STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035260	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fountain Hills Post Acute	16300 East Keith McMahan Drive Fountain Hills, AZ 85268

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, review of clinical record, and review of facility policy and procedure, the facility failed to ensure medication was administered and stored according to policy for two of four sampled residents (#4 and #2). The deficient practice resulted in residents accidentally ingesting medication.Findings Include:-Regarding Resident #4:Resident #4 was admitted to the facility on [DATE], with diagnoses that included hyperlipidemia, anemia, type 2 diabetes mellitus, chronic pain syndrome, pressure ulcer of right buttock, and pressure ulcer of right ankle.An admission minimum data set (MDS) assessment dated [DATE], revealed Resident #14 had a brief interview for mental status (BIMS) score of 14, indicating intact cognition.A physician order dated September 30, 2025, for arformoterol tartrate inhalation nebulization solution 15 mcg/2ml indicated for 2 ml, to inhale every 12 hours as needed for chronic obstructive pulmonary disease (COPD).The clinical record revealed no evidence of a physician order for albuterol inhaler or for cortisone cream.Additionally, there was no evidence of a Self-Administration of Medication assessment or any other medication self-administration assessment completed for Resident #4.The facility visitor sign-in log was reviewed on October 15, 2025, and revealed that Resident #4's most recent visitor signed into the facility on October 11, 2025.An observation was conducted on October 15, 2025, at 8:11 A.M. of Resident #4 in bed in his room. On the bedside table next to Resident #4 was a clear plastic bag with an albuterol inhaler and a tube of cortisone cream. An interview with Resident #4 was conducted on October 15, 2025, at 8:11 AM, and Resident #4 stated that the inhaler and cortisone cream were his medications from home. The observation continued on October 15, 2025, at 8:11 AM, and a staff member knocked on the resident's door, greeted the resident, and then stated that the staff was delivering the resident's breakfast tray. The staff member brought in the resident's breakfast tray, and set up the breakfast tray on the resident's bedside table, right next to the clear plastic bag with the medications. An interview was conducted on October 15, 2025, at 9:27 A.M. with the Registered Nurse (RN / Staff #8) assigned to Resident #4's unit. Staff #8 stated that nurses store medications in the medication cart, and during medication pass nurses administer medications as ordered to the residents. Staff #8 stated that nurses watch the residents take the medications and sign off on the Medication Administration Record (MAR). Staff #8 stated that medications are not left at bedside for residents. Staff #8 stated that residents can be assessed to self-administer their medications if they are deemed safe and appropriate to do so. Staff #8 stated that Resident #4 is not allowed to self-administer medications. Staff #8 then entered Resident #4's room and picked up the albuterol inhaler and cortisone cream from the resident's bedside table and brought them to the hallway for further inspection. Staff #8 stated that it was an albuterol sulfate inhaler and cortisone cream, and that she did not see the medications before. Staff #8 reviewed the clinical record and then stated that the resident did not have physician orders for either medication, and that the facility's process would be to take the medications and store them in the medication cart until they could be returned to the resident's family.-Regarding Resident #2:Resident #2 admitted to the facility on [DATE], with (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diagnoses that included vascular dementia, heart failure, chronic atrial fibrillation, severe chronic kidney disease, and presence of cardiac pacemaker.A quarterly MDS assessment dated [DATE], revealed that Resident #2 had a BIMS score of 14, indicating intact cognition.Review of the clinical record revealed no evidence of a Self-Administration of Medication assessment completed for Resident #2.A physician order for melatonin oral tablet 3 mg indicated to give one tablet by mouth at bedtime at 7:00 P.M.A physician order for tamsulosin HCl oral capsule 0.4 mg indicated to give one capsule by mouth at bedtime for benign prostatic hyperplasia (BPH) at 7:00 P.M.A physician order for rivastigmine tartrate capsule 3 mg indicated to give 1 capsule by mouth two times a day for dementia as evidenced by aggressive behaviors, at 8:00 AM and at 7:00 P.M.Another physician order for acidophilus oral tablet indicated to give one tablet by mouth two times a day for gastrointestinal health, at 8:00 A.M. and 8:00 P.M.Review of the MAR for September 2025 revealed that an RN (Staff #29) had signed on the MAR that Resident #2 had refused the following medications on the evening of September 12, 2025: melatonin oral tablet, tamsulosin HCl oral capsule, rivastigmine tartrate capsule, and acidophilus oral tablet.Additionally, the MAR for September 2025 revealed that a Licensed Practical Nurse (LPN / Staff #55) had signed the MAR that Resident #2 received his morning medications as ordered on the morning of September 13, 2025.Also, the MAR for September 2025 revealed that on September 13, 2025, Resident #2 was placed on change of condition monitoring every shift for three days for a medication error.In addition, on September 13, 2025, the MAR revealed that Resident #2 received a one-time dose of