

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2025
NAME OF PROVIDER OR SUPPLIER Sandridge Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 255 West Brown Road Mesa, AZ 85201	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, facility documentation, and policy review, the facility failed to ensure 1 of 3 sampled residents (Resident # 16) was free from abuse by another resident (# 22). The deficient practice could result in other residents being abused.</p> <p>Findings include:</p> <p>-Regarding Resident (# 22)</p> <p>Resident (# 22) was admitted to the facility on [DATE] with diagnoses of major depressive disorder, Post Traumatic Stress Disorder, bipolar disorder, and hemiplegia and hemiparesis affecting left non-dominant side.</p> <p>A Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 0 indicating severe cognitive impairment. It was also noted that the resident is rarely understood.</p> <p>A comprehensive care plan dated December 3, 2024, revealed that Resident (# 22) makes statements of auditory hallucination and delusions. Interventions include, maintaining calm with a slow, understandable approach, and staff to observe for signs and symptoms of depression and emotional distress notifying physician as needed.</p> <p>A comprehensive care plan dated December 4, 2024, revealed that Resident (# 22) has a behavioral problem including history of methamphetamine use with hallucinations, paranoia, and irritability. The care plan also revealed that Resident (# 22) at times would leave the facility for long periods of time. Interventions include staff are to intervene as necessary to protect the rights and safety of others by diverting attention and removing from situation which includes taking to alternate location as needed.</p> <p>A behavioral progress note dated June 8, 2025 at 5:56 p.m., revealed that Resident (# 22) in her motorized chair wheeled herself out of the front door of the facility.</p> <p>A Medication Administration note dated June 9, 2025 at 12:50 a.m. regarding the removal of her 'carrot' splint to left upper extremity was not completed due to Resident (# 22) not in the building.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A behavioral progress note dated June 9, 2025 at 5:12 a.m. indicated that Resident (# 22) returned to the Facility at approximately 3:15 a.m., talking nonsensically. Resident (# 22) told staff that she was smoking methamphetamine while she was out of the Facility.</p> <p>A behavioral progress note dated June 10, 2025 at 11:11 a.m. written by Director of Nursing (DON/Staff # 17) indicated that Resident (# 22) continued to talk nonsensical throughout morning and she continued to have delusions and hallucinations. The progress note also indicated that Resident (# 22) had an altercation with another resident and Police were called with the crisis team and Resident (# 22) was transferred to a Behavioral Health Center.</p> <p>-Regarding Resident (# 16)</p> <p>Resident (# 16) was admitted to the facility on [DATE] with diagnoses of cerebral infarct, schizoaffective disorder bipolar type.</p> <p>A Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13 indicating mild cognitive impairment. The assessment also indicated verbal behaviors directed toward others.</p> <p>Review of a facility investigation report, which was not dated, revealed that on June 9, 2025 at approximately 10:00 a.m. activity staff responded to Resident (# 16) and Resident (# 22) having a verbal altercation in the activity room and observed Resident (# 22) swing her ankle foot orthosis (AFO) brace at Resident (# 16). The report also revealed that the Crisis team was called to the Facility for Resident (# 22), who was taken to a Behavioral Health Center and has been discharged from the facility.</p> <p>A Skin Assessment was performed on June 9, 2025, on Resident (# 16) which indicated that he had no new skin issues at the time.</p> <p>Observation of Resident (# 16) was conducted on June 18, 2025 at 2:38 p.m. revealed resident sleeping in bed comfortably with no marks on resident's face. Bed is clean and room is clean. Resident (# 16) did not appear in any distress. An attempt to interview Resident #16 was made, but resident declined and went back to sleep.</p> <p>An interview was conducted with Activities Assistant (Staff #5) on June 18, 2025 at 2:52 p.m., who stated that while she was getting ready for an activity, she heard Resident (# 16) calling derogatory names at Resident (# 22) and Resident (# 22) yelling back at him. Staff (# 5) immediately separated the residents within the activity room and calmed down the situation. Staff (# 5) did not report the initial verbal altercation and returned to prepping for activities and began to hear the commotion start again, when she went back to activity room Staff (# 5) saw Resident (# 22) swing something metal from her wheelchair, hitting Resident (# 16) in the head knocking his head back. Staff (# 5) stated that she swung the metal object using her right hand. Staff (# 5) immediately took Resident (# 22) to her room and notified Staff's (# 5) direct report of the incident.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview conducted with DON (#17) on June 18, 2025 at 3:32 p.m., he stated that he was immediately notified of the incident and the residents were already separated and he notified the Administrator and started to make other notifications, including the Police Department. DON (# 17) stated Resident (# 16) was assessed, and no injuries or redness were discovered. DON stated that when Police Department came to the Facility, Resident (# 22) had requested to be sent out to Behavioral Health Hospital, despite the fact that it was documented that Resident (# 22) was nonsensical at this time. DON stated that the crisis team came out and Resident (# 22) was transferred to a Behavioral Health Center.</p> <p>A Policy and Procedure titled, Abuse, Exploitation and Misappropriation Prevention Program, revised April 2021, stated that residents have the right to be free from abuse which includes verbal and physical abuse. The Policy also indicates that the facility is committed to protect residents from abuse by other residents.</p>		