STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035251	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Park Post Acute	2555 North Price Road Chandler, AZ 85224

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff and resident interviews, and facility policy, the facility failed to promote and facilitate residents' self-determination through a resident's choice of clothing for one of one sampled residents (#9). This deficient practice could lead to residents having feelings of unimportance and lack of dignity. Findings Include: Resident #9 was admitted on [DATE] with diagnoses that included history of transient ischemic attack, and cerebral infarction, protein-calorie malnutrition, major depressive disorder, chronic obstructive pulmonary disease, cognitive communication deficit and chronic instability of knee. A quarterly Minimum Data Set (MDS), dated [DATE], revealed Resident #9 had a Brief Interview of Mental Status (BIMS) of 10, indicating moderate cognitive impairment. An initial observation was conducted on April 8, 2025 at 10:00 AM of Resident #9, who was sitting in her wheelchair, in her room, dressed in a hospital gown. During a brief interview conducted with the resident at that time, she stated she would like to be dressed in her clothes. She stated the staff wanted her to wear hospital gowns. A Care Plan Report, dated May 22, 2024, indicated Resident #9 required one-person assistance with dressing. April 2025 Tasks were reviewed in the electronic medical record. There were 18 scheduled tasks for dressing upper body and 18 scheduled tasks for dressing lower body. 15 of the 18 upper body tasks were marked as not applicable or not attempted. 11 of the 18 lower body tasks were marked as not applicable. There was no evidence of resident refusals for dressing in the medical record. Resident #9 was observed dressed in a hospital gown during observations on the morning and afternoon shifts on April 8, 2025 and April 9, 2025. An observation of Resident #9 was conducted on April 9, 2025 at 9:51 AM. She was sitting in her wheelchair, in her room, dressed in a hospital gown, with the gown untied and the neck of the gown hanging down on the resident's chest. The resident stated she wanted to get dressed in her clothes and indicated that she could not remember the last time she was dressed in her own clothing. (continued on next page)

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
	035251	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Park Post Acute	2555 North Price Road Chandler, AZ 85224

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on April 9, 2025 at 9:53 AM with a certified nursing assistant, (CNA/staff #43), who stated that Resident #9 is a fighter. The CNA, stated she doesn't remember ever seeing the resident dressed in regular clothes and that the resident usually stayed in her bed anyway. An interview was conducted on April 9, 2025 at 12:08 PM with a physical therapy assistant (PTA/staff #100), who stated Resident #9 had clothes in her closet and that the resident liked wearing her purple dress. The PTA stated she had not seen the resident dressed in clothes for quite a while. The PTA stated the CNAs are allowed to assist the resident with dressing. An interview was conducted on April 9, 2025 at 1:52 PM with the Director of Nursing (DON/staff #48), who stated Resident #9 is encouraged to get up from bed and to be active. She stated Resident #9 does have clothes available, but she was unaware that the resident preferred to be dressed in clothes, rather than a hospital gown. An interview was conducted on April 10, 2025 at 9:08 AM with a CNA (#85) who stated they always ask residents if they want to get dressed into regular clothes or not. She stated normally the residents in this hall [meaning the long-term care residents] wanted to get dressed. She further stated that some residents liked to stay in bed, but staff still offered to get them dressed. She also stated that if residents refused assistance with dressing, it should be documented in the medical record. Following that interview, at 9:12 AM, the CNA (#85) entered Resident #9's room and was heard to ask Resident #9 if she wanted to get dressed. Resident #9 stated she did want to get dressed. However, Resident #9 was observed in the hospital gown at 9:40 AM, went to physical therapy in the hospital gown at 10:17 AM, returned from therapy in the hospital gown at approximately 10:35 AM, and was still in the hospital gown at 11:07 AM. Resident #9 was observed dressed in her clothes at 12:25 PM. An interview was conducted with the CNA (#85) on April 10, 2025 at 11:07 AM, who stated Resident #9 had requested to get dressed around 9:00 AM, but when she went in to dress her, the resident was in a wheelchair, so she chose to leave her in the hospital gown. The CNA stated she needed to get her charting done and that she would assist the resident with dressing before the end of her shift. An interview was conducted with Resident #9 on April 10, 2025 at 12:25 PM, who stated she was happy being dressed. She stated it was a lot of work, but she preferred being dressed to being in the hospital gown. An interview was conducted on April 10, 2025 at 12:48 PM, with the DON (staff #48), who stated a reasonable time frame to get a resident dressed after the resident requested assistance, would be within an hour or so, unless something came up to prevent it. The DON stated a resident being in a wheelchair would typically not constitute a reason to not assist the resident with getting dressed. An interview was conducted on April 11, 2025 at 9:12 AM with the DON (#48) who stated she agreed that resident choices were important and that staff should give Resident #9 an opportunity to get dressed daily. A policy titled, ADL (activities of daily living)-services to carry out, stated that residents would be involved in decision making and given choices related to ADL activities. It stated ADL care included dressing, and the facility would provide assistance according to the resident's assessed needs and level of support.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035251	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Park Post Acute	2555 North Price Road Chandler, AZ 85224