midodrine HCl oral tablet 10mg for a blood pressure of 67/35 at 1:16 P.M. Resident #2 also received sodium chloride 0.9% 500 ml intravenously for blood pressure of 67/35 on September 13, at 1:17 P.M.Review of the clinical record revealed no progress notes completed on September 12, 2025 for Resident #2.A progress note dated September 13, 2025, revealed that the nurse (Staff #55) was alerted by a certified nursing assistant (CNA) that a visitor found medications at bedside in Resident #2's room, and administered them to Resident #2. The nurse immediately proceeded outside to where Resident #2 and the visitor were to obtain vital signs. The resident's vital signs were assessed, with blood pressure of 67/35, pulse of 62 bpm, O2 91%, and the resident was brought back inside. The provider was notified and gave orders to give 10 mg dose of midodrine, and 500 ml IV fluid bolus to be followed by 100 ml/hr for a total of 1000 ml. An IV was started in the resident's right hand. The progress note also revealed that Staff #55 had already administered the resident's morning medications earlier in the day with a CNA present. The Director of Nursing (DON) was called and notified.A BIMS assessment dated [DATE], revealed Resident #2 had a BIMS score of 12, indicating moderately impaired cognition.A signed statement dated October 15, 2025, from the facility administrator (Staff #40) revealed that visitor sign-in logs are generally scanned and digital copies are stored electronically, and once scanned, the visitor sign-in logs are then shredded. The statement revealed that the visitor sign-in logs for September 7-14, 2025 were missed during the scanning process and were shredded.An interview was conducted on October 15, 2025, at 9:12 A.M with Resident #2. Resident #2 stated that now the facility staff administer medications and watch him take the medications, however recently there was a problem with a staff member leaving medication on the counter and that he got a double dose of medication by accident. Resident #2 stated that when that happened, he felt weak and as if he could not move.An interview was conducted with an RN (Staff #61), who was the unit nurse for Resident #2 on October 15, 2025, at 10:30 A.M. Staff #61 stated that the process for administering oral medications to residents is that a nurse checks the orders, checks the dosage, checks the resident's allergies, and checks the resident's name. Then, Staff #61 stated that the nurse performs hand hygiene, issues the medications in a cup, and then stays with the resident to make sure the medications are administered and to ensure the resident does need help or does not choke. Staff #61 stated that medications are never left with the resident because the resident may get confused and forget to take the medications or they could get knocked over and missed, or hidden and taken together with the next dose. Staff #61 stated that no residents on the unit are allowed to self-administer medications.A telephonic interview was (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conducted with Resident #2's power of attorney (POA) on October 15, 2025, at 10:36 A.M. The POA stated that there was an incident on September 12, 2025 where the nurse left Resident #2's evening medications on a bedside table in the resident's room. The POA stated that the following morning, on September 13, 2025, Resident #2 was given his usual morning medications by a nurse, and that a family friend was visiting Resident #2 and saw the cup of medications left out from the night before and thought that Resident #2 had not taken his morning medications. The family friend then encouraged Resident #2 to take the medications, which he did. The POA stated that this was a potential double dose of medications, and that she was notified of this incident by the family friend and by the facility. The POA stated that when Resident #2 confronted the nurse (Staff #29) about leaving the medications on the bedside table, that the nurse told Resident #2 that the resident was arguing with him, so he left the medications on the table.A telephonic interview was conducted on October 15, 2025, at 11:03 A.M. with the family friend who visited Resident #2 on September 13, 2025. The visitor stated that she should have double-checked with the nurse about the pills that she found at bedside. The visitor stated that when she arrived, between 11:00 A.M. to 1:00 P.M., Resident #2 was in his room, and that she saw the cup of 3-4 pills on the nightstand, and she said to Resident #2 that he missed his pills, and then Resident #2 took the pills. The visitor stated that she wanted to double-check afterward, so she called the resident's POA, who then stated that the pills could have been left from the night before. The visitor stated that, at that time, Resident #2 seemed a little off and more fatigued than usual. The visitor stated that she then notified facility staff. Additionally, the visitor stated that she was informed that Resident #2 had already received his morning medications, and the staff acted right away and assessed the resident's vital signs. The visitor stated that the resident's blood pressure dropped. Then, the visitor stated that Resident #2 received IV fluids and afterward Resident #2 seemed ok. The visitor stated that afterward, the facility staff were monitoring Resident #2.A telephonic interview was conducted with Resident #2's nurse practitioner (NP / Staff #99) on October 15, 2025, at 11:14 A.M. Staff #99 stated that if a resident had a medication error, that she would expect the nurse to notify her. Regarding Resident #2, Staff #99 