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	08/09/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47910 Based on observations, resident and staff interviews, clinical record review, and policy review, the facility failed to ensure that dignity was maintained for one sampled resident (#23). The deficient practice could result in residents not being treated in a dignified manner. Findings include: Resident #23 was admitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy, hepatic encephalopathy, postprocedural hypertension, hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease. Review of the MDS (Minimum Data Set) assessment dated [DATE], revealed a BIMS (Brief Interview of Mental Status) was not conducted, but the assessment revealed there is evidence of an acute change in the residents mental status from the resident's baseline. The assessment also revealed the resident needed supervision or touching assistance with upper body dressing, partial/moderate assistance with lower body dressing. Review of the care plan dated July 7, 2024 revealed the resident had an ADL (activity of daily living) self-performance deficit related to impaired mobility and muscle weakness. The care plan interventions included patient often removes gown, prefers to wear off shoulders, encourage to discuss feelings about self-care deficit. An initial observation of the resident was conducted on August 5, 2024 at 9:56 a.m. Resident #23 was observed in the resident's room lying in bed that is closest to the door to the hallway. The door was completely open. Resident #23 was lying in bed at an angle with both breasts exposed and in an incontinence brief. Multiple residents and staff in the hallway. (Staff/CNA#7) then entered the resident's room and placed clothing on the resident. A second observation of the resident was conducted on August 6, 2024 at 12:42 p.m. The resident was observed sleeping in bed and fully dressed. A third observation was conducted August 9, 2024 at 8:30 a.m. The resident was observed in bed dressed in a hospital gown. Nasal cannula was not properly placed and was observed hanging off her face and not in her nostrils. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A fourth Observation was conducted on August 9, 2024 at 11:25 a.m. resident observed in bed, upper body exposed with door open, curtain partially drawn but resident could be observed from the hallway-housekeeping in hallway, two CNA's (Certified Nursing Assistant)-observed seated at the end of the hallway, with other resident in room no privacy curtain closed between the two residents. Additionally, following observations were conducted: 08/09/24 11:28 AM CNA/staff #64 walked by resident's room twice 08/09/24 11:29 AM LPN/Staff #141walked by resident's room 08/09/24 11:30 AM ADON/Staff #167 walked by resident's room 08/09/24 11:30 AM Shower Aide/Staff #96- observed the resident's condition from the hallway and entered the resident's room. An interview was conducted on August 9, 2024 at 11:37 a.m. with (Shower Aide/Staff #96). Staff #96 stated he observed the resident had her gown off from the hallway. He stated she may have got confused with the sheet and gown. He stated anyone could have observed the resident from the hallway. He further stated it's a dignity thing for the resident. An interview was conducted on August 9, 2024 at 12:30 p.m. with the Director of Nursing (DON/ Staff #145) who stated the resident likes to have her clothing pulled down and that this is care planned. Review of the care plan clearly states prefers to wear off shoulders. The DON stated the risks associated with this, is that it could affect dignity issues for the other resident's. The DON however stated they haven't had anyone complain. She further stated it is the responsibility of the facility to educate the resident, as it is their right and to make sure that it is noted in their chart. Review of the facility policy titled Dignity and Respect states it is the policy of this facility that all residents be treated with kindness, dignity and respect.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47910 Based on observation, resident and staff interviews, clinical record review and facility policy and procedures, the facility failed to ensure care and services related to an indwelling urinary catheter was provided to two residents (#164 and #300) out of 20 sampled residents. The deficient practice could result in residents being at risk for urinary catheter complications and urinary tract infections. Findings include: Resident #164 was admitted on [DATE] with diagnosis (dx) that includes encephalopathy, unspecified, unspecified hydronephrosis, malignant neoplasm of endometrium, obstructive and reflux uropathy, unspecified. The care plan revealed the resident had an indwelling catheter related to obstructive uropathy. The goals were that the resident will remain free from catheter related trauma through review and will show no signs or symptoms of a urinary infection through the review date. The interventions for the catheter were to position the catheter bag and tubing below the level of the bladder and away from entrance room door, secure catheter to facilitate flow of urine, prevent kinking of tubing, and accidental removal, and resident requires moderate to maximum assist with bed mobility, transfers, locomotion, dressing, toileting, hygiene, and bathing. