

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035144	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2025
NAME OF PROVIDER OR SUPPLIER Peoria Post Acute and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 13215 North 94th Drive Peoria, AZ 85381	
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, interviews, facility documentation, and policies, the facility failed to ensure medications were not left unsupervised at the bedside for one resident (# 3). This deficient practice could result accidental ingestion, incorrect administration, or unauthorized access of medications. The sample size was 3. Resident # 3 was admitted to the facility on [DATE] with diagnoses of dependence on renal dialysis, Type 2 Diabetes Mellitus, chronic pain, and legal blindness. The quarterly Minimum Data Set (MDS) dated [DATE], included a Brief Interview for Mental Status (BIMS) score of 12, indicating the resident was cognitively intact. The clinical record failed to reflect a physician's order or an interdisciplinary care team review, allowing medications to be left at the resident's bedside. The Counseling/Disciplinary Notice dated June 24, 2025, provided a written warning to the administering Registered Nurse (RN/Staff # 17). The corrective action of the disciplinary notice provided education with the nurse on the five rights of medication administration, however the facility policy identified seven rights of medication administration. The list of medications left behind by the RN was attached to the notice, and included:-Aspirin 81 mg- Cinacalcet 30 mg x 2 tablets-Famotidine 20 mg 1/2 tab-Fexofenadine 180 mg 1 tablet-Glycolax Powder 17 gram-Minoxidil 2.5mg 1 tablet-Renal Vitamin 0.8 mg 1 tablet- Sertraline 100 mg 1.5 tablets-Vitamin C 500 mg 1 tablet-Zinc 50 mg 1 tablet-Clonidine 0.1 mg 2 tablets-Docusate sodium 100 mg 1 tablet- Lantus insulin- Oyster shell 500 mg 1 tablet- Sevelamer Carbonate 800 mg 3 tabletsThe facility provided documentation that the clinical educator (Staff # 10) provided education entitled Learning Medication at Bedside in-service for licensed nursing staff for day and night shift on June 24, 2025. An observation of a Lantus Solar star insulin pen, and a medicine cup of medications were observed on top of the side dresser during an interview with the resident on June 24, 2025 at 10:45 a.m. At 10:51 a.m. on June 24, 2025, Staff # 17 was observed retrieving the cup of medications and insulin pen from the top of side dresser, and then administering the cup of pills with a cup of water after the resident's identification was confirmed. After the resident swallowed the pills, the RN was observed administering the Lantus Solostar into resident's abdomen according to professional standards. The observation failed to reflect the oral medications were identified to the resident prior to administration. During an interview with the resident at 10:45 a.m. on June 24,2025 the resident revealed that he does not self-administer medications, but the nurse will come back in to give it to him. After the RN left the room, the interview with the resident resumed. The resident revealed that he was visually impaired, and did not know exactly what he was receiving but stated he was pretty sure his phosphorus binders were in there. An interview with Staff # 17 was conducted on June 24, 2025 at approximately 10:56 a.m. The nurse revealed that it was unusual for her to have left the medications by bedside. She recalled that the resident refused the pills without the filtered water, so she left the pills in the room to fulfill the resident's request. The nurse confirmed the resident did not have an order to self-administer medications. The nurse reflected that the correct process was to, take the medications with me, and if he refused the medications, it should have been discarded. An interview conducted with a Certified Nursing Assistant (CNA/Staff # 34) was conducted on June 24, 2025 at 12:20 p.m. Staff #34 revealed that if a CNA found medications by the bedside, they are to alert the nurse, so the medications can be disposed of properly. An interview was conducted on June 24, 2025 with a Licensed Practical Nurse (LPN/Staff #27) at 12:27 p.m., revealed that meds left at the bedside are dangerous because someone can take it and not know what it is. During an interview with LPN/Staff # 45, on June 24, 2025 at 12:45 revealed that when medications are given, the nurse is expected to wait until the resident swallows the pills to ensure that the medications are taken. The LPN advised against leaving medications unattended in the room because someone else could take the medications accidentally. If medications were found by the bedside, the LPN revealed that the medications are supposed to be discarded in the trash. The facility's policy Flex Administration of Drug Policy, reviewed January 2025, revealed the seven rights of medication administration are followed to ensure safety and accuracy of administration.</p>		