

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035106	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Tempe Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 6100 South Rural Road Tempe, AZ 85283	
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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, and staff interviews, the facility failed to ensure that the comprehensive person-centered care plan was reviewed and revised to address Type 2 Diabetes Mellitus for one resident (Resident #6). This deficient practice could result in inadequate monitoring of blood glucose levels, increasing the risk of a hypoglycemic event for the resident. The universe was 70, and the sample size was 3. Findings include: Resident #6 was admitted to the facility on [DATE], with diagnoses including Type 2 Diabetes Mellitus (DM), congestive heart failure, and hypertension. A care plan, dated February 12, 2026, revealed a focus area for Diabetes Mellitus with a goal to have no complications related to diabetes through the review date and interventions including administering diabetes medications as ordered by the doctor and monitoring and documenting for side effects and effectiveness. The resident was discharged and re-admitted to the facility on [DATE], following a hospitalization for generalized weakness, failure to thrive, and functional decline, with active diagnoses including Type 2 DM without complications, congestive heart failure, and hypertension. A care plan, dated July 24, 2026, revealed the most recent plan of care for Resident #6, which omitted Type 2 Diabetes Mellitus from her current plan of care, no active focus areas, interventions, or goals for managing her blood glucose levels or monitoring for hypoglycemia. A nursing progress note, dated July 25, 2026, at 7:53 PM, revealed that the resident had new-onset lethargy and hypotension, and the physician was notified. A physician progress note, dated July 27, 2026, at 11:35 AM, revealed that the nurse practitioner noted increased confusion, weakness, and poor oral intake, and ordered STAT laboratory studies. Under the assessment and plan, the nurse practitioner stated that for her Type 2 Diabetes Mellitus, blood glucose should be monitored before meals and at bedtime, her diabetic diet and prescribed medications should be continued, and her regimen should be adjusted based on glucose trends. However, no active orders or care plan documentation were identified for blood glucose monitoring. A clinical record of blood glucose, dated July 28, 2026, at 2:50 AM, revealed a blood glucose value of 34.0 mg/dL, indicating severe hypoglycemia. A nursing progress note, dated July 28, 2026, at 3:27 AM, revealed that the resident had pitting edema in all extremities, was hypotensive, bradycardic, and desaturating at 70% on room air, and was transferred emergently to a hospital via paramedics. A discharge Minimum Data Set (MDS) assessment, dated July 28, 2026, revealed that the resident was able to understand and be understood, had clear speech, and had adequate hearing and vision. An interview was conducted on July 30, 2026, at 2:02 PM with a certified nursing assistant (CNA/Staff #884). She stated that she has worked at the facility for over two years and is responsible for checking resident temperatures at the beginning of her shift when the nurses are doing vitals. She stated that she is not responsible for checking anything for residents with diabetes and is not really aware of any of the symptoms or signs (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
--	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035106	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Tempe Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 6100 South Rural Road Tempe, AZ 85283	
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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of high or low blood sugar. She stated that if she had any concerns about a resident, she would grab her nurse first thing. She stated that for low blood sugar, she would expect to give glucagon or, if the resident is able to eat or drink, give them juice and snacks and notify the doctor. She stated that there should be orders for those things and that if there is a diabetic resident with no orders, the staff should notify the doctor to try to get some orders. She explained that if a resident is diabetic, the lack of a care plan or active monitoring orders means that staff would be unaware that the resident is diabetic, which risks missed signs of hypoglycemia. An interview was conducted on July 30, 2026, at 2:10 PM with a licensed practical nurse (LPN/Staff #789). He stated that for a resident diagnosed with Type 2 DM, staff should check blood sugars in the morning and at night. He reviewed the resident's active orders and stated that he did not see any active orders for blood glucose monitoring or medications such as insulin or glucagon for the month of July. He reviewed the care plan and stated that he did not see anything in her care plan for the month of July regarding her diabetes, even though she had an active diagnosis of diabetes. He stated that the risks of not having a diabetes care plan or monitoring orders include a hypoglycemic event. He explained that she had her blood sugar checked only one time during her admission. He stated that when her vitals were dropping and she became hypotensive, bradycardic, and required oxygen, staff did not find that her blood sugar was low until they were preparing her for discharge and checked her blood sugar, and he believed this occurred