stated that the nurse notified her of the medication error promptly, and that Staff #99 was informed that Resident #2 had low blood pressure, so Staff #99 gave orders for Resident #2 to receive IV fluids and that the resident tolerated it well.A telephonic interview was conducted with a CNA (Staff #80) on October 15, 2025, at 12:25 P.M. Staff #80 stated she usually works on Resident #2's unit and that she heard about the incident of Resident #2's medication error when she came back from her days off. Staff #80 stated that she heard in report that Resident #2 had a visitor who found medication on the resident's bedside table and gave him those medications, and the nurse had already given the resident his morning medications that day.A telephonic interview was conducted on October 15, 2025, at 12:54 P.M. with an LPN (Staff #55), who was Resident #2's nurse on September 13, 2025. Staff #55 stated that in the morning on September 13, she entered Resident #2's room with a CNA. Staff #55 stated that she gave Resident #2 his morning medications and that the CNA witnessed this. Staff #55 stated that several hours later, the same CNA notified her that there was an issue, that the resident's visitor found medications at bedside and had given them to the resident. Staff #55 stated that Resident #2's vitals were assessed and that his blood pressure was low. Then, Staff #55 stated that she notified the provider, who ordered midodrine and IV fluids for Resident #2, and that Staff #55 also notified the resident's POA of the incident.A telephonic interview was conducted on October 15, 2025, at 1:35 P.M. with an RN (Staff #29). Staff #29 stated that he was the nurse for Resident #2 on September 12, 2025, and that Staff #29 went to give Resident #2 his evening medications, and that Resident #2 was refusing the medications. Staff #29 stated that he set the medications in the cup down on the nightstand because he was going to check on the resident later, but accidentally left the medications there. Staff #29 stated that the next day, the DON called him about the incident, and that is when he realized he forgot the medications there. Staff #29 stated that he had to do some training on medication administration after the incident.An interview was conducted with the DON (Staff #72) on (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	October 15, 2025, at 1:41 P.M. The DON stated that her expectation for nurses administering oral medications would be for staff to verify the order, the dose, and the time, pull the pill card, and pop the pill from the pill card into a cup, and then go into the resident's room and administer the medications. The DON stated that the medications should absolutely not be left at bedside for residents. Regarding Resident #2, the DON stated that the nurse (Staff #29) admitted that he left the medications at bedside on September 12, 2025. Then, the DON stated that the next day, Resident #2 received his morning medications and did not realize the medications were there, and that the visitor administered the medications that were left in the cup and then notified the nurse. The DON stated that the nursing staff then acted quickly and notified the provider and monitored Resident #2's blood pressure, and that the resident stabilized. The DON stated that Staff #29 had a write-up and received supplemental training regarding the incident.Review of the facility policy titled Medication Administration - Oral, revised May 2017, revealed it is the policy of the facility to accurately prepare, administer and document oral medications. Procedures for administering unit doses included: identify resident electronic MAR orders, remove unit dose medications from cards into med souffle cup for resident, administer drugs to resident, document administration of medication, and keep med cart locked when away from cart. The policy also included that no medication is to be administered without a physician's written order, medicine room doors are to be kept locked at all times, the nurse preparing the drug administers it, and the person administering medication must remain with the resident until all medication has been swallowed. Review of facility policy titled Self Administration of Medications, revised May 2022, revealed it is the policy of the facility to respect the wishes of alert, competent residents to self-administer prescribed as allowable under state regulations. The purpose of the policy revealed to determine the ability of alert residents to participate in self-administration of medications, and to maintain the safety and accuracy of medication administration. If a resident desire to participate in self-administration, the interdisciplinary team will assess and periodically re-evaluate the resident based on change in the resident's status. The residents cognitive, communication, visual, and physical ability to carry out this responsibility will be evaluated. If the interdisciplinary team determines that this resident is unable to carry out this responsibility, the interdisciplinary team may withdrawal this right. If the resident is a candidate for self-administration of medications, this will be indicated in the chart. Nursing will be responsible for monitoring self-administered doses in the resident's medication administration record (eMAR). Storage and location of drug administration (e.g., resident's room, nurses' station, or activities room) will comply with state and federal requirements for medication storage.Review of federal regulation 42 CFR 483.45 (h), revealed that in accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.