STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035300	A. Building B. Wing	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mirabella at Asu	65 East University Avenue Tempe, AZ 85281

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 9Number of residents cited: 2Based on clinical record reviews, staff interviews, and review of facility policy, the facility failed to ensure that a current copy of the advance directives were in the clinical record for 2 of 9 sampled residents (#31 and #4) residents. The deficient practice could result in resident wishes not respected and followed. -Resident #31 was admitted on [DATE] with diagnoses of displaced intertrochanteric fracture of the right femur, subsequent encounter for closed fracture with routine healing, Parkinson's disease, hypertensive chronic kidney disease, Stage 3 chronic kidney disease and depression.The portable medical order signed by resident #31 and dated [DATE] included that the resident had a code status of no CPR (cardiopulmonary resuscitation) and no artificial means of nutrition desired.The hospital discharge summary report dated [DATE] revealed the resident had an advance directive, had no preexisting DNR/DNI (Do Not Intubate) directives and a copy was not in the resident's chart.The clinical admission note dated [DATE] revealed the resident followed commands, was oriented to person and place, was experiencing signs of short-term memory loss and had mild cognitive impairment. The documentation also included that the resident had a pleasant mood, had no unwanted behaviors witnessed, had insomnia and did not wander at night.An alert charting dated [DATE] included that the resident was transferred from the hospital and was admitted at the facility for therapy s/p (status post) right femur fracture.A physician order dated [DATE] included for an advance directives of DNR.The alert charting dated [DATE] revealed the resident was alert and oriented to self and place and was noted to be confused at times through the night.The physiatry progress note dated [DATE] included the resident was alert and oriented x 1-2, forgetful and had a good mood. Assessment included deconditioning, gait instability, right femur fracture, cognitive impairment and ground level fall.The activities care plan dated [DATE] revealed the resident was alert and oriented. The encounter note dated [DATE] included that the resident's code status was DNR and no CPR.The face sheet of the the clinical record revealed that the resident had a code status of DNR (Do Not Resuscitate).However, further review of the clinical record revealed no evidence that a current copy of the Do Not Resuscitate (DNR) advance directive had been signed by the resident since her admission to the facility on [DATE].-Resident #4 was admitted on [DATE] with diagnoses of mechanical complications of other prosthetic devices, Parkinson's disease without dyskinesia and benign prostatic hyperplasia (BPH) without lower urinary tract symptoms.The alert charting dated [DATE] revealed the resident was alerted and oriented x 3. The clinical admission note dated [DATE] included that the resident was oriented to person and place, makes self understood and understands others. The orange Prehospital Medical Care Directive (Do Not Resuscitate) form dated [DATE], was signed by the resident's Power of Attorney (POA). However, the following required sections were left blank: Signature of the doctor or other healthcare provider and date; and, Signature of a witness and date. Further review of the form revealed that the name of the resident's POA was written in the section designated for the resident's name.The encounter note dated [DATE] revealed current code status of DNR; and that, there was a POLST (Physician Orders for Life-Sustaining Treatment) form or POLST-like form in the electronic medical record documenting (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident preferences. An undated pink portable medical order form included no CPR, do not attempt to resuscitate and comfort-focused treatments were marked. This form was signed by the resident's POA (Power of Attorney). However, the required section on Health Care Provider was not signed and dated. During an interview conducted on [DATE], at 3:07 p.m., Certified Nurse Assistant (CNA/staff #48) stated that a resident's code status was typically documented in the clinical record and on the Kardex. She said that code status was also discussed during shift change when staff exchange information. The CNA stated that it would be difficult to remember every resident's code status without checking the clinical record. She stated that if she found a resident unresponsive and was unsure of their code status, she would call out for a nurse or ask someone to get the nurse immediately.In an interview with a Registered Nurse (RN/staff #47) on [DATE], at 4:07 p.m., the RN stated that advance directives must be obtained from the resident or their Power of Attorney (POA) upon admission, even if the resident had a previous admission with advance directives already on file. He said that it was important to obtain new directives at each admission, as the resident's wishes may have changed depending on their current medical condition. He also stated that advance directives must be signed by both the resident or POA and the provider; and, if either signature was missing, the form was considered incomplete and not valid.An interview conducted on [DATE], at 9:57 a.m., Licensed Practical Nurse (LPN/staff #11) who stated that upon a resident's admission, she obtains information about the resident's code status. She said that if the resident is a Do Not Resuscitate (DNR), a form must be signed by the resident or their representative and then submitted to the provider for signature. She further stated that until the provider signs the form, the resident was considered full code. The LPN also stated that residents' code statuses were discussed daily during staff huddles to ensure all staff are aware of each resident's current status.During an interview with the Director of Nursing (DON) on [DATE], at 10:24 a.m., she stated that upon a resident's admission, staff were expected to have the resident or their Power of Attorney (POA) sign an advance directives form to indicate whether the resident is a full code or Do Not Resuscitate (DNR). She stated that the provider must also sign the form; and, until both the resident/POA and the provider have signed the DNR form, the resident was considered full code. Regarding residents #4 and #31, the DON stated that she will review the clinical records and ensure that advance directives forms were signed and completed.In a later interview with the Director of Nursing (DON) on [DATE], at approximately 10:45 a.m., the DON stated that both the pink and orange advance directive forms for Resident #4 were signed by the resident's Power of Attorney (POA) but had not been signed by the provider. She also stated that she would obtain a current advance directive for Resident #31.Review of the facility policy on Advance Directives revised on [DATE] revealed that it is their policy to inform and educate residents and or responsible party of their right to make health care decisions on admission and periodically. During orientation, administrative staff will discuss the legal requirements necessary for residents to complete an Advance Directive. Upon admission, the social services director or facility designee will meet with the resident or the resident's legal representative (if resident is determined as unable to make relevant health care decisions). During this meeting, documents will be reviewed in accordance with the Resident's Rights Policy and Procedure. The social services director or designee will then ask the resident or the resident's legal representative whether the resident has completed an Advance Directive or POLST, and if not, whether the resident wishes to formulate an Advance Directive. If a resident has completed an updated Advance Directive or POLST, the Social Services Director or designee will document this in the Advance Directive section of the medical record and include a copy of the Advance Directive as well. In the absence of an Advanced Directive or POLST or in the absence of a physician order consistent with the resident's wishes, the facility will proceed with full code measures.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and review of facility policy and procedures, the facility failed to ensure that the attending physician documented acknowledgement of their monthly Medication Regimen Review recommendations for three of five sampled residents (#8, #10 #15). The deficient practice could result in regulatory recommendations provided by a licensed pharmacy not being considered during treatment of the residents. Findings Include: - Regarding Resident #8 Resident # 8 was admitted on [DATE] with diagnoses to include repeated falls, acute embolism malnutrition, anxiety and depression. The residents MDS (Minimum Data Set) dated August, 2025 revealed a BIMS (Brief Interview for Mental Status of 12, indicating that the resident had moderate cognitive impairment. The resident's care plan initiated on July 24, 2025 revealed the resident was at risk for falls, high risk medications were in use and anticoagulants prescribed. On July 29, 2025 Amiodarone HCL 200 Milligram, 2 tablets two times daily via G -Tube was ordered. On July 29,2025 Apixaban Oral 5 Milligram,1 tablet two times daily via G-Tube was ordered. Review of the medication administration record for August revealed that the medication was administered as ordered. The medical record included the Consultant Pharmacist Medication Regimen Review (MRR) dated July 25, 2025. The recommendation was to review the resident's dose of Amiodarone as it was considered in the high range for the elderly. A review and clarification were requested. The MRR further revealed a concern regarding a significant interaction between Amiodarone and Apixaban. The document revealed that a dose adjustment or more frequent monitoring may be necessary. No evidence of a documented reply was found in the resident's clinical record. - Regarding Resident #10 Resident # 10 was admitted on [DATE] with diagnoses to include non-displaced fracture of the fifth metacarpal bone, left hand, falls, mood disorder and cerebral infarction. The residents MDS (Minimum Data Set) dated July 22, 2025 revealed a BIMS (Brief Interview for Mental Status of 14, indicating that the resident was cognitively intact. The resident's care plan initiated on January 13, 2025 revealed that the resident was prescribed high (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	risk medications. On February 27, 2025 Buspirone 5 milligram by mouth two times daily was ordered. On February 19, 2025 Citalopram Hydrobromide 40 milligram one time daily was ordered. On February 27, 2025 Duloxetine HCL 30 milligram delayed release sprinkles one capsule in the morning was ordered. Review of the medication administration record for August revealed that the medication was administered as ordered. The medical record included the Consultant Pharmacist Medication Regimen Review dated July 17, 2025. The recommendation was to review the resident to determine if a gradual dose reduction for Buspirone, Citalopram and Duloxetine was