because of her diabetes. An interview was conducted on July 30, 2026, at 2:57 PM with the director of nursing (DON/Staff #857). She stated that the process for residents with Type 2 diabetes upon admission depends on the patient, but they should monitor signs and symptoms for diabetes and develop a plan of care. She reviewed the record and stated that she did not see any orders for blood glucose monitoring and confirmed that diabetes was not on her care plan for the July admission. She reviewed the nurse practitioner note dated July 27, 2026, and stated that the note directed that blood glucose should be monitored before meals, and she agreed that they should have been managing her diabetes. She stated that the risk of not care planning for Type 2 diabetes is a failure of disease process management, which leaves the staff unaware that a resident is diabetic and unable to monitor for signs of hypoglycemia. A review of the facility's policy titled Comprehensive Person-Centered Care Planning, revised May 2022, revealed that it is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. 1. Within 48 hours of the resident's admission, the facility will develop and implement a baseline care plan that includes instructions needed to provide effective and person-centered care. 2. The baseline care plan will include minimum healthcare information necessary to properly care for a resident including, but not Limited to: a) Initial goals based on admission orders, b) Physician orders, c) Dietary orders, d) Therapy services, e) Social services; and f) PASARR recommendations, if applicable.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035106	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Tempe Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 6100 South Rural Road Tempe, AZ 85283	
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, observations, and facility policies, the facility failed to ensure that one resident (Resident #6) received needed treatment, monitoring, and care in accordance with professional standards of practice for Type 2 Diabetes Mellitus. This deficient practice resulted in the resident's blood glucose level falling below the normal range, placing the resident at risk for a hypoglycemic event (low blood sugar). The universe was 70, and the sample size was 3. Findings include: Resident #6 was admitted to the facility on [DATE], with diagnoses including Type 2 Diabetes Mellitus (DM), congestive heart failure, and hypertension. A care plan, dated February 12, 2026, revealed a focus area for Diabetes Mellitus with a goal to have no complications related to diabetes through the review date and interventions including administering diabetes medications as ordered by the doctor and monitoring and documenting for side effects and effectiveness. Resident #6 was discharged and most recently readmitted to the facility on [DATE], with active diagnoses including Type 2 DM, Transient Cerebral Ischemic Attack, Adult Failure to Thrive, Unspecified Atrial Fibrillation, Heart Failure, Unspecified Asthma, Mild Protein-Calorie Malnutrition, Acidosis, Anemia, and generalized muscle weakness. A care plan, dated July 24, 2026, revealed the most recent plan of care for Resident #6, which omitted Type 2 Diabetes Mellitus from her current plan of care and contained no active focus areas, interventions, or goals for managing her blood glucose levels or monitoring for hypoglycemia. A review of physician orders revealed there were no active physician orders for blood glucose monitoring, daily fingerstick checks, insulin, or oral hypoglycemic medications upon her readmission. However, review of discontinued physician orders revealed that during prior admissions the resident had physician orders for Blood Glucose checks twice daily, Glucophage (Metformin) 1,000 mg by mouth twice daily, Jardiance (Empagliflozin) 25 mg by mouth daily (later adjusted to 10 mg daily), Humalog (Insulin Lispro) sliding scale before meals, Glucagon 1 mg intramuscularly as needed for symptomatic blood glucose below 65 mg (milligrams)/dL (deciliter), and a hypoglycemia protocol directing staff to administer 4 ounces of juice or two glucose tablets with a protein supplement for blood glucose below 65 mg/dL and recheck the blood glucose in 15 minutes. These diabetes-related physician orders were all discontinued by February 13, 2026, and were not reinstated upon the resident's readmission on [DATE], despite her continued diagnosis of Type 2 Diabetes Mellitus. A laboratory report, dated July 26, 2026, at 7:09 a.m., with sample collected on July 25, 2026, at 10:20 p.m., revealed her blood glucose was 65 mg/dL, the lowest value within the laboratory reference range. It further revealed she had a critically low albumin level of 0.8 g (grams)/dL and total protein of 3.8 g/dL, indicating severe deconditioning and protein-calorie malnutrition. A Nurse Practitioner progress note, dated July 27, 2026, at 11:35 a.m., revealed that the resident was assessed for increased confusion and documented a clinical directive under her plan for Type 2 Diabetes Mellitus to monitor blood glucose before meals and at bedtime, continue a diabetic diet and prescribed medications, and adjust her regimen based on glucose trends. Further review of her active orders revealed no order for blood glucose monitoring. There was no documented evidence that the physician or nurse practitioner was notified that the ordered monitoring was not being performed. A discharge Minimum Data Set (MDS) discharge assessment, dated July 28, 2026, revealed that the resident was able to understand and be understood, had clear speech, and had adequate hearing and vision. A blood glucose monitoring record, dated July 28, 2026, at 2:50 a.m., revealed the resident's blood sugar was critically low at 34.0 mg/dL. This check was her first and only fingerstick blood sugar check during the four-day admission. A nursing progress note, dated July (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035106	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Tempe Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 6100 South Rural Road Tempe, AZ 85283	