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. The MDS assessment also revealed the resident had an indwelling urinary catheter, required substantial to maximum assistance with toileting hygiene and required substantial to maximum assistance for transfers. The physician order dated July 15, 2024 included for indwelling Catheter Care Q (every) shift and prn (as needed). In an observation conducted on August 5, 2024 at 9:58 a.m., resident #164 was observed being wheeled by a staff through the facility hallway with her catheter bag hanging filled with urine and uncovered attached to the bottom cross bars of the resident's wheelchair. The uncovered catheter bag was dragging on the floor as the resident was being pushed in her wheelchair. An interview was conducted on August 5, 2024 at approximately 10:05 a.m. with CNA (Certified Nursing Assistant/ Staff#7) who had stated the resident should have had a cover on her catheter and placed one on the catheter bag and repositioned the bag so that it did not drag on the floor. She stated the risks associated with the catheter can cause an infection from dragging on the floor. An interview was conducted on August 9, 2024 at approximately 11:32 a.m. with a CNA (Staff# 134) who stated there are signs or orange dots on the resident's door to indicate PPE is required with care. She stated when providing catheter care it is important to make sure the tubing is not kinked and to empty as needed or every shift, clean the catheter tubing to prevent infections and to place the catheter bag with a cover on the wheelchair. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on August 9, 2024 at approximately 11:05 a.m. with a Licensed Practical Nurse (LPN/Staff #141) who stated all catheters should have a cover and be hung below the resident's waist. She further stated the resident should not attend activities or go to therapy without a catheter cover. She stated the CNA's are responsible for making sure the resident's catheters have a cover and are placed correctly. Staff # 141 stated resident #164 recently had a urinary infection and could be at risk again with her catheter dragging on the floor. An interview was conducted with Director of Nursing (DON/staff #145) on August 9, 2024 at 12:32 p.m., the DON stated her current expectation is that there is an order and a care plan for the catheter and that placement of the catheter should be below the bladder, make sure that it is not dragging on the floor and should have privacy bag. 50553 Regarding Resident #300: Resident #300 was admitted to the facility on [DATE] with diagnoses including fluid overload, muscle weakness, and neuromuscular dysfunction of the bladder. Review of a nursing progress note dated April 8, 2022 at 7:25PM revealed that the resident was identified to have been incontinent of bowel and bladder on the date of admission. Review of physician orders for April 2022 revealed no evidence of physician orders for having or changing an indwelling Foley catheter or catheter care. Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated April 2022 revealed no evidence of catheter care being provided, including no evidence of the catheter being cleaned or changed, in the month of April 2022. Review of the resident's care plan initiated on April 9, 2022 revealed no focus area regarding the resident having an indwelling catheter or interventions for providing catheter care. Review of the Toilet Use task dated April 2022 revealed that all entries for this task on April 11, 2022 were charted as NA (Not Applicable). Additionally, this task area did not address emptying of the catheter or specifically cleaning of the catheter. Review of the discharge Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had an indwelling catheter in place for a diagnosis of a neurogenic bladder. An interview was conducted on August 9, 2024 at 8:38AM with a Licensed Practical Nurse (LPN/ Staff #160) who stated that there should be physician orders for catheter care. She also stated that if there are no orders for catheter care for a resident with a catheter, she would let the physician know. She also elaborated that there may be batch orders that can be initiated for catheters, and the size of the catheter and balloon should be noted. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on August 9, 2024 at 9:12AM with a Certified Nursing Assistant (CNA / Staff #95) who stated that catheter care should be provided by CNAs every time the resident is changed. She reports that it should be charted in the Electronic Health Record (EHR), Point Click Care (PCC). She was unable to identify specifically which area or task to record catheter care in. An interview was conducted on August 9,2024 at 10:10AM with the Director of Nursing (DON/ Staff #145) who stated she expected her nursing staff to follow provider's orders for catheter care and to document the care in the TAR. She also stated that there are batch orders for catheters, so there should be an order in the medical record, and catheters should be reflected in the care plan. When asked if Resident #300's medical record should have reflected an order for an indwelling catheter and care, she stated that she was not in the DON position at that time and therefore did not know what the expectation and policy was at that time. Review of the facility policy titled, Catheter Care, Indwelling, revealed that each resident with an indwelling catheter should receive catheter care daily and as needed for soiling. The policy included to cover drainage bag with privacy bag. This policy also revealed that documentation of catheter care is done under the toileting task. This policy was revised May 2007, July 2012, and July 2013 and was reviewed July 2023 and July 2024, indicating this policy applied for Resident #300 during her stay at the facility. Review of the facility policy titled, ADL's - hygiene, grooming, toileting, bathing, oral care, dressing, grooming, mobility, transfers, ambulation, etc., revealed that residents should be given the appropriate treatment and services to attain or maintain the highest practicable well-being of each resident in accordance with a written plan of care. This policy also revealed that ADL care, including personal hygiene, will be provided according to the resident's needs, and it will be documented in the medical record. This policy was revised on November 2007 and July 2015, and was reviewed multiple occasions since these dates, indicating this policy applied for Resident #300 during her stay at the facility.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48814 Based on review of clinical records, policy, and staff interviews the facility failed to ensure an order for pain medication was followed as prescribed for one of six sampled residents (Resident #88) by failing to administer pain medication within the physician ordered parameters. The deficient practice of administering unnecessary medication may result in undesirable medication-induced harm. Findings Include: Resident #88 was admitted into the facility on [DATE] and discharged on [DATE] with diagnoses that included cutaneous abscess of left lower limb, pedestrian on foot injured in collision with car, sequela weakness and muscle weakness. Review of care plan, initiated on June 30, 2024 revealed that the resident was prescribed an opioid for pain, and interventions included to administer opioid as prescribed. Review of the physician orders revealed the following order dated July 1, 2024: Oxycodone-Acetaminophen tablet (an Opioid) 5-325 milligram to give 2 tablets by mouth every 4 hours, as needed for pain 6-10. Review of an admission minimum data set (MDS) asessment from July 3, 2024, the Brief Interview for Mental Status (BIMS) score was 15 which indicated intact cognition. Review of the July 2024 Medication Administration Records (MAR) revealed that Oxycodone-Acetaminophen medication was administered outside of physician ordered parameters (pain 6-10) on: Saturday July 13, 2024 for pain level of 4. Sunday July 14, 2024 for pain level of 3. Monday July 22, 2024 for pain level of 3. Sunday July 28, 2024 for pain level of 3. An interview was conducted with Licensed Practical Nurse (LPN, staff # 155) on August 08, 2024 at 12:24 p.m., who stated that according to the pain scale: 10 means most pain and 0 means no pain. She further stated when assessing for pain, nurse should observe residents for facial expression, anxiety and breathing. She also stated that the risk for medication administer outside of order parameters could result in an over dose or interaction with other medications. An interview was conducted with Director of Nursing (DON, staff # 145) on August 08, 2024 at 12:47 p.m., who stated when administering medication to resident staff follow the 7 rights (right medication, right patient, right dose, right time, right route, right reason and right documentation). She also stated that the pain scale corelates the level of pain with the medication administered per physician orders. The DON stated the risk of not following physician order parameters would depend on the patient and the medication. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the policy titled, Documentation of Medication Administration-Oral, revealed to verify resident medication cards with medication orders. It also revealed that no medication is to be administered without a physician's written order and if there is any question in regard to dosage, the person in doubt should not give the drug until dosage has been clarified. A review of the policy titled, Pain Management, revealed to document on the Care Plan any preventive or care interventions (pharmacological and non-pharmacological) for any resident admitted with pain. It also revealed that medication(s) received, refused, and response to medication will be documented on the Medication Administration Record (MAR).