appropriate, the document revealed a request for the provider to document his/her decision. No evidence of a documented reply was found in the resident's clinical record. -Regarding Resident #15 Resident #15 was admitted to the facility on [DATE] with diagnoses that included displaced fracture of lateral malleolus of left fibula, unspecified sequelae of cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. Review of the admission MDS (minimum data set) assessment dated [DATE] revealed a BIMS (brief interview of mental status) score of 15, which indicated the resident was cognitively intact. High-Risk Drug Classes, Section N – Medications revealed, resident #15 was taking antidepressant and anticoagulant at the time of the assessment. Review of the electronic medical records (EMR) revealed the active psychotropic medication order: Fluoxetine Hydrochloride Oral Tablet 60 Milligram (Fluoxetine HCl) give 1 tablet by mouth one time a day for depression. Review of the Consultant Pharmacist's Medication Regimen Review (MRR) revealed documented recommendations for Resident #10 by the Pharmacist/Staff #100 reported July 17, 2025. Documentation recommendations included routings for medical doctor (Staff #100) which included: This residents stay is approaching or has reached the 30-day point. Please determine if a gradual dose reduction (GDR) or discontinuation of any of this resident's psychotropic medication fluoxetine can be attempted (unless contraindicated). Please, make any notes below. Thank you. Follow-through note written to physician. Despite documentation indicating, please, make any notes below; follow-through note written to physician no acknowledgement was documented for this recommendation by Medical Doctor/Staff #105. An interview was conducted on August 7, 2025 at 1:38 PM with Director of Nursing (DON/Staff #33) (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	who stated that any recommendations that the Pharmacy sends she gives them to the provider for review. Staff #33 stated that usually the pharmacy reviews are done for either the new admissions or as needed. Staff #33 stated that the recommendations are printed once they are available in the pharmacy website; but that, she has to keep logging in to check for incoming recommendations. Staff #33 stated that the facility presently has one provider for all the residents. Staff #33 stated that the provider reviews the recommendation and staff carry out whatever the provider orders or recommends; and that, the notes are done on the recommendation when they are carried out. Staff #33 stated that there was a recent change in provider and were still adjusting with the way the pharmacy reviews are done because the providers were new. Staff #33 reviewed the EMR for any uploaded documented recommendation acknowledgements by the provider, however she did not find any documents at that time. A phone interview was conducted August 7, 2025 at 2:09 PM with Nurse Practitioner/Staff #110 alongside the DON. Staff #110 confirmed that she worked in collaboration with the attending Medical Doctor (Staff #105) at the facility. Staff #110 stated that the medical doctor and her had received a stack of pharmacy recommendation reports on August 4, 2025 and was not sure when she was supposed to be doing that. Staff #110 stated usually checks her bin and the medical doctor (Staff #105) and stated that the medical doctor nor she had done any monthly medication reviews prior to Monday (August 4, 2025). Staff #110 stated that the risks of not review recommendations depend on the recommendation and was unsure since she was only given the documents recently on Monday. Staff #110 confirmed that she had not reviewed any MRR for Resident #15. After the phone interview, Staff #33 reiterated that the risk of not reviewing the pharmacy recommendations would depend on the recommendations. Staff #33 stated that the facility expectations were that if the pharmacy makes recommendation the physician or provider should review them. Further review of pharmacy recommendations reports was conducted alongside the DON which revealed many provider notes were unavailable after the month of May 2025. Staff #33 stated that the facility had a large turn over in June 2025; and that, the provider changes happened so the providers were getting adjusted; and that, this was when the lag time occurred due to change of new provider. Staff #33 admitted that last week, I forgot to hand it to her. Another interview was conducted on August 7, 2025 at 4:25 p.m. with the Director of Nursing (DON)/Staff #33 who stated that she received an email from the provider today regarding the MRR; and that, the provider stated that they just reviewed the MRR today. The DON stated that this does not meet her expectations. The facility is currently working on coordinating better with Pharmacy and the Provider. The DON stated she would provide a copy of the email from the provider. Review of the facility policy titled, Medication Management: General (revised 2017) revealed, it is the policy that the residents' medications are managed in accordance with the state/federal regulations and facility standards; the consultant pharmacist will review each resident's medication regimen at least once a month; the pharmacy medication review recommendation will be acted upon in a timely manner.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Number of residents sampled: 16Number of residents cited: 0The facility failed to ensure that all food in the nourishment refrigerator was labeled according to facility policy. Findings include: During the initial observation of the nourishment refrigerator conducted on August 5, 2025 at 11:46 a.m., the following items were found to be stored with no resident name, room number and no open or received date.