STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035196	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandridge Post Acute	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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, review of clinical records, and review of facility policies and procedures, the facility failed to ensure that the medical record was complete and accurate for one resident (#10). This deficient practice could lead to inadequate investigation, monitoring, and follow up to ensure the resident's safety and well-being.Findings include: Resident #10 was admitted to the facility on [DATE], with diagnoses that included atherosclerotic heart disease of the native coronary artery without angina pectoris, hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, dysphagia following cerebral infarction, dysphagia, paraplegia, essential (primary) hypertension, hyperlipidemia, a personal history of recurrent pneumonia, a history of falling, and gastrostomy status.A review of the intake and five-day report provided by the facility revealed that on December 18, 2025, at approximately 10:30 AM, the Administrator (staff #88) was made aware by Nurse Manager (Staff Member # 77) of an allegation of verbal abuse. Resident #10 alleged that a CNA (certified nursing assistant / Staff 66) told him to Shut the f**k up. The nurse manager, staff # 77, responded to the scene and ensured the resident was safe before immediately reporting the allegation to the Administrator. The Administrator responded to the resident's room immediately after receiving the allegation. This allegation was not entered into the resident's medical record nor documented in the facility's risk management system.A review of the quarterly Medicare Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating intact cognition.An interview was conducted on January 8, 2025 at 10:40 AM with the Administrator (Staff #88), who stated that per facility's policy, all incidents were required to be entered into the Risk Management system (the facility's internal tool); however, no documentation was found for Resident #10. Staff #88 stated this action was not in accordance with facility policy. The Administrator (Staff # 88) acknowledged this lapse and expressed regret and disappointment regarding the failure to follow established procedures. Administrator (Staff # 88) further stated that the potential outcome of this omission was inadequate follow-up related to the resident's well-being and any incident in a resident's clinical record should have been documented in Risk Management and reflected in monitoring and follow-up, including the progress notes. An interview was conducted on January 8, 2025 at 11 AM with the Director of Nursing (DON / Staff #55). He stated, as per facility's policy, all incidents should have been documented under Risk Management, which served as the internal investigation record. For Resident #10, the DON stated that he was not present at the time of the incident. Incidents involving verbal abuse should have been documented under psychosocial notes in the progress notes. Documentation did not need to be uniform among all staff and could have been entered in different areas of the resident's medical record; however, it was required to be recorded somewhere within the resident's clinical chart. DON (Staff # 55) stated that for Resident #10, no documentation was found in the Risk Management system related to (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	this incident and it was not appropriate for incidents to go undocumented. DON (Staff # 55) further stated that there were no observed adverse reactions or outcomes for the resident related to this incident. A policy titled, Charting and Documentation, with a revised date of July 2017, revealed that the facility should record any events, incidents or accidents involving the resident in their medical records.