STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035241	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Mountain Post Acute	8008 S. Jesse Owens Parkway Phoenix, AZ 85042

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51730 Based on clinical record review, staff interviews and policy reviews, the facility failed to ensure that 1 of 3 sampled residents (#2) received long-acting insulin per hospital discharge orders upon admission. The deficient practice could result in uncontrolled blood sugar levels. Findings include: Resident #2 was admitted on [DATE] with diagnoses that included type 2 diabetes mellitus, Parkinson's disease, and dementia. Review of final orders/discharge instructions from the referring hospital, dated February 13, 2024 (prior to admission), included that the patient was to continue insulin Glargine (insulin glargine/Lantus) 15 units twice daily without any changes. Review of physician's orders dated February 13th- 19th,2024 revealed no evidence of physician orders regarding Insulin Glargine despite being listed on the hospital final orders/discharge instructions. An order summery dated February 13, 2024 revealed all medication orders were reviewed by the attending physician and he concurred with the present plan of care and discharge plan. Further review of physician orders dated February 14, 2024 included Glucose monitoring with instructions to notify the provider if glucose is less than 70 or more than 400 mg/dL. A Care Plan dated February 14, 2024, revealed a focus of Diabetes Mellitus with interventions that included diabetes medication as ordered by doctor, monitor/document for side effects and effectiveness, monitor/document/report to MD PRN (as needed) signs and symptoms of hyperglycemia. An Admission MDS (Minimum Data Set) assessment dated [DATE] included that the resident had a BIMS (Brief Interview for Mental Status) score of 2, which indicated severe cognitive impairment. The assessment indicated the resident had clear speech, was not oriented to time or place and at times appeared anxious, fearful and wandered. On February 18, 2024 the resident's blood glucose test results were 572.0 mg/dL. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated February 18, 2024 revealed that the resident's blood sugar was 572.0 mg/dL at 1:06pm and the provider was notified. However, there was no evidence regarding the provider's response including any medication changes, related to the increase in blood glucose levels. On February 18, 2024 at 4:41pm, the resident's blood glucose level was 219.0 mg/dL. A nursing progress note dated February 18, 2024 revealed blood glucose level at baseline and well controlled, despite evidence of blood glucose fluctuations during the day. A review of the resident's blood glucose results on February 19 through February 20, 2024 revealed: February 19, 2024 - 8:32 am- 229.0 mg/dL - 11:37 am- 271.0 mg/dL - 5:01 pm- 333.0 mg/dL - 10:03 pm- 321.0 mg/dL February 20, 2024 - 8:03 am- 337.0 mg/dL - 8:33 am- 337.0 mg/dL - 12:03 pm-337.0 mg/dL - 4:45 pm -357.0 mg/dL - 7:08 pm- 335.0 mg/dL A FNP (Family Nurse Practitioner) progress note dated February 20, 2024 indicated that, the resident's blood glucose remains elevated and to start a low dose of Glargine/Lantus 5 units at bed time. A Physician Order dated, February 20, 2024 was written for Insulin Glargine 5 units at bed time, despite the hospital's final order/discharge instructions for Glargine 15 units twice a day on February 13, 2024. A review of resident's blood glucose results dated February 21, 2024 revealed the following: - 8:80 am- 350.0 mg/dL - 8:31 am- 350.0 mg/dL - 12:28 pm- 397.0 mg/dL (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 2:00 pm- 314.0 mg/dL - 8:55 pm- 301.0 mg/dL A Physician's Order dated February 21, 2024 revealed an increase in Glargine/Lantus to 15 units at bed time. Review of resident's blood sugar results dated February 22, 2024 revealed: - 7:46 am- 328.0 mg/dL - 12:08 pm- 505.0 mg/dL - 3:30 pm-180.0 mg/dL A nursing progress note dated February 22, 2024, revealed that the provider was notified at 12:08 pm and received verbal orders to administer 22 units of Lispro. Despite the blood glucose reading of 505.0 mg/dL at 12:08 pm, on February 22, 2024 a daily skilled note, dated February 22, 2024 at 1:51 pm , revealed the resident's blood glucose