STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035270	A. Building B. Wing	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ahwatukee Post Acute	15810 South 42nd Street Phoenix, AZ 85048

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled:3Number of residents cited:3The facility failed to send a copy of the notice of transfer or discharge to the representative of the Office of the State Long-Term Care (LTC) Ombudsman for 3 of 3 sampled residents (#142, #147, and #150). The deficient practice could result to residents not being able to access an advocate who can inform them of their options and rights related to discharges. Based on closed record review, staff interviews, review of facility documentation and policy, and the State Agency (SA) complaint tracking system, the facility failed to send a copy of the notice of transfer or discharge to the representative of the Office of the State Long-Term Care (LTC) Ombudsman for three discharged residents (#142, #147, and #150). The deficient practice could result to residents not being able to access an advocate who can inform them of their options and rights related to discharges.Findings include:-Regarding Resident #150:Resident #150 was admitted to the facility on [DATE] with a diagnosis that included hypertension and status post recovery from incarcerated/strangulated inguinal hernia repair.Review of admission/readmission progress note dated February 28, 2025 revealed resident was able to communicate needs and wants effectively. Resident verbalized understanding. admission consent forms were signed by the resident's representative/family at bedside.Review of nursing progress notes dated March 2, 2025 revealed a change of condition relating to resident was unhappy with the food and resident was requesting to be discharged back home.Review of provider progress notes dated March 3, 2025 revealed resident's family member was requesting for resident to go home by Friday and case management was aware of the request.Review of the 5-day Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 3.0, severe impairment.Review of nurse progress note dated March 7, 2025 revealed resident was discharged against medical advice (AMA), and resident's representative/family wanted resident to return back home. Staff educated the resident and resident's representative on leaving AMA and the risk involved. The staff notified resident's provider of resident discharging AMA.Resident #150 was discharged from the facility on March 7, 2025.-Regarding Resident #142:Resident #142 was readmitted to the facility on [DATE] with a diagnosis that include anxiety, depression, and chronic back pain.Review of BIMS clinical assessment dated [DATE] revealed a score of 15.0, cognitively intact.Review of Interdisciplinary Team (IDT) progress notes dates March 14, 2025 revealed Resident #142 was bedbound, required minimum assistance for transfers and required contact guard assistance for activities of daily living.Review of progress notes revealed Resident #142 has an order for Gabapentin 100 mg (milligram), methocarbamol 500 mg, and Morphine Sulfate Oral Tablet 15 mg for pain management. Review of progress note dated March 18, 2025 revealed Resident #142 left the facility AMA, left without medication, and was picked up by the resident's family member. The progress notes revealed that the resident was educated on risks of leaving AMA including worsening of illness. The Director of Nursing (DON) and the resident's provider were notified of resident leaving AMA.Resident #142 was discharged from the facility on March 18, 2025.-Regarding Resident #147:Resident #147 was admitted to the facility on [DATE] with a diagnosis that includes Coronary (continued on next page)

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Artery Disease (CAD), Heart Failure, Hypertension, Diabetes Mellitus (DM), Malnutrition, and Anxiety DisorderReview of records revealed Resident #147 was under the care of hospice from April 24, 2025.Review of care plan initiated on April 28, 2025 revealed Resident #147 requires hospice care, and at risk for rapid decline in activities of daily living function, sudden onset or worsening of skin integrity, weight loss, nausea/vomiting, pain, abnormal breathing, and impaired psychosocial wellbeing. The interventions include to administer medication as ordered, assist with activities of daily living, establish a daily routine, and coordinate resident's needs with hospice staff.Review of admission MDS assessment dated [DATE] revealed resident had a BIMS score of 7.0, severe impairment.Review of care plan dated May 1, 2025 revealed resident has nutritional risk related to type 2 diabetes, chronic gout, decreased by mouth intake related to progression of disease and resident was under the service of hospice care.Review of records revealed resident's blood sugar were checked at least three times a day from May 9, 2025 through June 26, 2025.Review of case management progress note dated June 26, 2025 revealed that Resident's Power of Attorney (POA) was upset and was demanding to speak with