STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035280	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sante of Mesa	5358 East Baseline Road Mesa, AZ 85206

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, review of records and review of policies and procedures, the facility failed to ensure that services met professional standards of quality by failing to administer medications according to physician ordered parameters for one of five sampled residents (#4). The deficient practice could result in residents to receiving medications that did not meet the provider parameters. Resident #4 was admitted on [DATE] with diagnoses that included displaced trimalleolar fracture of right lower leg, contusion of lower back and pelvis, anxiety disorder, type 2 diabetes with chronic kidney disease, morbid obesity, and major depressive disorder.A care plan initiated on July 12, 2025 revealed the following areas of focus:Hypertension related to CHF (congestive heart failure) and kidney disease with interventions, initiated July 12, 2025, that included to give anti-hypertensive medications as ordered.Potential for actual alteration in comfort/pain related to recent hospitalization, initiated on July 12, 2025, with interventions that included to administer analgesics as ordered.Right distal fibula fracture status post GLF (ground level fall), initiated on July 25, 2025, with interventions that included to administer medications as ordered. An Admission/Medicare 5-day Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview of Mental Status (BIMS) score of 13, which indicated intact cognition. The assessment also revealed no rejection of care behaviors present. The assessment indicated hypertension, heart failure, orthostatic hypotension, renal insufficiency and diabetes mellitus as active diagnoses, and almost constantly had pain.-Regarding Hydrocodone-AcetaminophenOn July 13, 2025 a provider ordered Hydrocodone-Acetaminophen 5/325 mg (milligram), give 1 tablet every 4 hours, as needed (PRN) for pain 6-10/10 on pain scale, was ordered by the provider on July 13, 2025, and was discontinued on August 28, 2025.A Medication Administration Record (MAR) for August 2025 revealed that Hydrocodone- Acetaminophen, 5-325mg, 1 tablet every 4 hours PRN pain 6-10/10, had been administered outside of the ordered parameters as follows for a pain levels of:2 on August 18, 20253 on August 20, 20254 on August 25, 20255 on August 19, 2025, and August 26, 2025 on two occasions. Progress notes dated August 1, 2025 through August 31, 2025, revealed no evidence as to why the Hydrocodone-Acetaminophen had been administered outside of parameters, or that the provider had been notified. -Regarding MidodrineOn July 31, 2025 a provider ordered Midodrine HCl Oral Tablet 5 MG (Midodrine HCl), give 0.5 tablet by mouth three times a day for hypotension (HTN), hold if systolic blood pressure (SBP) > (greater than) 140.A Medication Administration Record (MAR) for August 2025 revealed that Midodrine HCL oral 5mg 0.5mg tablet, for hypotension, hold if SBP greater than > 140 had been administered outside of the ordered parameters as follows regarding systolic blood pressure:8/2/2025 at 12:00 PM, blood pressure 142/758/23/25 at 08:00 AM, blood pressure 150/628/23/2025 at 12:00 PM, blood pressure 142/808/23/2025 at 04:00 PM, blood pressure 145/718/25/25 at 1200 PM, blood pressure 142/66Progress notes dated August 1, 2025 through August 31, 2025, revealed no evidence as to why Midodrine HCL had been administered outside of parameters, or that the provider had been notified. -Regarding Sacubitril-Valsartan:On July 12, 2025 a provider ordered Sacubitril-Valsartan Oral Tablet 24-26 MG (Sacubitril-Valsartan), Give 1 tablet by mouth two times a day for HTN, Hold for SBP 110 or HR (heart rate) less than 60.A Medication Administration Record (MAR) for August 2025 revealed that Sacubitril-Valsartan 24-26 mg (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1 tablet by mouth 2x/day for HTN (hypertension), hold for SBP 110 or HR less than 60, had been administered outside of the ordered parameters as follows:HR of 55 on August 1, 2025HR of 59 on August 3, 2025HR of 59 at 8:00 AM and 8:00 PM on August 17, 2025.HR of 56 on August 22, 2025HR of 58 on August 23, 2025 Progress notes dated August 1, 2025 through August 31, 2025, revealed no evidence of why Sacubitril-Valsartan had been administered outside of parameters, or that the provider had been notified. -Regarding Metoprolol Tartrate:On July 12, 2025 a provider ordered Metoprolol Tartrate Oral Tablet, give 12.5 mg by mouth two times a day for HTN, hold for SBP less than 110, HR less than 60.A MAR for August 2025 revealed that Metoprolol Tartrate 12.mg by mouth for HTN hold for SBP less than 110, HR less than 60, had been administered outside of the ordered parameters:HR of 55 on August 1, 2025HR of 59 on August 3, 2025, and on August 17, 2025 twice.HR of 58 on August 23, 2025 Progress notes dated August 1, 2025 through August 31, 2025, revealed no evidence of why the Metoprolol Tartrate had been administered outside of parameters, or that the provider had been notified. An interview was conducted on September 3, 2025 at 3:15 PM with a Licensed Practical Nurse (LPN/staff #76), who stated that the facility policy is to follow provider orders as written, including the parameters for blood pressure and pain medications. She stated that should a medication be administered outside of parameters and the nurse should notify the provider for updated orders. The LPN also stated that if the SBP is outside of parameters, the blood pressure should be rechecked for accuracy, and if it is still outside of parameters the medication should be held, and that nursing should document in the medical record that the medication was held. The LPN reviewed the clinical record from August 1, 2025 through August 31, 2025 and stated that the following medications had been administered outside of provider ordered parameters: Midodrine HCL had been administered outside of parameters on 6 occasions, Hydrocodone-Acetaminophen had been administered outside of parameters on 7 occasions, and Sacubitril-Valsartan had been administered outside of ordered parameters on 8 occasions, and that Metoprolol Tartrate had been administered outside of ordered parameters on seven occasions. The LPN further stated that there was no evidence in the clinical record as to why the medications had not been administered following provider orders, or that the provider had been notified. The LPN stated that the risk of administering medications outside of parameters could result in resident's not receiving medications as ordered.An interview was conducted on September 4, 2025 at 9:25 AM with the Director of Nursing (DON/staff #145), who stated that she expected nurses to follow provider orders as written, including parameters. The DON stated that she would expect the nurse to hold administration of the medication or call the provider for clarification. The DON reviewed the clinical record from August 1, 2025 through August 31, 2025 and stated that the following medications had been administered outside of the provider ordered parameters: Metoprolol Tartrate on 5 occasions, Sacubitril-Valsartan on 6 occasions, Midodrine on 6 occasions, and Hydrocodone-Acetaminophen on 7 occasions. The DON further stated that the clinical record revealed no evidence regarding why the medications were not administered following provider orders, or that the provider had been notified. The DON stated that these medications were not administered as ordered and it did not meet her expectations. She further stated that she had not been previously aware, and that staff need to ensure they document any verbal conversations with the provider in the clinical record. The DON also stated that the risk of not administering medication following provider orders could result in the physician not being aware/informed of the resident's status.Review of a policy titled, Administering Medications, included that medications must be administered in accordance with the orders, including the time frame.