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	12/29/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interviews, and facility policy, the facility failed to ensure one resident (#33) received care and services necessary to attain or maintain their highest practicable physical well-being, as evidenced by failure to notify the provider when blood pressure medication was held and failure to obtain and document vital signs before hospitalization. The deficient practice could potentially limit the provider's ability to assess the resident's condition and potentially delay appropriate medical intervention. The sample size was 3. Findings include:Resident (#33) was admitted to the facility on [DATE], and discharged to the hospital on November 12, 2025, with a diagnosis including acute pyelonephritis, acute respiratory failure, unspecified whether with hypoxia or hypercapnia, dysphagia, oral phase, cognitive communication deficit, essential (primary) hypertension. Review of the care plan, date-initiated October 29, 2025, revealed a focus on hypertension related to congestive heart failure. Interventions include Give anti-hypertensive medications as ordered. Monitor for side effects such as orthostatic hypotension and increased heart rate (Tachycardia), and effectiveness. Monitor/record medication side effects, report to the medical doctor as necessary. Review of the Medicare 5-day Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) of 15, indicating cognition was intact. No identified indicators for mood or behaviors. The assessment revealed the resident required substantial maximum assistance with activities of daily living. Review of the assessment revealed the resident had medically complex conditions, including heart failure, hypertension, diabetes mellitus (DM), respiratory failure, and acute pyelonephritis. Further review of the assessment revealed the resident received insulin injections, antidepressants, opioids and continuous oxygen.Review of the order summary revealed a current order for Amlodipine Besylate Tablet 5 mg, give 1 tablet by mouth one time a day for hypertension (HTN). Start date October 30, 2025. Vital signs every shift, start date October 29, 2025.Review of the eMAR Medication Administration Note, effective date November 1, 202,5 at 9:20 am revealed hypertension medication 5mg Amlodipine Besylate Tablet was held due to resident #33's blood pressure 108/63. Further review revealed no documentation that the provider was notified of the held medication. Review of the eMAR Medication Administration Note, effective date November 6, 2025, at 8:22 am revealed hypertension medication 5mg Amlodipine Besylate Tablet was held due to resident #33 blood pressure 117/73. Further review revealed no documentation that the provider was notified of the held medication. Review of the medication administration record for November 2025 revealed the resident's vital signs were documented on November 12, 2025, in the am shift. There were no additional vital signs documented for November 12, 2025. Review of the weights and vitals summary for November 12, 2025 revealed vital signs were obtained at 8:45 am with the following readings: blood pressure-158/76, pulse-80, 20 breaths per minute, temperature-98.6.Record review revealed that on November 1, 2025, and November 6, 2025, Resident # 33's blood pressure medication was held due to low blood pressure parameters. However, there was no documentation that the provider was notified of the held medication. Additionally, prior to the resident being transferred to the hospital on November 12, 2025, vital signs were not obtained and documented, limiting the provider's ability to assess the resident's condition and potentially delaying appropriate medical intervention.Review of the progress nursing notes, effective date November 12, 202,5 4:34 PM revealed a nursing note documenting Confirmed with AMR that transport nonemergent will arrive by 1610.Review of the progress nursing notes, effective date November 12, 202,5 6:20 PM, revealed a nursing note documenting x3 attempts to speak with charge at BUMC ED with no success to provide report. Was picked by AMR and family following in a private vehicle. The report was given at the bedside to paramedics. All pertinent documentation was given to the driver.An interview was conducted on December 30, 2025, at 12:41 PM with Registered Nurse (RN/Staff #9). RN/Staff#9 stated that most of the facility's blood pressure medications do not have parameters and that nurses have to rely on their nursing judgement. Staff #9 stated it is the nurse's responsibility to obtain the vital signs due to the nurses not receiving the vital signs until 10 am from the certified nursing assistants, and that blood pressure medications are due at 8 am. Staff #9 stated if medications are held,d the provider should be notified and obtain an order for parameters and a care plan for the new parameters. Staff #9 stated that the risk of not informing the provider of held medications is that staff will continue to administer medications as ordered by the MAR, not realizing the medication had been held. Staff #9 stated the facility process for residents sent to the hospital is to obtain a new set of vital signs, and the risks in not obtaining a new set prior to discharge to the hospital is the hospital