someone who could help get the resident out of the facility. The resident's POA stated the facility was not providing therapy services. The POA was informed that the resident was admitted to the facility for long term care, and during the care conference it was explained to the POA that the resident was on hospice services which meant therapy services were not available. In addition, the progress note revealed that the resident's POA was educated by the director of nursing and case management that the facility's dietician monitors all risk related to decline in nutrition risks, all diabetic concerns were monitored based on physician's order, symptoms and medication management; monthly activity calendars were given to residents, activity calendars were placed around the facility at the start of the month; and the activity director along with the activity assistant visits residents who were not able to attend. The POA was informed that the provider gave order to discharge resident home per POA request with hospice care. The progress note revealed resident would be liable for private pay at daily charge if resident would like to stay. In addition, the progress note revealed that the resident's provider was notified regarding resident leaving without hospice and the discharge of the resident was not a safe discharge. The resident's POA signed the AMA form and removed Resident #147 out of the facility.Resident #147 was discharged from the facility on June 26, 2025.An interview was conducted on August 7, 2025 at 12:44 PM with Case Manager/Staff #59. Staff #59 stated that every month there should be notification of discharge sent to the Ombudsman. The notification of discharge usually is sent on the last day of each month or the beginning of the next month. Staff #59 stated that she sent the June and July 2025 notification of discharges to the Ombudsman this week. In addition, Staff #59 stated that the facility went through different case managers for the last three months. Staff #59 stated that she just started last week and Staff #600 was the case manager last month. Furthermore, Staff #59 stated that the type of discharges she encounters include residents that were discharged to home, assisted living, resident leaving the facility AMA, and these types of discharges are send to the Ombudsman. Staff #59 stated that there was no notice of discharges sent to the Ombudsman for seven months. In addition, Staff #59 stated that for residents discharging AMA, she will meet with the resident and talk to the resident because the resident is leaving without medication, equipment, and or home health care services. Staff #59 stated that if a resident leaves without signing the AMA form, it should be documented in the progress note because some resident refused to sign the AMA form. And, if resident is not alert or oriented and wants to leave AMA, she will notify the resident's doctor, family, and the director of nursing (DON). Staff #59 stated that she recently spoke with the Ombudsman and the Ombudsman informed her that she has not received any notice of discharges since December.An interview was conducted on 08/08/2025 8:35 AM to Ombudsman (Staff #700). The Ombudsman stated that she received the December and November 2024 Notice of Discharge from the facility but did not receive the other notices for this year except the one Staff #59 send her couple days ago.An interview was conducted on August 8, 2025 at 10:58 AM with the Social Service Director (Staff #152) in his (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	office. Staff #152 stated that he has been in the social service director position for three weeks and his responsibilities include managing all long-term care (LTC) residents, he conducts admission assessment such as BIMS, he is the main contact for LTC insurance companies, he completes Preadmission Screening and Resident Review (PASRR) for review, he manages grievances, and conducts all care plan meetings. Regarding resident discharges such as transferring to another facility, he stated that he will send an email or contact the Ombudsman. Staff #152 stated that he will contact the Ombudsman when there is a change in the level of care such as resident transferring or discharging to an assisted living home, group home, or to a detox facility because it is part of the discharge process. He will send every month notice of discharges to the Ombudsman. He stated that the case management is responsible in sending the notice of discharges to the Ombudsman. Furthermore, Staff #152 stated that the risk if the notice of discharge list was not sent to the Ombudsman, such as for instance the discharge was not a safe discharge or resident was not in agreement with the discharge, it could lead to rehospitalization, unsafe environment and potential abuse of the resident. Staff #152 stated that is why he starts discharge planning on day one to try to find alternatives and to make sure the discharge is safe.Additional interview was conducted on August 8, 2025 with Case Manager (Staff #59) and Unit Manager/Infection Preventionist (Staff #109) in the social service director's office. Staff #59 stated that her responsibility includes helping with discharges, making sure residents have everything they need. Staff #59 stated that after residents are discharged , she follows up with them within thirty days, the discharged resident list is sent to the Ombudsman at the end of the month, and Staff #59 stated that she sent one notice of discharge to the ombudsman for the month of June and July 2025 discharge list on August 6, 2025 because she has to do it and this week she did not know who was the Ombudsman representative covering for their facility. Staff #59 stated that the importance of sending the discharge list to the Ombudsman is to make sure residents have a safe discharge and the Ombudsman can follow up with the discharged residents. During the interview, Staff #109 stated that she was assigned to cover case management for the months of April, May and June. Staff #109 stated that she honestly did not sent the notice of discharge to the ombudsman. The case management was not her full-time position. Staff #109 stated that since she was made aware of the importance of sending the notice of discharge to the Ombudsman, she stated that her facility sent a notice of discharge to the Ombudsman this week. Staff #109 stated that the previous months from January through May 2025, the facility did not sent notice of discharge to the Ombudsman. Staff #109 stated that the facility had multiple case management staff turnover and she had no access to what was sent to the Ombudsman. Staff #109 stated that the risk if a notice of discharge was not sent to the Ombudsman is that the resident won't have an advocate to follow up with their needs.Review of facility's document titled, Admission/Discharge To/From Report, revealed that from January 2025 through June 2025, the facility had a total of 245 discharges.An interview was conducted on August 8, 2025 at 11:33 AM with the DON (Staff #66). The DON stated that regarding discharges, their case manager assists in setting up discharges, the resident's provider is notified of discharges, and the Ombudsman is notified of discharges at the end of the month. The DON stated that her case manager was not sending notice of discharges to the Ombudsman, and her facility went through different case managers previously. The DON sated that there is no risk if the Ombudsman was not notified of a resident's discharge.Review of facility's policy titled, Resident Rights, with a revision date of February 2021 revealed (1.) Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to (x.) communicate with outside agencies (e.g., local, state, or federal officials, state and federal surveyors, state long-term care ombudsman, protection or advocacy organizations, etc.) regarding any matter.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Number of residents sampled:6Number of residents cited:3The facility failed to ensure three residents necessary medications were ordered and available for use.Based on clinical record review, interviews, and review of facility policies, the facility failed to ensure that medications were available as ordered for three residents (#5), (#43), and (#7). The deficient practice could result in not receiving medications that are physician ordered and necessary. Findings include:-Resident #5 was admitted to the facility on [DATE] with diagnoses that include a cerebral infarction, hemiplegia, aphasia, anemia, bipolar disorder, schizophrenia, and epilepsy.A review of the Quarterly MDS (Minimum Data Set) dated June 22, 2025 noted the resident had a BIMS of 99, indicating severe cognitive impairment. The care plan revised September 16, 2024 revealed the resident uses antidepressant medication related to poor appetite. With a goal of resident will be free from discomfort or adverse reactions related to the antidepressant therapy and with a noted intervention of give antidepressant medications as ordered by the physician.Review of the physician's orders dated March 5, 2025 revealed Mirtazapine oral tablet 7.5mg milligrams with instructions to give 2 tablets by mouth one time a day for depression as evidenced by poor appetite.A review of progress notes dated May 14, 2025 at 3:10 p.m. revealed that Mirtazapine 7.5mg medication was not given and coded as Other / see nursing notes, however the note related to the administration did not provide a reason. A review of progress notes dated May 15, 2025 at 2:00 p.m. revealed that Mirtazapine 7.5mg medication was not administered due to pending from pharmacy. A review of progress notes dated May 16, 2025 at 5:57 p.m. revealed the Mirtazapine 7.5mg medication was not administered due to pending delivery from pharmacy. -Resident #43 was admitted to the facility on [DATE] with diagnoses that include hemiplegia, aphasia, diabetes mellitus type 2, anemia, anxiety, hyperlipidemia, depression, and hypertension.A review of the admission MDS (Minimum Data Set) dated April 29, 2025 noted the resident had a BIMS of 3, indicating severe cognitive impairment. The care plan revised