- 1 Yogurt Parfait- 1 cup containing an unidentified white liquid- 1 carton Protein drink- 1 pink thermos containing an unknown substanceAt the time of the observation certified nursing assistant (CNA) / staff #21 was asked to confirm that the names and dates were absent on these items. Staff #21 confirmed the information and stated the items would be discarded immediately.During the follow up observation of the nourishment refrigerator at 2:12p.m. on August 7, 2025 a tan grocery bag with unidentified food items was discovered. No labels or dates were visible on the bag or food items. When the bag was removed from the refrigerator Registered Nurse (RN) /staff # 47 stated that the bag was his lunch. He further stated that the refrigerator was for resident food and staff food should not be stored in that location.An interview with Nutritional Services Manager/ Staff #49 was conducted on August 7,2025 at 9:26 a.m. She stated that the residents were served snacks upon request. The snacks were stored in the kitchen and staff retrieve them as needed. She further stated that the nourishment refrigerator was the responsibility of the nursing staff.An interview with Licensed Practical Nurse (LPN)/ staff # 2 was conducted on August 7,2025 at 2:04 p.m. Staff # 2 stated that if a resident had food that he or she wishes to be stored in the refrigerator, nursing staff would put the resident name, room number and open date in a visible location and would place it in the nourishment refrigerator. All food must be labeled and discarded within 72 hours of the open date. An interview with the Director of Nursing (DON)/Staff #33 was conducted on August 7,2025 at 2:26 p.m. The DON stated that any food brought in or stored in the resident's nourishment refrigerator must dated and labeled with the resident's name and room number. She stated that this refrigerator was the responsibility of the nursing staff and they were to check for labeling, including name, room number, open and expiration dates. She further stated that this refrigerator was only to be used for resident food, and staff food should not be stored in this location. The DON stated that the findings did not meet her expectations and this practice could cause the residents to become ill from foodborne illness.The facility policy Dietary Services: Food brought into Facility by Family/Visitors (7/2025) revealed that the facility will ensure all items from an outside source will be covered, labeled with the resident's name and room number and dated. The food is to be easily distinguishable from facility food. The policy further revealed that outside food stored in the refrigerator must be discarded 3 days after the date brought in. All food or beverages not properly labelled must be discarded.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 5Number of residents cited:Based on observations, clinical record review, staff interviews and facility policy review, the facility failed to ensure that signs were posted related to enhanced barrier precautions (EBP) for two residents (#12 and #31) of 5 sampled residents. The deficient practice could result in transmission of infections to staff and other residents. Findings include: -Resident #4 was admitted on [DATE] with diagnoses of mechanical complications of other prosthetic devices, Parkinson's disease without dyskinesia and benign prostatic hyperplasia (BPH) without lower urinary tract symptoms. The alert charting dated June 26, 2025 included that the resident was alert and oriented x 3 and had a foley catheter 16Fr in place which was draining well. The clinical admission note dated June 26, 2025 revealed the resident had an intact, patent catheter in place due to urinary retention. The physician order dated June 26, 2025 included to provide urinary catheter care every shift for preventative care/hygiene. The daily skilled note dated June 28, 2025 included resident had an indwelling urinary catheter/Foley catheter. An encounter note dated June 29, 2025 included indwelling catheter was in place with clear yellow urine. Diagnoses included BPH without lower urinary tract symptoms. Plan was to continue to monitor the indwelling urinary catheter. The order note dated June 29, 2025 revealed that the provider was notified regarding foley catheter being dislodged and was changed; and that, the resident had an appointment on July 7, 2025 for suprapubic catheter placement. The discharge instruction form dated July 7, 2025 revealed that the resident had a suprapubic catheter placement. A physician order dated July 7, 2025 included for the following:-Suprapubic catheter care output every shift; and,-Check leg bag and that bag is not changeable and can only be changed by urology. The daily skilled note dated July 8, 2025 included that the resident had an external urinary catheter and had suprapubic insertion with a leg bag. The physiatry progress notes dated July 21 and July 28, 2025 revealed that the resident had suprapubic catheter in place. The daily skilled note dated August 4, 2025 included the resident had an external urinary catheter. During observations conducted on August 4, 2025 at 9:10 a.m., there was a blue drape with pockets that contained PPE (Personal protective equipment) such as gloves and gowns which was hanging by the resident room door. There was no signs related to what type of precautions was posted. In an interview with a certified nurse assistant (CNA/staff #41) conducted on August 4, 2025 at 9:44 a.m., the CNA stated that resident #4 was on EBP (enhanced barrier