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff and resident interviews, and facility policy, the facility failed to ensure the views and grievances of the resident council were acted upon promptly regarding wheelchair cleaning. This deficient practice could lead to the resident council not feeling heard and issues not being resolved in a timely manner. Finding include: Resident #20 was admitted on [DATE] with diagnoses that include conversion disorder with seizures or convulsions, muscle weakness, major depressive disorder, chronic obstructive pulmonary disease and demyelinating disease of central nervous system. Resident #6 was admitted on [DATE] with diagnoses that included myasthenia gravis, spinal muscular atrophy, gastro-esophageal reflux disease and muscle weakness. Resident #16 was admitted on [DATE] with diagnoses that included muscle weakness, aural vertigo, overactive bladder, cognitive communication device and hypertension. Resident Council meeting minutes for the past year revealed that residents had asked for their wheelchairs to be cleaned since January 2024. Minutes for January 8, 2024 stated, Please wash the wheelchairs, they have not been cleaned in months/years in some cases. October 2024 stated, Residents asked for wheelchairs to be washed. January 14, 2025 stated, Wheelchairs need to be washed for LTC residents. March 19, 2025 stated, Want wheelchairs to be cleaned more often, need to be power washed. There was no evidence in the minutes of the wheelchairs being cleaned subsequent to the expressed concern. A Grievance Log, dated March 19, 2025, indicated a concern regarding wheelchair cleaning. The response section of the log indicated that wheelchair cleaning had been scheduled, but did not indicate a date. An interview was conducted on April 9, 2025 at 10:30 AM, with the Resident Council President (resident #20) and two other members of the Resident Council, Resident #6 and Resident #16. The three members stated the wheelchairs were very dirty and needed to be cleaned. They stated they felt frustrated that their requests for cleaning the wheelchairs had not been completed. An interview was conducted on April 10, 2025 at 10:22 AM, with the Resident Council President (resident #20) who stated she would have expected the wheelchairs to have been cleaned within a few months, or less, from the time of the initial request. An interview was conducted on April 10, 2025 at 10:43 AM, with the Executive Director, (ED/staff #93), who stated he prefers to address Resident Council concerns as soon as possible. He indicated that he typically responds either immediately or up to a week's time. Regarding the wheelchair cleaning, the ED stated the chairs had been wiped down during a recent night shift. The ED provided a Word document stating that all of the wheelchairs had been cleaned during the night shift on February 28, 2025 and during the weekend of March 15, 2025. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035251	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Park Post Acute	2555 North Price Road Chandler, AZ 85224

