected or colonized with multidrug-resistant organisms (MDROs). Furthermore, guidance from the Centers for Medicare & Medicaid Services (CMS) Center for Clinical Standards and Quality, Safety and Oversight Group—QSO-24-08-NH—states that EBP is recommended for residents with chronic wounds or indwelling medical devices during high-contact resident care activities, regardless of their MDRO status.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 110Number of residents cited: 1Based on observations, clinical record review, staff interviews, and policy review, the facility failed to ensure that individualized activities were consistently offered to one resident (#9). The facility census consisted of 110 residents, and the target sample size was 22. The deficient practice could result in residents not consistently being provided with activities that meet their interests and support their physical, mental, and psychosocial well-being.Findings include:Resident #9 was admitted to the facility on [DATE], with diagnoses including: vascular dementia, unspecified severity, with other behavioral disturbance.During the initial pool conducted on September 16, 2025, at 11:12 a.m., resident #9 stated that she finds the activities juvenile and childlike and has no interest in them. Resident #9 stated she wished they would offer her more adult-like activities that she could participate in. A review of a Care Plan, initiated on February 20, 2023, revealed a focus on activities with resident #9, who was observed to be resting, unavailable, and requiring sensory/activity stimulation within her comfort zone. Resident #9 has a history of homelessness and wishes to be alone. Interventions included: 1:1 interaction will offer reminiscing and conducting interests. The sister will assist/offer correspondence as wished and tolerated. Will offer enrichment sensory activities, comfort foods, sounds of relaxation, provide 1:1 support in-room activities with supplies, conversation, and comfort. Will offer interaction with visiting & facility pets, will offer past interests: books, newspapers, magazines to read, card/word games, trivia, bingo, and puzzles. Will offer to go outside for 1:1 interaction, will offer to listen to music, watch news, shows, and movies. Review of the quarterly assessment dated [DATE], revealed that resident #9 can state her preferences. Diagnosed with Vascular Dementia with a history of homelessness, and prefers to be alone. Resident #9, on occasion, accepts 1:1 for short periods at a time. Resident #9 continues to enjoy a variety of TV programs, snacking on treats provided by familyA quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview of Mental Status (BIMS) score of 03, which indicates severe cognitive impairment. Review of the activity participation task in Point Click Care revealed no documentation for the last 30 days for social activity, which includes the care planned pet visits, meal/food/snack social, bingo, and board games. There is no documented evidence that the activities were offered or that the resident refused to participate in he offered activities of interest. Review of the activity task for one one-on-one activity on August 29, 2025, and September 4, 2025, is documented as the resident refused. A review of the progress notes revealed no documented activity progress notes.An interview was conducted on September 19, 2025, at 2:38 pm with the Activity Director (Staff #79). Staff #79 stated the resident's program of activities and goals for resident #9 is a preference to be in the room and rest, sensory activities, and comfort, and wishes to be alone. Staff #79 stated the activity department provides one-on-one interventions twice per week, per the resident's care plan, and activities of choice. Staff #79 stated that if a resident refuses to participate, the refusal is documented in the resident's activity record or manually inputted on the resident activity attendance sheets. Staff #79 reviewed the resident's activity record for care planned activities. Staff #79 acknowledged there were two days, August 29, 2025, and September 4, 2025, that were documented as the resident refused within thirty days. Further review of the manually documented activities for resident #9 by staff #79. Per record review by the activity director, she acknowledged there was no documentation that the resident was offered activities per the resident's care plan for June, July, and August 2025. Staff # stated that the activity staff will encourage and offer residents the opportunity to participate in an activity of preference, and if they choose not to participate, then the refusal is documented in the resident's chart. Staff # stated her expectation for the activity staff is that they are documenting the offered activities and refusals. Staff #79 stated that the risk of not providing residents' activities or documenting their refusals or participation is that it gives the appearance that the offered activity did not occur, or risk for (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	isolation.An interview was conducted on September 19, 2025, at 10:47 am with Registered Nurse (RN/Staff #67). Staff #67 stated that staff will assist the residents in participating in activities of choice, and if they are aware of a certain activity that a resident may enjoy, the activity staff will go around and ask for help in getting the residents to the activities. Staff #67 stated that nursing staff will follow up to ensure that the residents are attending. Staff #67 stated the activity department offers the residents activities daily and on weekends. Staff #67 stated that if a resident refuses to participate in activities, he will try to identify and address the reasons why. Staff #67 stated that he would start by asking the resident to identify the problem. If it turns out to be a persistent problem, we will notify the provider and document a change in behavior note in the resident's chart. An interview was conducted on September 19, 2025, with the interim Administrator (Staff # 201) and Administrator in Training (AIT/Staff # 204). Staff # stated that the activity department was offering the resident, but the resident is refusing the activities. Staff # stated he expects that all interactions with residents by the activity department are documented. Review of the facility policy titled Delivery of Activity Services, revised 07/2007, reviewed 07/2027, states, It is the policy of this facility to ensure that residents have the right to choose the types of activities and social events in which they wish to participate.Review of the facility policy titled Documentation and Charting, revised 7/2022, states that it is the policy of this facility to provide:1. A complete account of the resident's care, treatment, response to the care, signs, symptoms, etc., as well as the progress of the resident's care.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and facility policy, the facility failed to ensure medications were administered within ordered parameters and according to accepted standards of practice for 1 of 5 residents reviewed for unnecessary medications (Resident #6). The census was 110, and the sample size was 22. The deficient practice had the potential to cause adverse drug effects and place residents at risk for harm from unnecessary medications that were not clinically indicated at the time of administration.Findings include:Resident #6 was admitted on [DATE], with the diagnosis of hypotension and unspecified dementia, unspecified severity, with anxiety.A physician's order dated July 1, 2024, revealed an order for Midodrine HCl Tablet 2.5 MG, one tablet three times a day for hypotension. The order also revealed that the medication is to be held if the systolic blood pressure (SBP) is greater than 120.A quarterly MDS (Minimum Data Set) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 03, which indicated severe cognitive impairment.A review of the Medication Administration Record (MAR) for August 2025 revealed that Midodrine HCl Tablet 2.5 MG had been administered out of ordered parameters at 10:00 AM on August 11, 2025 with the SBP of 134; August 15, 2025 with the SBP of 137; August 18, 2025 with the SBP of 143; and August 29, 2025 with the SBP of 133. As well as at 1:00 PM on August 20, 2025, with the SBP of 131, and on August 31, 2025, with the SBP of 142. And, as well as at 8:00 PM on August 1, 2025 with the SBP of 126; August 2, 2025 with the SBP of 128; August 3, 2025 with the SBP of 130; August 6, 2025 with the SBP of 122; August 7, 2025 with the SBP of 122; August 15, 2025 with the SBP of 137; August 17, 2025 with the SBP of 134; August 18, 2025 with the SBP 138; August 20, 2025 with the SBP of 131; August 26, 2025 with the SBP of 149; and August 29, 2025 with the SBP of 123.A review of the MAR for September 2025 revealed that Midodrine HCl Tablet 2.5 MG had been administered out of ordered parameters at 1:00 PM on September 7, 202,5, with the SBP of 141; September 14, 2025, with the SBP of 132; and September 17, 202,5, with the SBP of 128.An interview was conducted on September 18, 2025, at 11:25 AM with a Registered Nurse (RN/Staff #107), who advised that the hypotensive medication, Midodrine, is expected to be administered per the physician's orders, as it will require the administering nurse to confirm that the ordered parameters are being met. Staff #107 stated that the physician's order for Resident #6 stated to administer one tablet of Midodrine three times a day; however, to hold the medication if Resident #6's systolic blood pressure were to reach greater than 120. Staff #107 also advised that the risk of administering Midodrine outside the parameter of greater than 120 could cause a spike in the Resident's systolic blood pressure, induce cardiac arrest, or stroke.An interview was conducted on September 18, 2025, at 11:56 AM, with the Director of Nursing (DON/Staff #200) and a Clinical Resource (Staff #206), where Staff #200 stated that the facility expected nursing staff