precautions) because the resident had an indwelling catheter. She stated that a staff/visitor need to wear gown and gloves if they are entering the resident room and will be touching the resident or providing direct care. Multiple random observations was conducted on August 4 at 11:50 a.m., August 5 at 8:10 a.m. and 9:52 a.m., August 6 at 9:27 a.m. and August 7, 2025 at 11:09 a.m. revealed that resident #4 continued on EBP. However, there were no EBP signs posted/found. An observation of the room of resident #4 was conducted on August 7, 2025 at 12:05 p.m. with the registry nurse (staff #2) and the RN (staff #47) who both stated that there was no signs/posting found. The registry nurse (staff #2) stated that resident #4 was on EBP because of an indwelling catheter and there should be a sign regarding EBP posted with the blue drapes. The RN (staff #47) stated that there was no reason shy the resident's room did not have any signs on EBP posted. -Resident #31 was admitted on [DATE] with diagnosis of displaced intertrochanteric fracture of the right femur, subsequent encounter for closed fracture with routine healing. The skin check dated August 1, 2025 revealed that the resident had staples and surgical dressing on the front right trochanter. The physician order dated August 2, 2025 included for EBP every shift for wounds. An observation was conducted on August 4, 2025 at 8:10 a.m. The was a yellow drape with pockets that contained PPE was hanging on door to the room of resident #31. There was no signs posted regarding instructions and the type of precautions the resident had. In an interview conducted with a registered nurse (RN/Staff #10) on August 4, 2025 at 8:14 a.m., the RN stated that resident #31 was on EBP because of the surgical wound. She stated that (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PPE should be donned before entering the room if a staff/visitor would be touching the resident or provide direct care to the resident; and that, staff/visitor do not need to don PPE if they are just going to talk with resident #31. The nurse pointed to the yellow drape hanging on the door but did not notice the lack of signage/posting. An interview was conducted with a registry nurse (staff #2) on August 7, 2025 at 12:05 p.m. The registry nurse stated that the blue or yellow drapes containing PPE hanging over/on the resident room doors indicated that the residents were in some king of precautions. She stated that there should be signs posted at the door to inform visitors/staff or any individual who wish to enter the room; and that, this posting will tell the individual to go see the nurse who will then instruct the individual on what to put on before entering the resident room and any other instructions that the individual need to know to be inside the resident room. At 12:09 p.m., a registered nurse (RN/staff #47) joined the interview and confirmed what the registry nurse had stated regarding posting/signage. During an interview conducted with a CNA (staff #48 on August 7, 2025 at 3:07 p.m., the CNA stated that the color of the drape containing PPE hanging on the resident's room door tell staff what type of precautions the resident has. She stated that if the drape is colored blue, it indicated that the resident was on EBP for either presence of a foley catheter or a PICC (peripherally inserted central catheter) line; and if the drape is colored yellow, the resident was on contact precautions. An interview with a licensed practical nurse (LPN/staff #11) was conducted on August 8, 2025 at 9:57 a.m. The LPN stated that the blue and yellow drape with pockets and containing PPE that was hanging over a resident room door indicated that the resident was on some kind of precaution. She stated that if the resident had an indwelling catheter or PICC lines, the drape would be blue for EBP; and, if the resident was on contact precautions such as C-diff infections, the drape would be yellow. She stated that any individual (staff/visitor) who will be touching the resident such as staff providing direct care of visitors hugging the resident, would have to wear a gown and gloves on before entering the resident on EBP. The LPN said that each room that was on any type of precautions such as EBP should have signs posted as to what type the precautions the resident has and to don the required PPE before entering the resident room. Further, the LPN stated that there should always be a sign posted on the resident room door for residents on precautions; and, if there was not any signs posted, this meant that the facility may have ran out of available signs to post. During an interview with the Director of Nursing (DON) conducted on August 8, 2025 at 10:24 a.m., the DON stated that the facility knows type of infection the resident has prior to the resident being admitted at the facility. She stated that when the resident was admitted , staff will ensure that the right precautions was followed. She said that on a daily basis, the nurses including herself conduct daily rounds and check for availability of the PPE, ensuring that there is adequate PPE and ensuring that staff/visitor were following the precautions in place. The DON further stated that there should be signs posted as to the type of precautions and what PPE was to be used to enter the resident room on any type of precautions. Regarding resident #4, the DON stated that she was made aware that the room did not have signs posted yesterday. She stated that she and the nurses conducted rounds and she did not know why she and her staff missed resident #4 having no signs posted. The facility policy on Infection Control Precautions - Categories of Transmission Based