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on April 10, 2025 at 3:20 PM with the ED, who confirmed that the Resident Council made several requests for wheelchair cleaning, that the requests began over a year ago, and that they were first wiped down on February 28, 2025. An interview was conducted on April 11, 2025 at 8:49 AM with Resident #6 who stated the facility lightly cleaned some of the chairs one time, rather than doing a deep cleaning. She stated many chairs remained filthy. A policy titled, Grievances, indicated the Grievance Official would evaluate and investigate concerns and take immediate action to resolve the concern. The policy further states that the Grievance Official or designee will respond to individuals expressing concerns within three working days of the initial concern and describe steps taken toward resolution.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035251	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Park Post Acute	2555 North Price Road Chandler, AZ 85224

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff and resident interviews, and facility policy, the facility failed to ensure that one of one sampled resident's (#32) was free from abuse. The deficient practice could result in other residents being abused. Findings include: Resident # 32 was admitted [DATE] with diagnoses that included cerebral palsy, dependence on wheelchair, difficulty in walking, and major depressive disorder. Physician orders included: -Percocet 5-325 mg tablet, give 1 tablet by mouth every 4 hours as needed for pain 1-10/10, dated 5/11/2022 -Doxepin HCL Capsule 10 mg (milligram) by mouth every 12 hours for depression, dated 7/24/2023. Review of progress notes dated June 1, 2024 through August 4, 2024, revealed no evidence of the resident exhibiting any behaviors. A quarterly Minimum Data Set (MDS) assessment dated [DATE], included a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The assessment also revealed that the resident had exhibited no behaviors within the assessment reference date (ARD). The assessment also included that the resident's hearing was adequate and no hearing aid or hearing appliances were normally used. The assessment indicated that the resident was able to understand others with clear comprehension. A care plan initiated on April 29, 2024, revealed that the resident had a history for an alteration in mood or exhibition of behavioral symptoms related to depression. Interventions included to interact in an empathetic and supportive manner and to monitor and document each behavioral event. Further review of the care plan initiated on April 29, 2024, revealed that the resident had a hearing deficit, with interventions that included allowing the resident adequate time to respond, repeat as necessary and reduce environmental noise. An Incident Note dated July 14, 2024 at 7:11 PM, revealed that Resident #32 reported that her roommate's husband was accusing her of inappropriately touching his wife. Resident #32 further reported that the roommate's husband was verbally aggressive and told her to shut the fuck up, you bitch repeatedly, while she was trying to explain to him that she cannot get out of bed. The Incident Note also included that Resident #32 was too scared to return to her room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035251	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Park Post Acute	2555 North Price Road Chandler, AZ 85224

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Reportable Event Record/Report dated July 15, 2024, revealed that Resident #32 reported to a Registered Nurse (RN/staff #83) that her roommate, Resident #9's husband confronted Resident #32, accusing her of having put her hands on his wife, and that Resident #32 admitted to engaging in the argument. The report also included that Resident #32 did not feel threatened or fearful, and Resident #9 denied being injured or touched in any way. Resident #9's husband was removed from the situation, and further visits were supervised. The report also indicated that Resident #9's husband had recently been moved from independent living into assisted living by his family, because he had become increasingly confused. A nursing progress note dated July 16, 2024 at 6:54 PM, revealed that Resident #32 had no complaints or negative verbalization regarding previous conversation with resident and husband. An Interdisciplinary Note (IDT) dated July 17, 2024 at 9:30 AM, included that the Executive Director (ED) and interdisciplinary team had discussed the incident with the resident and the resident reported feeling safe with no concerns regarding her safety or well-being. The note further relayed that the resident was satisfied with the facility's interventions and acknowledged her role in alerting and confronting her. A Medication Administration Record (MAR) dated July 2024, revealed no evidence that Resident #32 exhibited behaviors related to depression episodes during the month. Further review of the July 2024 MAR, Behavior Tracking, revealed no evidence that the resident displayed any behaviors from July 1, 2024 through July 31, 2024 A Treatment Administration Record (TAR) dated July 2024, revealed no evidence that Resident #32 displayed any side effects related to psychotropic medication use, July 1, 2024 through July 31, 2024. An interview was conducted on April 9, 2025 at 11:14 AM with a Licensed Practical Nurse (LPN/staff #44), who stated that once a resident reports abuse or abuse is observed the incident should be reported to the Director of Nursing (DON) and ED. She also stated that abuse could include mistreatment, emotional/physical abuse, and verbal abuse. She further stated that verbal abuse could include a staff member or visitor raising their voice to a resident or yelling at the resident. The LPN stated that she was not present when the July 14, 2024 incident occurred, but she heard that Resident #9 had accused Resident #32 of something, and Resident #9's husband yelled at Resident #32. The LPN stated that would constitute verbal abuse. An interview was conducted on April 9, 2025 at 12:33 PM with Resident #9, who stated that she did not recall any interactions between her husband and Resident #32, but that everything gets jumbled. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035251	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Park Post Acute	2555 North Price Road Chandler, AZ 85224