to administer medications per the physician's orders and stated parameters. Staff #200 reviewed August and September MARS for Resident #6 and reviewed the administration of Midodrine. Staff #200 confirmed that Resident #6 received Midodrine out of parameters at 10:00 AM on August 11, 2025, with the SBP of 134; August 15, 2025, with the SBP of 137; August 18, 202,5, with the SBP of 143; and August 29, 20,25, with the SBP of 133. As well as at 1:00 PM on August 20, 2025, with the SBP of 131, and on August 31, 2025, with the SBP of 142. And, as well as at 8:00 PM on August 1, 2025 with the SBP of 126; August 2, 2025 with the SBP of 128; August 3, 2025 with the SBP of 130; August 6, 2025 with the SBP of 122; August 7, 2025 with the SBP of 122; August 15, 2025 with the SBP of 137; August 17, 2025 with the SBP of 134; August 18, 2025 with the SBP 138; August 20, 2025 with the SBP of 131; August 26, 2025 with the SBP of 149; and August 29, 2025 with the SBP of 123. As well as in September at 1:00 PM on September 7, 2025, with the SBP of 141; September 14, 202,5, with the SBP of 132; and September 17, 2,25, with the SBP of 128. Staff #200 further stated that the risk of receiving Midodrine out of parameters could have the potential for possible hypertension concerns. Staff #206 advised that Resident #6's administration of (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Midodrine out of parameters had been addressed at the end of August during the routine Medication Regimen Review. Staff #200 and Staff #206 advised that administering medications out of parameters had been discussed during huddle meetings, with no documentation signed for education completion. Staff #200 confirmed that education on medications administered outside of parameters took place on September 11, 202bu ut, but was unable to provide documentation to support the education provided. Staff #200 also advised that the administration of Midodrine out of the ordered parameters for Resident #6 was not within the facility's expectations. A policy titled Physician Orders, with the last review date of September 2024, revealed that drugs or biologicals shall not be administered except upon the order of a person lawfully authorized to prescribe for and treat human illnesses.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on clinical record review, facility documentation, staff interview, and policy review, the facility failed to ensure the Narcotic Log/count Q shift Monitoring sheet was accurately completed. The deficient practice could result in narcotics not being accounted for. During an observation conducted on September 17, 2025, at 9:58 AM of the medication cart 200 even numbered room, with License Practical Nurse (LPN/Staff #39) stated that the Narcotic Log/Count Q shift Monitoring was incomplete for the following days in September 2025: 10, 11, 13, 14, 15. She further stated that there was no day shift nurse signature for September 10th and 11th of 2025. She also stated that there was no night shift nurse signature for September 13th, 14th, and 15th of 2025An interview was conducted on September 17, 2025, at 10:16 AM with the Unit Manager (LPN/Staff # 117), who stated that the medication cart 200 Odd number room Narcotic Log, Count Q Shift Monitoring was incomplete for nursing signatures for the following dates in September 2025: 3, 7, 14, 15, and 16. He further stated that the section Quantity was incomplete for the 14th and 15th of September 2025. A further interview was conducted on September 18, 2025, at 2:59 PM with (LPN/Staff # 39), who stated that the facility's expectation for Narcotic Log/ Count Q Shift Monitoring is that at the start and end of the shift, the nurses would sign the log. He also states that nurses would be accepting responsibility and that nurses are saying that the narcotic count is accurate. He further stated that not filling out the Narcotic Log/ Count Q Shift Monitoring would not be accurate. He then stated that this can impact the resident because if there is a need for a medication, then that medication may not be available because of missing information on the Narcotic Log/count Q shift Monitoring. An interview was conducted on August 18, 2025, at 3:36 PM with the Director of Nursing (staff/# 200), who stated the Narcotic Log/count Q Shift Monitoring would have an On coming and Off coming nurse count the narcotic card to match the record. She also stated that the Narcotic Log/Count Q shift Monitoring would be signed at the same time by the two nurses who are counting. She then stated the sections: Quantity, and the Nurse's initial should be completed. (DON/Staff # 200) also stated that an incomplete Narcotic Log/Count Q Shift Monitoring can cause the narcotic count to be incorrect, and there would be a loss in pain control. A policy review on May 2025 titled Medication Administration revealed that At each shift change, a physical inventory of all controlled medication is conducted by two licensed nurses and is documented on an audit record.