

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  035241	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/21/2025
NAME OF PROVIDER OR SUPPLIER  South Mountain Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  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.  (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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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> The facility failed to ensure proper monitoring for 1 out of 3 dialysis residents (#1).Based on clinical record review, interviews, and facility policy, the facility failed to ensure proper monitoring for 1 out of 3 dialysis residents (#1). The deficient practice could result in the inability to detect changes of condition. Findings include: Resident # 1 was admitted on [DATE] with diagnoses of end stage renal disease, dependence on renal dialysis, hemiplegia following cerebral infarct, and need for assistance of personal care. Review of the Resident's care plan dated May 7, 2025 revealed that Resident #1 was on hemodialysis due to end stage renal disease. Resident #1 was to receive dialysis on Tuesdays, Thursdays, and Fridays, with facility intervention of obtaining vital signs and weight, reporting significant changes in pulse, respirations and blood pressure immediately Review of Resident # 1's Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 9 which indicated resident had moderate cognitive impairment. The MDS also revealed that resident does receive dialysis. Review of the Resident's orders revealed an order dated May 7, 2025, for dialysis on Tuesdays, Thursdays, and Saturdays. The order did not have an end date. Further review of Resident's # 1 orders revealed an order dated June 17, 2025 for vital signs before and after hemodialysis every day shift and every night shift to start on June 19, 2025 with no end date. Review of Dialysis reports revealed that Resident # 1 received dialysis on July 1, 3, 5, 8, 12, 16, and 17, 2025. Review of Resident # 1 Medical Administration Record (MAR) for the month of July 2025, revealed that pre and post vitals were not documented on July 16, 2025 and post vitals were not documented on July 17, 2025. Furthermore, pre and post vitals were taken on July 15, 2025 and July 19, 2025 when dialysis was not performed. An interview conducted on July 21, 2025 at 2:10 p.m., with Licensed Practical Nurse (LPN/ Staff # 10) revealed that before residents go out for dialysis vitals are done, the residents are clean, and they have arrangements with food. When the residents return from dialysis we always do vitals and go over any new orders they may have. It is important we get vitals because if medications were held, especially if they have heart medications we want to make sure heart rate does not drop after dialysis.An Interview with Social Services Director (Staff # 36) on July 21, 2025 at 2:35 p.m., revealed that there had been problems with Resident # 1's transportation company arriving late or not at all. When that happens they have to either reschedule or the facility pays for transportation. Staff # 36 revealed that formal complaints have been sent into Resident #1's insurance company. Staff # 36 stated that his current transport is the only transport company that would accept Resident # 1's insurance.An interview conducted with Director of Nursing (DON/ Staff # 21) on July 21, 2025, at 2:57 p.m. revealed that they have had some transportation issues regarding Resident # 1. There were days the transport company did not show up and the facility had to cover the cost of transportation to return him back to the facility. The DON revealed that on July 16, 2025, they changed dialysis days from Tuesday, Thursday, Saturday to Monday, Wednesday, Friday. In reviewing the MAR, DON # 21 said that the correct pre and post dialysis orders were not in the system so staff were still performing them and documenting them on Thursday, and Saturday. DON # 21 stated that her expectation would bet that vitals are preformed prior to transporting to dialysis and upon return from dialysis. A policy and procedure titled, Nursing Services, Physician Orders dated July 2024, revealed that it is the policy of this facility to accurately implement orders in addition to medication orders (treatment, procedures) only upon the order of a person duly licensed and authorized to do so in accordance wit the resident's plan of care.</p>		