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on April 9, 2025 at 1:00 PM with Resident #32, who stated that on July 14, 2024, her roommate's husband yelled at the night CNA saying that he was going to report her for not doing the resident's care correctly. Resident #32 stated that earlier that morning at around 4:00 AM a CNA was changing Resident #9's brief, and Resident #32 heard Resident #9 hit the CNA, and that she (Resident #32) acted like she was asleep. Resident #32 stated that she heard Resident #9 yell, I'm going to report her, you better back me up to Resident #32, and that she acted like she was asleep and would not respond to Resident #9 and her husband. Resident #32 stated that Resident #9's husband yelled at her saying she was a liar, that she was not asleep, and that she heard everything. Resident #32 stated that she yelled back at Resident #9 and her husband, stating that she was asleep and she did not hear anything. Resident #32 stated that the incident made her feel scared, and angry. An interview was conducted on April 10, 2025 at 11:03 AM with RN (staff #83), who stated that verbal abuse could include the use of cuss words, belittling people and calling them names. The RN stated that the husband of Resident #9 was usually nice, but on July 14, 2024 he was not as nice as usual. She further stated that Resident #9's husband told her that Resident #32 was touching his wife, and while Resident #9's husband reported this, Resident #32 was listening to what he was saying, but that Resident #32 did not respond. The RN relayed that she explained to Resident #9's spouse that Resident #32 could not get out of bed and required assistance, and that explanation seemed to pacify Resident #9's husband. The RN further explained that after Resident #32 got up that morning at approximately 11:00 AM, and reported to the RN that Resident #9's husband was verbally abusive to Resident #32. The RN also stated that she reported this to the DON and an investigation was initiated. The RN stated that Resident #9's husband was placed on supervised visits and that Resident #9 was moved to another room on the day of the incident. The RN further stated that Resident #32 was not behavioral, but that Resident #32 had the reputation for making things up. The RN also stated that for Resident #32, the incident was real, and that the resident was scared. The RN stated that staff supported Resident #32 throughout the day, and that Resident #32 went on and on about the incident for several days after the incident. The RN also stated that from her point of view the incident that occurred on July 14, 2024 was verbal abuse. An interview was conducted on April 10, 2025 at 3:00 Pm with the DON (staff #48), who stated that she would define verbal abuse as yelling for no reason, cursing, and talking down or speaking aggressively to someone, and the use of inappropriate language. The DON stated that on July 14, 2024, the nurse called and reported that the husband of Resident #9 came into the facility and accused Resident #32 of touching his wife. The DON stated that Resident #9's husband and Resident #32 did get into an argument, back and forth about the situation. The DON stated that Resident #32 provoked the husband of Resident #9 by quoting something and used her acting skills. The DON also stated that Resident #32 and Resident #9's husband were separated, and the CNA that performed care the night before was suspended pending the investigation. The DON further stated that Resident #32 relayed that she was in the room the whole time that the CNA was providing care to Resident #9, and that Resident #9 was yelling during the care being provided. The DON stated that when Resident #9's husband came in that morning, his wife told him that Resident #32 laid hands on her. The DON reviewed the incident note dated July 14, 2025 at 19:11, and stated that per the note, Resident #32 may have had psychosocial harm from the incident with Resident #9's husband. The DON further stated that Resident #32 did say that she provoked Resident #9's husband. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035251	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Park Post Acute	2555 North Price Road Chandler, AZ 85224