April 23, 2025 revealed that the resident requires anti-depressant medication, with a goal of medication use will result in the maintenance in the resident's functional status, with a noted intervention of administer antidepressant medication as ordered by the physician.Review of the physician's orders dated April 23, 2025 revealed Mirtazapine oral tablet 15mg with instructions to give 1 tablet by mouth one time a day for depression as evidenced by decreased appetite.A review of progress notes dated July 10, 2025 at 8:27 p.m. revealed that Mirtazapine tablet 15mg was not administered due to N/A awaiting from pharmacy. A review of progress notes dated July 10, 2025 at 8:32 p.m. revealed that atorvastatin calcium tablet 80mg medication was not administered due to N/A awaiting from pharmacy. A review of progress notes dated July 11, 2025 at 9:28 p.m. revealed that atorvastatin calcium tablet 80mg medication was not administered due to N/A awaiting from pharmacy. A review of progress notes dated July 11, 2025 at 9:30 p.m. revealed that Mirtazapine tablet 15mg medication was not administered due to awaiting from pharmacy. A review of progress notes dated July 12, 2025 at 10:03 p.m. revealed that Mirtazapine tablet 15mg medication was not administered due to awaiting delivery. -Resident #7 was admitted to the facility on [DATE] with diagnoses that include osteomyelitis, muscle wasting, depression, diabetes mellitus type 2, hypertension, chronic kidney disease, anemia, and anxiety.A review of the admission MDS (Minimum Data Set) dated June July 9, 2025 noted the resident had a BIMS of 15, indicating no cognitive impairment. The care plan revised July 4, 2025 revealed the resident uses antianxiety medication related to anxiety disorder as evidenced by restlessness. With a goal of medication use will result in the maintenance of the resident's functional status, and a noted intervention of administer medication as ordered by the physician.Review of the physician's orders dated July 22, 2025 revealed buspirone HCl oral tablet 7.5mg with instructions to give two tablets by mouth every 12 hours for anxiety as evidenced by restlessness.An interview conducted with a (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Licensed Practical Nurse (LPN/staff #64) on August 8, 2025 at 10:25 p.m., the LPN state that residents running out of medications happens a lot unfortunately. The LPN further stated that when they notice a resident is low or out of medications, they notify the provider and call the pharmacy. The LPN stated further that sometimes it's a pharmacy issue, being reordered too soon, or because of a cost control. The LPN stated that when they will document about the pharmacy being called but it kind of depends on who you work with on who to relay it to and who follows up on that medication. The LPN stated that it does get overlooked often unfortunately. The LPN concluded that if they had to guess, the missing medications were pulled from other residents, borrowing from them rather than getting them refilled correctly. An interview conducted with resident #7 on April 8, 2025 at 10:30 a.m., The resident stated that He has been here probably a month and a half. He states that often the nurses come into his room and state they don't have his medications. He further states it doesn't feel like it's ever addressed, and that his medications are missing often, sometimes 2-3 days in a row. He states the buspar is the biggest one, but that he has also had issues with his pain medicine. The resident concluded that he also ends up waiting long periods for pain medications, long after they are due. An interview was conducted on October 20, 2023 at 11:00 a.m. with the Director of nursing (DON/staff #66). The DON stated that when a resident is admitted they are assessed head to toe, assessments are performed and medications are activated in the system which then gets pinged to the pharmacy and should be delivered within a couple of hours. The DON stated that they get 2-3 pharmacy deliveries a day. The DON stated that if a medication is missing the nurse is supposed to put the medication on hold and notify a provider. The DON further stated that missing medications and the nursing staff not reordering appropriately did not meet her standards. The DON concluded that what bothers her is that the nurses know the protocol, but don't always notify the management staff when there is a problem, and that she will be more cautious in the future. A review of facility policy titled ?Administering medications' revised April 2019 revealed that the director of nursing services supervises and directs all personnel who administer medications and/or have related functions. The policy also revealed that medications are administered in accordance with prescriber orders, including any required timeframe.A review of facility policy titled ?Medication and Treatment orders' revised July 2016 revealed that the drugs and biologicals that are required to be refilled must be reordered from the issuing pharmacy to ensure that refills are readily available.