is being monitored, blood glucose level at baseline, well controlled. Review of resident's blood sugar results dated February 26, 2024 revealed the following: - 7:35 am- 219.0 mg/dL - 7:37 am- 219.0 mg/dL - 12:18 pm- 319.0 mg/dL - 4:43 pm- 398.0 mg/dL - 8:21 pm- 266.0 mg/dL Per a physician order, dated February 26, 2024 at 6:05 pm, Glargine order was changed to 20 units at bedtime. A daily skilled note dated February 26, 2024 revealed the resident's blood glucose is being monitored, blood glucose level is not baseline or well controlled, and that Teachings/Education were not provided regarding Blood Glucose levels. Review of resident's blood sugar results dated February 27, 2024 revealed the following: - 7:05 am- 337.0 mg/dL - 8:29 am- 337.0 mg/dL - 11:06 am- 144.0 mg/dL (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 5:07 pm- 326.0 mg/dL - 7:47 pm- 444.0 mg/dL - 7:49 pm- 444.0 mg/dL - 10:52 pm- 342.0 mg/dL A Nursing Progress note dated February 27, 2024 relayed that the FNP was notified at 7:49 pm regarding increase in blood sugar to 444.0 mg/dL, and received an order to administer Lispro 15 units and to recheck blood sugars in 2 hours. On February 28, 2024 Resident #2 was placed on hospice and all orders for blood sugar monitoring and insulin treatment were discontinued at 1:50 pm. An interview was conducted on December 17, 2024 at 2:45 pm with a Licensed Practical Nurse (LPN, staff #10) who stated when admitting a new resident, she would review discharge paperwork and compare discharge orders with what is in EMDR (Electronic Medical Record). If an order is missing, she would notify the provider and determine if orders need to be entered or changed, and ask for clarification. She, also stated that she would be concerned if a Glargine order was not in the EMDR, but was included in the final hospital orders. Furthermore, she stated that the provider would catch this discrepancy. An interview conducted on December 18, 2024 at 10:10 am with FNP (staff #13), stated that during a resident admission, providers review final orders from the hospital, and they continue the same orders until they become familiar with the resident and determine if a medication needs to be changed. The FNP reviewed the clinical record and stated that he did not know why Glargine had not been ordered on admission, but blood sugars were monitored four times a day, and would be adjusted as indicated. An interview was conducted with the Director of Nursing (DON, staff #33) on December 18, 2024 at 11:46 am, she stated that the primary provider will review the orders for any changes when a resident is admitted , orders are placed in the EMDR, and assessments are completed. She further stated that the primary provider reviews the final orders/discharge instructions and there is a standing order in place that the provider has verified the orders, and if they want to make changes, they can write it on a paper for admissions to change. She reviewed the records for Resident #2 and stated that the attending provider reviewed the resident's medication on February 14, 2024 at 12:00 AM. She also stated that once everything is final the nurse would put in the medication orders. She stated that she does not know what happens to the form that has the changes, but she will check with Medical Records. Now those changes are documented in EMDR. During interview conducted on December 18, 2024 at 12:59 pm with Medical Records Director (staff #21), who stated that when a resident is admitted the hospital's final orders/discharge instructions are reviewed by the provider, and after the nurse adds the orders to the EMDR, the paperwork goes into a box and is uploaded by medical records into EMDR. She reviewed the clinical record and stated there is nothing as far as changes to final orders for Resident #2. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy and procedure titled, Nursing Services, Physician Orders, include admission orders are reviewed with physician upon admission based on the discharge instructions from the discharging facility and are transcribed accordingly. The policy further indicated that the facility accurately implements orders in addition to medication orders (treatment, procedures) only upon the order of a person duly licensed and authorized to do so in accordance with the resident's plan of care.