STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035282	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sante of Surprise	14775 West Yorkshire Drive Surprise, AZ 85374

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 - Some	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 clinical record review, interviews and facility policy review, the facility failed to ensure medications were administered according to physician instructions for two residents sampled out of five (#24 and #58). The deficient practice could result in medication errors that could harm residents. The universe was 62.Findings include:-Regarding Resident #58:Resident #58 was admitted to the facility on [DATE] with diagnoses that included: essential primary hypertension, type 2 diabetes mellitus, anxiety disorder, depression, pneumonia and muscle weakness.A care plan for resident #58 included for pain medication Oxycodone therapy related to chronic pain with a date of initiation of April 10, 2026. An intervention included to administer medications as ordered.The minimum data set (MDS) for Resident #58, dated April 13, 2026 revealed a brief interview for mental status (BIMS) score of 15, indicating no cognitive impairment.The orders for Resident #58 revealed Oxycodone oral tablet 10mg give 1 tablet by mouth every 6 hours as needed for pain 6-10 on pain scale 0/10 scale. Acetaminophen 325 mg give 2 tablets by mouth every 6 hours as needed for pain 1-5 on pain scale 0/10.The medication administration record (MAR) for May 2026 revealed that Oxycodone was given for pain 5/10 on May 4, 2026 at 0937 a.m., May 18, 2026 at 7:17 p.m. Oxycodone was given for pain level 5/10 and May 19, 2026 at 04:20 a.m. for pain level 5/10. Acetaminophen was given for pain level 10/10 on May 25, 2026 at 7:46 pm.-Regarding Resident #24:Resident #24 was admitted to the facility on [DATE] with diagnoses that included: fracture of lower end of right tibia, displaced fracture of lateral malleolus of right fibula, anxiety, essential hypertension and difficulty in walking.A care plan with a focus of alteration in comfort/pain was initiated on April 26, 2026, with an intervention that included to administer analgesics as ordered.The MDS dated [DATE] revealed a brief interview for mental status (BIMS) score of 13, indicating no cognitive impairment.Review of physician orders revealed that Dilaudid oral tablet 4mg give 0.5 tablet by mouth every 3 hours as needed for pain 6-10/10 on pain scale. Dilaudid oral tablet 4mg give 1 tablet by mouth every 4 hours as needed for pain 6-10/10 on pain scale.The medication administration record (MAR) for April 2026 revealed Resident #24 received Dilaudid 4mg 0.5 tablet for pain 5/10 on April 26, 2026 at 08:00 p.m., 5/10 on April 26, 2026 at 11:00 p.m. and 5/10 on April 27, 2026 at 04:29 a.m. Dilaudid 4mg 1 tablet by mouth every 4 hours as needed for pain 6-10/10 on pain scale was received by Resident #24 for pain 5/10 on April 27, 2026 at 07:46 p.m. and for pain 5/10 on April 28, 2026 at 08:20 p.m.An interview was conducted on May 28, 2026 at 09:42 a.m. with licensed practical nurse (LPN/ Staff #75) who revealed that when a resident has pain, the resident is asked for location of the pain and the pain scale number (0 to 10). Then the nurse administers medication according to what has been prescribed for that level of pain and check back for the effectiveness. Furthermore Staff #75 stated that if Oxycodone is given for a pain level of 5/10, when the order is for Oxycodone to be given for pain 6-10/10, that is a medication error. Staff #75 stated that the risk for giving medications outside of physician ordered parameters is that it would be considered a medication error.An interview was conducted on May 28, 2026 at 09:52 a.m. with assistant director of nursing (ADON/ Staff #77) who was covering for the director of nursing and revealed that if a resident has pain, the nurse will check to see if they have orders for medication and to give according to the parameters. If the resident has a pain level of 5/10 and the order is to give (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Oxycodone for pain level 6-10/10, the nurse should notify the provider that the guest (resident) has pain and the parameters does not match, and then get an order for a one time only order or if they do not want the Oxycodone but want Tylenol instead. Staff #77 then observed the MAR for Resident #58 and noted that Resident #58 had a pain level of 10/10 and acetaminophen was given, Oxycodone was given for pain level 5 on two occasions. Upon review of documentation notes in the electronic health record, there were no notes seen documenting why Resident #58 received the pain medications outside of the ordered parameters or any orders from the physician with an okay to give outside the parameters. Furthermore Staff #77 revealed that the risk of giving medications outside of physician ordered parameters could cause side effects to the guest (resident). Staff #77 continued the interview by stating that typically they will notify the provider and the nurse will fill out a risk management medication error form so they can monitor the guest for potential side effects. Giving medications outside of provider ordered parameters is considered a medication error per Staff #77.Review of the facility policy titled Administering Medications version 2.0, the policy statement states that medications are to be administered safely, timely and as prescribed.

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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 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. Based on observation, interviews, and review of facility policy and procedure, the facility failed to ensure medications were locked in 1 medication cart while left unattended. The deficient practice could lead to unauthorized persons gaining access to medications.An observation conducted on May 26, 2026 at 8:38 A.M. of the facility hallway revealed that a medication cart labeled P2 was not locked. There was no staff observed at the medication cart. The Licensed Practical Nurse (LPN/Staff#29) returned to the cart a few minutes later and tried to push in the lock, but it did not push in. She then used her key and put it in the lock of the medication cart and the key moved but it did not lock the medication cart. Next, she pulled on the drawers of the medication cart (P2) and they opened.An interview was conducted with LPN (Staff #29), on May 26, 2026 at 8:41A.M. who stated she forgot to lock the medication cart (P2). She stated she was having difficulty with the lock since she started her shift at 6:00 A.M., but did not make anyone aware that the lock was not working on the P2 medication cart. She further stated that there was no communication during the shift change meeting that the lock was not working properly on the medication cart (P2). The LPN (Staff #29) stated that the risk of a mediation cart being left unlocked, is anyone could grab medications out of the medication cart. An observation was conducted with the Director of Nursing (Staff #149) on May 26, 2026 at 8:50 A.M. who tried to push the lock in, but it did not work. Next, she put the key in the lock of the medication cart (P2) and the key turned in the lock, but it did not push in to lock the medication cart (P2). She pulled on the drawers of the medication cart and they opened.An interview was conducted with the Director of Nursing (DON/Staff # 149) on May 26, 2026 at 8:50 A.M. stated that medication carts should be locked when the nurse steps away from the medication cart. She stated that she was not made aware that the lock of medication cart (P2) was not working. She stated that she will notify the pharmacy to get fixed and during medication pass the nurse will need to place medication cart (P2) in the medication room that is locked at all times. DON (Staff #149) stated that the risk of leaving the medication cart unlocked anyone could come and steal medications out of the medication cart.An interview with Administrator (Staff #21) on May 28, 2026 at 1:02 P.M. revealed he was aware that the lock was not working on medication cart (P2) and he stated it was sent back to the pharmacy to be fixed.The facility policy on Storage of Medications- Revised 4/2007 revealed the facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others.