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	05/29/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of clinical record, and review of facility policy and procedure, the facility failed to ensure medication was acquired, received, and administered according to physician orders for one of three sampled residents (#2). The deficient practice could result in a resident not receiving medication as ordered by the physician.-Findings include:Resident #2 was admitted to the facility on [DATE], with diagnoses of secondary malignant neoplasm of the brain, malignant melanoma of skin, cognitive, social, or emotional deficit following nontraumatic intracerebral hemorrhage, visual disturbance, headache, chronic obstructive pulmonary disease, and a personal history of other venous thrombosis and embolism.A discharging hospital progress note dated March 27, 2026, for Resident #2 revealed that the assessment and plan for his brain metastasis included the resident being started on dexamethasone (corticosteroid medication).A physician's order dated March 28, 2026, included for dexamethasone tablet 2 mg, to give 1 tablet by mouth two times a day for cancer, with the first dose scheduled at 8:00 a.m., and the second dose scheduled at 10:00 p.m.A Medication Administration Record (MAR) for April 2026 revealed Resident #2 was administered dexamethasone 2 mg tablet at 8:00 a.m. on April 5, however was not administered the evening dose scheduled at 10:00 p.m. on April 5, and also did not receive the morning dose scheduled at 8:00 a.m. on April 6. The record included 7 on the missed dose administration times, which was coded for other / see nurse notes.An e-MAR (electronic Medication Administration Record) note dated April 5, 2026, revealed dexamethasone was not administered due to not available. There was no evidence that the physician was notified of the missed medication dose or that a pharmacy refill order was placed for the out-of-stock medication.Another e-MAR note dated April 6, 2026, revealed that dexamethasone was not administered due to pending delivery. There was no evidence that the physician was notified of the missed dose.An electronic pharmacy medication order log revealed that dexamethasone 2 mg tablets were ordered from the pharmacy on admission on [DATE], and again on April 6, 2026. There was no evidence of any other refill order for dexamethasone placed.A telephonic interview was conducted with Resident #2's family member on May 29, 2026, at 8:27 a.m., who stated that she was aware that Resident #2 had missed his scheduled steroid medication because the facility ran out of the medication, and that the medication was important because it controlled the swelling in his brain due to the brain tumor.An interview with a Registered Nurse / charge nurse (RN / Staff #12) was conducted on May 29, 2026, at 2:09 p.m., who stated that floor nurses notice when medications are running low in stock and re-order the medications through a contracted pharmacy by calling the pharmacy, faxing the re-order, or placing the re-order directly through the electronic medical record system. The RN stated the contracted pharmacy completes 3 medication runs per day, and can do an additional 4th run if needed. The RN stated that if a resident missed a dose of medication that was ordered by a physician, then that could have a negative impact on the resident's health. The RN stated that if a resident missed a dose of medication due to the dose being out of stock, then the nurse would be expected to notify the provider of the missed dose to keep the provider informed and to determine if the provider recommended a substitute medication to administer. The RN stated that the (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notification to the provider and any action recommended by the provider should be documented in the resident's medical record.A telephonic interview was conducted with a pharmacy technician from the facility's contracted pharmacy (Staff #70) on May 29, 2026, at 2:56 p.m., who stated that the pharmacy stocked dexamethasone 2 mg tablets. The staff then reviewed records and stated that there was no evidence that the dexamethasone 2 mg tablet was out of stock at any time during April 2026.An interview was conducted on May 29, 2026, at 3:18 p.m. with the Director of Nursing (DON / Staff #24), who stated that her expectation was for floor nurses to administer medications according to physician orders, to ensure the ordered dose matched the medication card in the cart, and to give the medication within an hour before or after the scheduled time. Additionally, the DON stated it was important for floor nurses to follow the facility policy to order medication refills from the pharmacy 3 days prior to running out of the medication so that the medication was available to the resident and no doses would be missed. The DON stated that a missed dose could impact a resident's health, depending on the medication and the indication for treatment. The DON stated that the facility's contracted pharmacy completed 3 medication delivery runs per weekday, 2 scheduled medication runs on Saturday, and one medication run on Sunday, and could perform an additional run if requested. The DON stated that her expectation if a resident's medication dose was missed was for the floor nurse to notify the provider, and to determine if the medication could be refilled from the contracted pharmacy or another local pharmacy, and for the nurse to follow the provider's recommendation either to place the medication on hold, or to give a substitute medication. The DON stated that the nurse's action, along with the provider's recommendation, should have been documented in the medical record. The DON also stated that there could be a risk to the resident, depending on the medication, if the provider was not notified of a missed medication dose.During the interview with the DON (Staff #24), the clinical record for Resident #2 was reviewed and the DON stated that the dexamethasone medication was ordered as a taper, and there were three administration routes scheduled, with the third administration route indicating one tablet twice a day, at 8:00 a.m. and 10:00 p.m. The DON stated that the third order administration route was indefinite with no end date indicated, and was scheduled to start on April 5, 2026, at 8:00 AM. The DON reviewed the MAR for April 2026, and stated that the morning dose on April 5 was administered, however, the evening dose on April 5 and the morning dose on April 6 were not administered. The DON reviewed the progress notes and stated that the nurse documented that the medication was not available due to running out of the medication on the evening of April 5, and that the nurse documented that the dose was missed on the morning of April 6, due to waiting on pharmacy delivery. The DON stated there was no evidence that the provider was notified in either instance. The DON stated that it would not meet her expectation of refilling the medication, nor of communication with the provider, and that the medication should have been there to administer.Review of a written statement by the DON (Staff #24), dated May 29, 2026, revealed the facility had no official policy on refilling medication prescriptions, however, nurses were requested to reorder the medication from the pharmacy 3 days before the last dose of medication.Review of the facility policy titled Medication Administration - Oral, dated September 2024, revealed that it was the policy of the facility to accurately prepare, administer, and document oral medications.Review of the facility policy titled Medication Access and Storage, E-kit Access, dated September 2024, revealed that the provider pharmacy would dispense medication in containers that met legal requirements, and that medications were kept and stored in these containers. The policy further revealed that only licensed nurses, the consultant pharmacist, and those lawfully authorized to administer medications are allowed to access medications.Review of the facility policy titled Physician Orders, dated September 2024, revealed that drugs should be administered only upon the order of a person duly licensed and authorized to prescribe such drugs, and that orders would be implemented accurately.Review of federal regulation CFR S483.45 revealed that the facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in S 483.70(f). A facility must provide pharmaceutical services (including procedures that assure the (continued on next page)

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