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28, 2026, at 3:27 a.m., revealed the resident was hypotensive (low blood pressure), bradycardic (low pulse), and had a critically low oxygen saturation of 70% on 5 liters of oxygen via nasal cannula. It further revealed that night nurses attempted to straight catheterize the resident, obtaining only 5 milliliters of urine, and increased oxygen delivery to her to 8 L/min via oxygen mask at 82% before paramedics emergently transferred her to a hospital. An interview was conducted on July 30, 2026, at 2:02 p.m. with a Certified Nursing Assistant (Staff #884/CNA) who had over two years of experience at the facility. She stated that she checks resident temperatures at the beginning of the shift when nurses perform vital signs. Regarding diabetes care, Staff #884 stated she was not aware of any of the symptoms or signs of high or low blood sugar. She stated that if she had any concerns, she would grab my nurse first thing. She stated that for low blood sugar, staff should give glucagon, or if the resident can drink or eat, give them juice/snacks and notify the doctor. She defined low blood glucose symptoms as cold, sweaty, and hard to arouse. She stated the risk of failing to monitor diabetic residents without active orders is that a resident with diabetes could deteriorate without staff's knowledge, and she stated that a nurse should immediately call the doctor to obtain monitoring orders if a diabetic resident is admitted without them. An interview was conducted on July 30, 2026, at 2:10 p.m. with a Licensed Practical Nurse (Staff #789/LPN). Staff #789 reviewed the resident's electronic health record and stated that she was diabetic, but there were no orders for blood glucose monitoring and no active orders for blood sugar injections like insulin or glucagon. He stated there was nothing in her care plan for July regarding her diabetes, and her blood sugar was only checked a single time during her stay. He stated that when she deteriorated, her heart rate and blood pressure were dropping, and they were attempting to get her oxygen up. He stated they checked her blood sugar right before discharging her and found it was low, which he believed was because of her diabetes. He further stated that the risk of failing to obtain orders and a care plan for a resident with Type 2 Diabetes is a severe, unmonitored hypoglycemic event. An interview was conducted on July 30, 2026, at 2:40 p.m. with a Registered Nurse (Staff #205/RN). Staff #205 stated that if a resident is admitted with a diagnosis of Type 2 Diabetes but has no meds or diet specified, the professional standard is to check blood sugars twice daily and call the doctor to ensure there are no monitoring orders. She further stated that the risk of failing to monitor blood sugars is that the resident could bottom out (hypoglycemia), which would cause confusion, shakes, sweating, and hunger, and she noted that she would refer such a resident to the dietitian to monitor their intake and keep them at baseline. An interview was conducted on July 30, 2026, at 2:57 p.m. with the Director of Nursing (DON/Staff #857). The DON reviewed the resident's clinical record and stated there were no active orders for blood glucose monitoring during her stay, except for the single check performed at discharge. She reviewed the Nurse Practitioner's progress note dated July 27th, which directed that her blood glucose should be monitored before meals, and stated that the facility had failed to implement this monitoring. She reviewed the care plan and stated that diabetes was completely omitted from her care plan. She stated that the risk of not care-planning Type 2 Diabetes is a failure of disease process management. She stated that without a care plan or orders, nursing and care staff would remain unaware that the resident is diabetic. She stated that the resident's risk of hypoglycemia should have been identified and addressed upon admission by obtaining the hospital report and immediately contacting the physician for orders. Review of the facility policy titled Blood Glucose Monitoring, reviewed July 2026, states that it is the policy of this facility to check and monitor finger stick blood glucose levels as ordered by the physician. Review of the facility policy titled Physician Orders, revised September 2025, revealed that it is the policy of this facility to accurately implement orders in addition to medication orders (treatment, procedures) only upon the order of a person duly licensed and (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035106	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Tempe Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 6100 South Rural Road Tempe, AZ 85283	
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	authorized to do so in accordance with the resident's plan of care. 3. admission orders are reviewed with the physician upon admission based on the discharge instructions from the discharging facility and are transcribed accordingly.		