

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035193	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER Allegiant Healthcare of Mesa		STREET ADDRESS, CITY, STATE, ZIP CODE 3130 East Broadway Road Mesa, AZ 85204	

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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50553</p> <p>Based on clinical record review, staff interviews, facility policy review, and observation of current practice, the facility failed to ensure one resident's medications were obtained and administered as ordered by the physician. The deficient practice led to one resident not receiving prescribed antibiotics for eight days, delaying treatment of infection.</p> <p>Findings include:</p> <p>Resident #33 was admitted to the facility on [DATE], following a hospital stay, with diagnoses including persistent vegetative state, quadriplegia, and respiratory failure with hypoxia.</p> <p>Review of the hospital records revealed that Resident #33 had admitted to the hospital on February 6, 2025 for a malfunctioning G-tube. While at the hospital, the physician noted that the resident had been previously hospitalized for multilobar pneumonia and septic shock. The physician noted on February 11, 2025 that the resident's sepsis was originally severe, but had been improving with an antibiotic regimen of cefiderocol and newly added gentamicin. The physician also noted that the plan was to continue cefiderocol and gentamicin upon discharge, and the prescriptions had been ordered.</p> <p>Review of the hospital discharge orders revealed an order to administer cefiderocol 2 grams IV Piggyback, three times a day for 8 days. Further review of the discharge orders revealed an order to administer gentamicin 240 milligrams IV Piggyback every 24 hours for 10 days. These orders also gave instructions on what pharmacy to pick up the medication at.</p> <p>Review of the facility's physician orders revealed the following orders:</p> <p>Cefiderocol Sulfate Tosylate Intravenous Solution. Reconstituted 1 GM (Cefiderocol Sulfate Tosylate)</p> <p>Use 1 gram intravenously three times a day for Infection for 8 Days</p> <p>Discontinued. Start date: 02/13/2025. End date: 2/21/2025</p> <p>Cefiderocol Sulfate Tosylate Intravenous Solution. Reconstituted 1 GM (Cefiderocol Sulfate Tosylate)</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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Use 1 gram intravenously three times a day for UTI until 02/21/2025 15:59</p> <p>Discontinued. Start date: 2/17/2025. End date: 02/21/2025</p> <p>Gentamicin in Saline Intravenous Solution 2 MG/ML (Gentamicin in Saline). Use 240 mg intravenously one time a day for Infection for 10 Days. Gentamicin (gentamicin 100 mg/ 50 mL-NaCl 0.9% intravenous solution)</p> <p>Discontinued. Order date: 02/13/2025. Start date: 02/14/2025. End date: 02/24/2025</p> <p>Gentamicin in Saline Intravenous Solution 2 MG/ML (Gentamicin in Saline). Use 240 mg intravenously one time a day for UTI for 10 Days gentamicin (gentamicin 100 mg/ 50 mL-NaCl 0.9% intravenous solution)</p> <p>Discontinued. Order date:02/17/2025. Start date: 02/18/2025. End date: 02/28/2025</p> <p>Gentamicin in Saline Intravenous Solution 2 MG/ML. (Gentamicin in Saline) Use 240 mg intravenously one time a day for UTI until 02/24/2025 23:59 gentamicin (gentamicin 100 mg/ 50 mL-NaCl 0.9% intravenous solution)</p> <p>Active. Order date: 02/17/2025. Start Date: 02/18/2025. End date: 02/24/2025</p> <p>Review of the Medication Administration Record for February 2025 revealed that no doses of Gentamicin or Cefiderocol were administered to Resident #33 between February 13, 2025 and February 18, 2025. Both orders were set originally to start on February 13, 2025. One dose of Cefiderocol was administered on February 19, 2025 at 6:00PM, and no doses of Gentamicin were administered on this date.</p> <p>Review of the nursing Medication Administration Notes revealed several notes stating that Gentamicin and Cefiderocol were on order and that the medications were unavailable. The nursing notes on February 14, 2025 revealed that Cefiderocol and Gentamicin IV medications were on order, and the NP was aware. The nursing note on February 15, 2025 revealed that these two medications were still not available, and that the provider and family were aware. A nursing note entered on February 18, 2025 revealed that the medications were still unavailable. The note revealed that the attending physician was notified, and a prescription order was sent to a different pharmacy. Nursing notes entered on February 19, 2025 revealed that the medications were still not obtained, and the nurse was attempting to order the medications. The nurse wrote that the provider, Director of Nursing (DON), and the resident's family were aware.</p> <p>Interview was conducted on February 20, 2025 at 10:34AM with Resident #33's Power of Attorney (POA) who confirmed that the resident had recently readmitted to the facility from the hospital. She stated that she was unaware of any issues obtaining the antibiotics needed to treat the resident. She also stated that the hospital had told her that they would not discharge the resident to the facility unless the facility was able to provide the needed antibiotics to the resident. The POA explained that she had some concerns about the resident's care and medications, but she was unable to reach the DON when she called, and no calls had been returned to her.