Precautions revised on July 2025 revealed that standard precautions shall be used when caring for residents at all times regardless of their suspected or confirmed infection status. Transmission-Based precautions are the second tier of basic infection control and are to be used in addition to standard precautions for patients who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission. EBP are recommended for residents known to be colonized or infected with MDRO (multidrug resistant organism) as well as those (who meet criteria) at increased risk for MDRO acquisition (e.g., residents with wounds or indwelling medical devices). Standard precautions still apply while using EBP. A sign will be used to alert staff of the implementation of EBP or ESP (enhanced standard precautions), while respecting the resident's privacy. Place a sign at the doorway instructing visitors to report to the nurses' station before (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	entering the room. The policy also included the use of CDC (Centers for Disease Control) sign and/or other measures to alert staff of the implementation of transmission-based precautions, while respecting the privacy of the resident. In the SNF (skilled nursing facility) setting, place a Contact precautions sign on the doorway of the resident. Duration of signage shall be for the duration of the illness.

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	035300	A. Building B. Wing	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mirabella at Asu	65 East University Avenue Tempe, AZ 85281

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 5Number of residents cited: 1 Based on clinical record review, staff interviews and review of facility policy and procedures, the facility failed to ensure there was adequate indication for the use of an antipsychotic for one of 5 sampled residents (#31). The deficient practice could result in resident receiving an unnecessary antipsychotic medication. Findings include: Resident #31 was admitted on [DATE] with diagnoses of displaced intertrochanteric fracture of the right femur, Parkinson's disease without dyskinesia, hypertensive chronic kidney disease, stage 3 chronic kidney disease and depression.The hospital Discharge summary dated [DATE] revealed the resident had depressive disorder and insomnia. Medications included Quetiapine (antipsychotic) 50 mg (milligrams) by mouth at bedtime and Quetiapine 25 mg by mouth at bedtime as needed to be combined with 50 mg dose if no success with sleeping.Further review of hospital discharge documentation revealed no evidence that resident #31 had psychotic behaviors such as hallucination and delusions.The clinical admission note dated August 1, 2025 revealed the resident followed commands, was oriented to person and place, was experiencing signs of short-term memory loss and had mild cognitive impairment. The documentation also included that the resident had a pleasant mood, had no unwanted behaviors witnessed, had insomnia and did not wander at night.An alert charting dated August 1, 2025 included that the resident was admitted for therapy s/p (status post) right femur fracture.There was no evidence found in the clinical record that an evaluation was conducted to determine that the use of Quetiapine was justified.Despite the lack of documentation of adequate indication for the use of Quetiapine, the physician order dated August 1, 2025 included for Seroquel (brand name for Quetiapine) 25 mg give 2 tablets by mouth at bedtime for insomnia and give 1 tablet by mouth every 24 hours as needed for insomnia at bedtime, to be combined with 50 mg dose if resident had no success with sleeping. It also included Quetiapine 50 mg 1 tablet by mouth at bedtime for sleep and give 0.5 tablet by mouth every 24 hours as needed for sleep to combine with scheduled 50 mg to equal 75 mg.This order was transcribed onto the MAR (medication administration record) for August 2025 and revealed that the medication was administered to resident #31 starting August 2, 2025. The documentation in the MAR revealed that the number associated with side effects related to Quetiapine was monitored and documented. However, there was no evidence found in the clinical record that the risk and benefits for the use of Quetiapine was explained to the resident or resident representative prior to the administration of Quetiapine on August 2, 2025. There was also no evidence that the target behavior for which Quetiapine was prescribed for was monitored. The baseline care plan dated August 2, 2025 did not include that the resident was taking any psychotropic or anti-psychotic medications. Interventions included to administer medications as ordered and to monitor/document for side effects and effectiveness.The alert charting dated August 2, 2025 revealed the resident was alert and oriented to self and place and was noted to be confused at times through the night.The mini nutrition note dated August 2, 2025 included the resident had severe dementia or depression and had suffered psychological stress or acute disease in the past 3 months.The physiatry progress note dated August 4, 2025 included the resident was alert and oriented x 1-2, forgetful and had a good mood. Assessment included deconditioning, gait instability, right femur fracture, cognitive impairment and ground level fall.The activities care plan dated August 4, 2025 revealed the resident was alert and oriented, friendly and seemed to appear in good spirits.The encounter note dated August 5, 2025 revealed a medication list that included Seroquel 25 mg give 2 tablets by mouth at bedtime for insomnia and give 1 tablet by mouth every 24 hours