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled, Abuse, revealed that each resident has the right to be free from abuse, neglect and mistreatment. Verbal abuse includes the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents, or within their hearing distance, regardless of their age, ability to comprehend, or disability.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035251	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Park Post Acute	2555 North Price Road Chandler, AZ 85224

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff and resident interviews, and facility policy, the facility failed to ensure pain management was provided, consistent with resident preferences, for one of one sample residents (#9). This deficient practice could lead to residents experiencing poorly controlled pain. Findings include: Resident #9 was admitted on [DATE] with diagnoses that included history of transient ischemic attack, and cerebral infarction, protein-calorie malnutrition, major depressive disorder, chronic obstructive pulmonary disease, cognitive communication deficit and chronic instability of knee. A quarterly Minimum Data Set (MDS), dated [DATE], revealed Resident #9 had a Brief Interview of Mental Status (BIMS) of 10, indicating moderate cognitive impairment. Further, the MDS revealed Resident #9 had pain almost constantly, that pain interfered with her day-to-day activities frequently and that she had rated her pain a 6/10 at the time of the assessment. A provider order was written on March 13, 2025, to administer scheduled Oxycodone (an opioid narcotic pain medication) 5 milligrams (mg), give 1 tablet by mouth one time daily for pain. A provider order was written on September 22, 2024, to administer Oxycodone 5 mg, give 1 tablet by mouth every 6 hours as needed (PRN). Two provider orders were written on March 26, 2025, to administer: Ibuprofen 400 mg, give 400 mg by mouth every 8 hours as needed for pain; and Tylenol 325 mg, give 2 tablets by mouth every 6 hours for pain 1-10 (rating on the 0-10 pain scale). An initial observation was conducted on April 8, 2025 at 10:00 AM of Resident #9, who was sitting in her wheelchair. She stated she had not received her pain medication that morning, and was experiencing pain in her left leg, rating it at a level 8 out of 10, with 10 being the worst pain. The April 2025 Medication Administration Record (MAR) revealed Oxycodone was scheduled to be administered at 9:00 AM every morning, and that Resident #9 had not received the scheduled dose of Oxycodone on April 7, 2025 or April 8, 2025. Further, the MAR did not indicate Resident #9 received any PRN pain medications during the month of April. The MARs for February 2025, March 2025 and April 2025, revealed the resident typically measured her pain between a 3-6 out of 10 on the 0-10 pain scale. A Care Plan Report, dated May 22, 2024, revealed Resident #9 had a left knee contracture and that she had the following pain management interventions: anticipate need for pain relief and respond immediately to any complaint of pain, observe and report decrease in functional abilities, ROM, withdrawal or resistance to care, report to nurse any change/refusal to attend things related to pain. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035251	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Park Post Acute	2555 North Price Road Chandler, AZ 85224