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview was conducted on February 20, 2025 at 11:08AM with a Pharmacist (Staff #291) from the pharmacy that was initially sent the order for the two antibiotics. The pharmacist stated that the timing of antibiotics is absolutely important, and that the pharmacy prioritizes filling antibiotics for this reason. The pharmacist stated that they received the orders for Resident #33's antibiotics on February 13, 2025. She then stated that their pharmacy does not fill those medications for Resident #33's insurance, and that several staff members from the facility, including the DON, were notified on February 14, 2025 via email that they would have to fill the order with the facility's other pharmacy service.</p> <p>Interview was conducted on February 20, 2025 at 11:31AM with a Licensed Practical Nurse (LPN/Staff #18), who explained that once an order is put in and activated, it is sent directly to the pharmacy. She stated that if the medications are not in the facility, it is expected to call and ask the pharmacy why the medication had not arrived. The LPN stated that if there is an issue getting the medication, the DON and provider are informed and the DON handles it from that point on.</p> <p>Interview was conducted on February 20, 2025 at 12:59PM with the [NAME] President of Quality and Operational Excellence (VP / Staff #304) from the second pharmacy to receive Resident #33's antibiotic orders. She confirmed that they had received an order from the facility for Resident #33's antibiotics on February 14, 2025. The pharmacy had then called the facility and spoke with an LPN (Staff #18), notifying them that they could not fill the orders, as the medications were outside of the formula of what their pharmacy provides. The VP then explained that the pharmacy received orders for both of the medications again on February 18, 2025, so the pharmacy had attempted to call the facility to speak with them. The pharmacy left a message with the receptionist detailing that these orders could not be filled on February 18, 2025.</p> <p>Interview was conducted on February 20, 2025 at 1:48PM with the Director of Nursing (DON/ Staff #27), who explained the process the nurses should take upon noticing a medication had not arrived from pharmacy is to call the pharmacy and notify the management. From there, the DON explained he would take over and contact pharmacy to see if there are issues with the fulfillment. When asked about Resident #33, the DON explained that the orders for the two antibiotics, Gentamicin and Cefiderocol, were originally sent to the first pharmacy on Thursday, February 13, 2025. On Friday, February 14, 2025, the DON stated that he talked to the pharmacy and referred the orders to the second pharmacy for fulfillment. The DON stated that both pharmacies were going back and forth with insurance authorizations. He explained that he next contacted the second pharmacy on Tuesday, February 18, 2025. He also spoke with the Nurse Practitioner (NP) on this date. He stated that he notified the NP that the facility was having difficulty obtaining antibiotics for Resident #33. The DON stated that the NP wanted the facility to wait for the antibiotics to be filled, and if they cannot be filled, the resident would be sent out. The DON could not provide a timeframe on how long the facility would wait for the medications, instead stating that the staff were monitoring the resident. The DON stated he had also inquired about using other antibiotics, but was told it was vital to use Gentamicin and Cefiderocol, due to the specific microbes needing to be treated. The DON explained that he had just received the cost of the medications from the pharmacy and had obtained approval for the facility to pay the cost of the medications through the first pharmacy this date, February 20, 2025. At this time, the facility was awaiting delivery of the medications. The DON elaborated that he educated the admission team to ensure that pre-authorizations are done prior to the resident arriving to the facility. The DON confirmed that the resident had been receiving both medications at the hospital, and identified that a delay in receiving these antibiotics could result in increased infection.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy titled, Administering Medications, indicated that medications shall be administered in a safe and timely manner, and as prescribed. The policy indicated that medications must be administered in accordance with the orders, including any required time frame.</p> <p>Review of the facility policy titled, Pharmacy Services- Role of the Provider Pharmacy, indicated that the provider pharmacy shall supply the facility with approved medications, biologicals, and supplies, as well as any compounded medications or investigational drugs that are needed.</p> <p>Review of the facility policy titled, Documentation of Medication Administration, revealed that if a medication is not administered, the Medical Doctor (MD) is to be notified as to why, including if the medication is not available. The policy indicated that in the event that medications that are prioritized to be critical of care are not given, including IV antibiotics, an immediate call to the MD should be made for further orders. This policy also indicated that documentation is to include the medication, dose and time scheduled, the reason for not administering, and the action plan for medication regimen.</p>