as needed for insomnia at bedtime, to be combined with 50 mg dose if resident had no success with sleeping; and, Quetiapine 50 mg 1 tablet by mouth at bedtime for sleep and give 0.5 tablet by mouth every 24 hours as needed for sleep to combine with scheduled 50 mg to equal 75 mg. Per the documentation, the resident had dementia and (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had past medical history of depression, dementia and Parkinson's disease; and that, the resident was frail, was in good spirits, was confused and was oriented to self only. Psychiatric examination included no current evidence of anxiety or depression. Diagnoses included Parkinson's disease and dementia in other diseases classified elsewhere without behavioral/psychotic/mood disturbance and anxiety. Plan was to continue Quetiapine.A review of the clinical record showed no evidence that the resident had psychotic behaviors such as hallucinations, delusions, or disorganized thinking or speech. There was also no documentation showing that the target behavior of insomnia Quetiapine was prescribed to treat was monitored or recorded.In an interview with a registry nurse (staff #2) conducted on August 7, 2025 at 12:05 p.m., the registry nurse stated that when a resident is admitted with or prescribed with a psychotropic medications such as Seroquel, she would obtain a consent that explains the risk and benefits for the use of the medications from the resident or resident representation prior to administering the medication to the resident. She stated that she would enter the order in the electronic record; and that, the order for the psychotropic medication such as Seroquel should have a diagnosis and target behavior that the medication was prescribed for. She stated that when the resident or resident representative consents for the psychotropic medication, she would administer the medication as ordered by the physician and would monitor and document the behavior, side effects and effectiveness of the medication.During an interview with the Director of Nursing (DON) on August 7, 2025, at 3:00 p.m., the DON stated that a signed consent for the use of psychotropic medications must be obtained from the resident or their representative before the medication is administered. She added that this consent should be documented in the electronic record. Regarding Resident #31, the DON stated she would ensure that a consent form for the administration of Seroquel was signed; and that, a new consent must be obtained with each admission and that staff cannot rely on a consent form signed during a previous admission.In an interview conducted with a registered nurse (RN/staff #47) conducted on August 7, 2025, at 4:07 p.m., the RN stated that when a resident is admitted with or prescribed a psychotropic medication, he ensures that consent is obtained and signed by the resident or their Power of Attorney (POA). He said that if the resident or POA refuses or does not sign the consent form, the medication is not administered, and the provider is notified. The RN stated that if consent was given, he enters the order into the electronic clinical record and ensures that the target behavior and the indication for the medication were documented. He further stated that Seroquel was an antipsychotic typically used to treat psychosis but acknowledged that it had also been used to help residents with sleep.An interview with Licensed Practical Nurse (LPN/staff #11) was conducted on August 8, 2025, at 9:57 a.m. The LPN stated that when a resident is prescribed an antipsychotic medication such as Seroquel, she verifies the order with the provider, informs the resident of the risks and benefits, and obtains signed consent from the resident or their representative. She explained that if consent is not obtained or the form is not signed, the medication is not given, and the provider is notified. The LPN said that once consent was obtained, she enters the order into the electronic medical record and administers the medication as prescribed. She also said that the order should include the indication for use, and after administration, she monitors for the target behavior and any side effects. Further, the LPN stated that Seroquel was an antipsychotic typically used for residents with serious mental illness (SMI) or other mental health diagnoses; and that, there were no current residents in the facility that were receiving Seroquel.During an interview with the Director of Nursing (DON) on August 8, 2025, at 10:24 a.m., she stated that when a resident was prescribed a psychotropic medication such as Seroquel, staff were required to obtain consent from the resident or their Power of Attorney (POA). She stated that the medication order must include the dose, frequency, indication, target behaviors, and possible side effects. The DON said that Seroquel is an antipsychotic typically prescribed for residents exhibiting psychotic behaviors such as hallucinations or psychosis. While reviewing the clinical record of Resident #31 with the DON, she stated that Seroquel had been prescribed to help the resident sleep. The DON further stated that Seroquel was an antipsychotic and should not be used for sleep. She also (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said that Resident #31 does not display psychotic behaviors, and stated that if the resident was experiencing difficulty sleeping, an appropriate alternative such as Ambien, a sedative-hypnotic, could be used instead.Review of the facility policy on Psychotropic Medications included that resident's medications are managed in accordance with the state/federal regulations and facility standards. The purpose