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	05/01/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility documentation, staff interviews and policy review, the facility failed to ensure that medications were properly stored and not left at the bedside for 1 of 1 residents sampled (Resident #160). The universe was 156. The deficient practice could result in residents and visitors having unrestricted access to medications. Findings include: Resident #160 was admitted to the facility on [DATE] with diagnosis that included metabolic encephalopathy, unspecified dementia, and other abnormalities of gait and mobility. Review of the care plan first initiated on March 18, 2026, revealed a focus for cognitive loss related to Alzheimer's disease or other dementias with interventions to explain all care before providing and to monitor for changes in cognitive status. Further review of the care plan revealed no evidence of Resident #160 being authorized or able to self-administer medications. Review of the modified admission minimum data set (MDS) dated [DATE] revealed Resident #160 had a brief interview for mental status (BIMS) score of 10, indicating the resident had moderate cognitive impairment. Further review of the MDS revealed the resident required moderate to maximum assistance with activities of daily living (ADLs). An observation was conducted on April 28, 2026 at 10:25 a.m. of Resident #160's room. An orange tube of diclofenac sodium, topical gel, 1% was observed on the resident's bedside table.There was no evidence of a medication self-administration evaluation within the electronic clinical record. There was no evidence of a physician's order for diclofenac sodium, topical gel, 1% within the electronic clinical record. An interview was conducted on April 28, 2026 at 10:25 a.m. with Resident #160. Resident #160 stated he obtained the diclofenac sodium, topical gel, 1% from his roommate who had an extra tube. Resident #160 stated he would use the cream on his knees where he experienced pain. An interview was conducted on April 28, 2026 at 10:35 a.m. with a certified nursing assistant (CNA/Staff #152). Staff #152 stated he assists residents with ADLs, changing residents, passing water and snacks, and ensuring the residents have everything they need. Staff #152 stated when he checks on his residents every two hours he would also ensure the resident does not have any dangerous or hazardous materials in their possession. Staff #152 further stated he would watch out for any medications left in the resident's room and immediately report anything dangerous to his nurse. Staff #152 stated if medications are left in a resident's room there is a potential for harm for anyone who enters that room. An observation was made on April 28, 2026 at 10:44 a.m. with a registered nurse (RN/Staff #167) of Resident #160's bedside table. Staff #167 stated diclofenac sodium, topical gel, 1% was a topical cream and usually used for arthritis. Staff #167 instructed the resident that he would have to confiscate the cream and obtain an order from the doctor to continue using the medication. An interview was conducted on April 28, 2026 at 10:44 a.m. with Staff #167. Staff #167 stated he does not have a set time when he rounds on his residents but stated he sees them enough throughout the day when passing medications. Staff #167 stated that he administers all kinds of medications which includes, topicals, over-the-counter medications, oral, intravenous, and intra-muscular and further stated all medications require a physician's order prior to administering. Staff #167 stated that if he noticed any medications at the resident bedside he would (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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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confiscate them and educate the resident on why medications cannot stay in a resident's room. Staff #167 stated the risks of unrestricted medications includes medication dosages not being properly monitored and the potential for overdose. At 10:54 a.m. staff #167 reviewed the electronic medical record for Resident #160 and stated that there were no orders for diclofenac sodium, topical gel, 1% or an order for self-administration of medications. Staff #167 further stated Resident #167 should not have had the cream and this practice does not meet the facilities expectations. An interview was conducted on May 1, 2026 at 8:39 a.m. with the Director of Nursing (DON/Staff #175). Staff #175 stated the facility needs a physician's order for all medications and treatments. Staff #175 stated her expectation for clinical staff is if any medications are discovered in the resident's possession to confiscate them and educate. Staff #175 stated facility staff are expected to not leave medications in a resident room if a resident is not in the room and they must hold onto the medications or ?waste' them. Staff #175 stated that if a resident wishes to self-administer, an evaluation must be completed as well as an order from the physician. Staff #175 further indicated that the ability to self-administer medications should be reflected in the care plan. Staff #175 reviewed the Resident's electronic medical record and confirmed there was no physician's order for diclofenac sodium, topical gel, 1%. Staff #175 stated there was no self-administration of medications evaluation and that the care plan did not include that Resident #175 was able to self-administer any medications. Staff #175 further stated the medication on the resident's bedside did not meet her expectations and stated potential drug interactions could occur if the facility is unaware of a medication being administered.Review of the Administering Medications policy last revised April 2019 revealed medications are administered in a safe and timely manner, and as prescribed.Review of the Self-Administration of Medications policy last revised February 2021 revealed that if it is deemed safe and appropriate for a resident to self-administer medications, it will be documented in the medical record and the care plan. Review of the policy revealed self-administered medications are to be stored in a secure place which is not easily accessible by other residents. Further review of the policy revealed if any medications are found at the bedside that are not authorized for self-administration are to be turned over to the nurse in charge.