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on April 8, 2025 at 10:28 AM with Resident #9, who stated her current pain level was an 8/10 and that she would prefer her pain level be less than or equal to a 3/10. She further stated she had not received any pain medications that day. An interview was conducted on April 9, 2025 at 7:25 AM with Resident #9, who stated she was experiencing pain in her left leg, rating it an 8/10. She was observed to have facial grimacing and verbal moaning. An interview was conducted on April 9, 2025 at 11:32 AM with a Licensed Practical Nurse (LPN/staff #44), who stated Resident #9 doesn't usually ask for pain medication and that if she (the LPN) asks Resident #9 if she's experiencing pain, the resident always said yes. The LPN stated she looked for physical signs instead, and that she had not seen any, so she chose not to administer PRN pain medications. The MAR confirmed that the LPN had not administered any PRN pain medications to the resident for the month of April. The LPN then (staff #44) reviewed the April MAR and stated Resident #9 did not receive her scheduled Oxycodone on April 7, 2025 or April 8, 2025. She stated the reasons for the missed medications were that Resident #9 was sleeping on April 7, 2025, and refused to take her medications on April 8, 2025. She stated she had re-attempted to administer the medications both days without success. The LPN reviewed the medical record and did not locate documentation of the re-attempts. She stated by signing off that the medications were not administered, that it was understood that the nurse had attempted two times. An interview was conducted April 9, 2025 at 1:42 PM, with the Director of Nursing (DON/staff #48), who stated staff should monitor residents for pain whenever they are in their rooms. She further stated that certified nurse assistants (CNA) should notify nurses if residents are resistant to cares, possibly indicating pain. The DON stated Resident #9 is capable of telling staff if she is experiencing pain. The DON also stated that if a resident refuses a medication, the provider should be notified and the nurse should offer the medication again. She expected there would be documentation of those tasks being performed in the medical record. The DON reviewed the medical record for Resident #9 and could not locate evidence that the nurse re-attempted to give the resident her Oxycodone on April 7, 2025 or April 8, 2025. Further, there was no evidence that the provider was notified. An interview was conducted on April 10, 2025 at 10:11 AM with a registered nurse (RN/staff #83), who stated she assesses residents for pain by asking them if they have pain, where the pain is located and what level the pain is on a scale of 0-10. She stated when a resident verbalizes they have pain, the nurse should administer a PRN pain medication if it is within provider orders. She further stated that if the resident refuses the medication, it should be documented in the medical record. An interview was conducted on April 11, 2025 at 9:13 AM with the DON who stated that residents should be administered PRN pain medications if they verbalize having pain, and that if Resident #9 stated she was experiencing pain, she should have received pain medication per order. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035251	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Park Post Acute	2555 North Price Road Chandler, AZ 85224

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a policy titled, Pain Management, indicated the facility is to provide an environment and programs that assist each resident to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. It also states the facility provides screening to determine if the resident has been or is experiencing pain, and monitors pain status and treatment effects on a regular basis, e.g. during routine medication pass.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035251	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Park Post Acute	2555 North Price Road Chandler, AZ 85224

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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on clinical record review, facility documentation, staff interviews, and policy review, the facility failed to ensure that glucometer controls were consistently completed. The risk could result in inaccurate blood sugar results and possible inaccurate insulin administration. Findings Include: A medication storage observation was conducted on April 10, 2025 at 12:25 p.m with the Assistant Director of Nursing (ADON/Staff #56). During the observation of medication cart #1, a March 2025 Quality Control Record sheet revealed that glucometer controls were not performed consistently on the following dates: -March 3-5, 8-11, 19, 22, 26, 2025. During the observation an interview was immediately conducted with the ADON on April 10, 2025 at 12:40 p. m, who stated that she expected glucometer quality controls to be performed daily by a night shift nurse. The ADON reviewed the March 2025 glucometer Quality Control Form and stated that the glucometer controls had not been completed consistently that month. The ADON further stated that the risk of glucometer controls not being completed daily could result in inaccurate blood glucose levels. not. An interview was conducted on April 10, 2025 at 12:52 p.m with the Director of Nursing (DON/staff # 48), who stated that glucometer calibration should be performed daily by the night shift, and should be documented on the glucometer log. The DON further stated that the ADON did relay that the March 2025 glucometer log controls were not documented consistently. She further stated that this was due to new nursing and temporary staff and turnover. She stated that the risk of not performing blood glucose controls daily could result in inaccurate blood sugar test results and inaccurate insulin administration. A policy titled, Glucometer Calibration, revealed that glucometers should be calibrated at least once a day. The test results will be recorded on the appropriate form that is kept in the glucometer logbook placed at the nurses ' station.