included to ensure that resident drug regimen is free from unnecessary drugs which was any drugs when used in excessive dose (including duplicate therapy), or excessive duration, or without adequate monitoring, or without adequate indications for its use, or in the presence of adverse consequences which indicate the dose should be reduced or discontinued, or any combination of the reasons above. Adequate indications for use was defined as documented rationale for administering a medication that is based upon an assessment of the resident's conditions and therapeutic goals, and after any other treatments have been deemed clinically contraindicated. This includes medication administered is consistent with manufacturer's recommendations and/or clinical practice guidelines, standards of practice, medication references, clinical studies or evidence-based reviews. Each medication will have a diagnosis, indication for use and therapeutic goal documented in the medical record. Residents may be admitted to the facility on psychotropic medications that were started in the hospital or the community without a clear document indication for why the medication was begun or should continue. The prescribing practitioner and IDT (interdisciplinary team) should determine if the medication is justified by conducting a comprehensive medical evaluation.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and policy review, the facility failed to ensure that the medication error rate was not 5% or greater for two of three residents (#37, #10). The deficient practice could result in further medication administration error.Findings include:Two medication administration errors were identified out of thirty-five opportunities during medication administration observation. The medication error rate was 5.71%.-Regarding Resident #37Resident #37 was admitted to the facility on [DATE] with diagnoses that included Parkinson's Disease without dyskinesia, essential hypertension, and unspecified dementia.A medication administration observation was conducted on August 6, 2025 at 8:56 PM with Licensed Practical Nurse (LPN/Staff #11). During medication administration for Resident #37, the LPN was observed placing one Docusate 100 milligram capsule into a medicine cup. Resident was administered the medication from the cup.Review of Medication Administration Records (MAR) physician orders for the Resident #37 revealed:Docusate Sodium Oral Capsule 50 milligram; give 1 capsule by mouth two times a day to soften stool. Start date August 2, 2025 and end date August 6, 2025.An interview was conducted on August 6, 2025 at 10:52 AM with Licensed Practical Nurse (LPN/Staff #11) who confirmed that she had administered to the Resident #37 Docusate 100 milligram capsule instead of 50 milligram capsules as ordered by the provider. Staff #11 stated she should have administered half of the dose instead as ordered by the provider.-Regarding Resident #10Resident #10 was admitted to the facility on [DATE] with diagnoses that included cognitive communication deficit, need for assistance with personal care, and history of falling.A medication administration observation was conducted on August 6, 2025 at 9:24 PM with Registered Nurse (RN/Staff #10). During medication administration for Resident #10, the RN was observed placing two Lactobacillus Rhamnosus GG oral - 200 milligram Inulin capsules into a medicine cup. Resident was administered the medication from the cup.Review of Medication Administration Records (MAR) physician orders for the Resident #10 revealed:Lactobacillus Rhamnosus (GG) Oral Capsule; give 2 capsules by mouth one time a day for prophylaxis. Start date February 1, 2025 and date August 6, 2025.An interview was conducted on August 6, 2025 at 9:40 AM with Registered Nurse (RN/Staff #10) who confirmed that the written order from the provider did not indicate any units for Lactobacillus Rhamnosus (GG). RN stated that, I don't know why that one (order) doesn't have the units, they usually have the units thus she would ask the doctor about that.An interview was conducted on August 6, 2025 at 11:32 AM with Director of Nursing (DON/Staff #33) who stated staff should follow the 5 R's when administering medications including right medication name, dose, strength, stop date, and parameters. Staff #33 stated that if any of these variables were missing that the staff should reach out to the doctor and clarify the order. Staff #33 reviewed the active order for the Resident #37 at 11:37 AM which indicated Docusate Sodium Oral Capsule 50 milligram; give 1 capsule by mouth two times a day to soften stool. Staff #33 stated that the way the order was documented, I would give 50 milligrams. Staff #33 reviewed the active orders for the Resident #10 at 11:41 AM who confirmed that she could not see the strength in the order for Lactobacillus Rhamnosus GG. Staff #33 stated that it was the facility's expectation that any order that is unclear would have to be clarified with the physician.Review of the alert charting progress note documented by Staff #10 on August 6, 2025 at 16:00 for Resident #10 revealed, patient had order for Lactobacillus Rhamnosus (GG) oral capsule with no unit of measure listed.Review of policy titled, Medication and Treatment Administration (revised [DATE]) revealed, it is the policy that administration standards for the delivery of medication and treatments will be adhered to by all staff responsible for providing these services; medications and treatments shall be administered as prescribed; the seven rights of medication administration shall be observed: right resident, right drug, right dose, right time, right route, right manufacturer.