STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035106	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2024
NAME OF PROVIDER OR SUPPLIER: Tempe Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE: 6100 South Rural Road, Tempe, AZ 85283	

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical review, staff interviews, and facility policy, the facility failed to ensure that physician orders were followed according to professional standards regarding blood sugar monitoring for two out of five sampled residents (#215 and #46). The deficient practice could result in residents with high blood sugar. Findings Include: -Regarding resident #215: Resident #215 was admitted to the facility on [DATE] with diagnoses that included Type II Diabetes Mellitus without complications. The care plan for Diabetes Mellitus initiated on November 09, 2024 included an intervention of diabetes medication as ordered by doctor; monitor/document for side effects and effectiveness. The Minimum Data Set (MDS) assessment dated [DATE] included a brief interview for mental status (BIMS) score of 00 indicating severe cognitive impairment. Review of the physician's order dated November 8, 2024, revealed an order for, Insulin Lispro solution 100 unit/milliliter (ml), inject as per sliding scale: if 0 - 60 =0 units asymptomatic or symptomatic blood sugar (BS) 60 and below; see as needed orders; 61 - 150 = 0 units; 151 - 200 = 3 units; 201 - 250 = 6 units; 251 - 300 = 8 units; 301 - 350 = 12 units; 351 - 400 = 15 units; 401+ = 18 units recheck, if still elevated in 60 minutes call medical doctor (MD), subcutaneously before meals and at bedtime. Review of the Medication Administration Record (MAR) dated November 2024 revealed the following: -November 10, 2024, BS was 447 and 18 units of insulin was administered. -November 12, 2024, BS was 463 and 18 units of insulin was administered. -November 13, 2024, BS was 430 and 18 units of insulin was administered. -November 16, 2024, BS was 491 and 18 units of insulin was administered. -November 17, 2024, BS was 449 and 18 units of insulin was administered. (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: 035106	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2024
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-November 18, 2024, BS was 415 and 18 units of insulin was administered. -November 19, 2024, BS was 402 and 18 units of insulin was administered. -November 20, 2024, BS was 401 and 18 units of insulin was administered. A review of the clinical record revealed no evidence that the BS was rechecked or that the physician was notified for the above dates regarding blood sugar. An interview was conducted on November 21, 2024 at 8:40 AM with a Certified Nursing Assistant (CNA/staff #17) who stated that blood sugar checks are done whenever they are scheduled. She also stated that the blood sugar results are given to the nurses and the nurses document the results in the electronic record. She further stated that she would notify the nurse about blood sugar results in any situation but especially if the resident is below 90 or over 250. In an interview with a Licensed Practical Nurse (LPN/staff #82) on November 21, 2024 at 8:41 AM, who stated that the process for administering insulin included: checking the blood sugar, depending on the result the resident could have either a standard and/or sliding scale order to give insulin, wiping the resident area with an alcohol pad, and administering the medication. She also stated that she would follow the sliding scale as it was written in the order. The LPN (staff #82) reviewed the physician order of insulin lispro for resident (#215) and verified that if the blood sugar was above 401 it should be rechecked in 60 minutes and if it is still 400 to notify the physician. The LPN then reviewed the above dates and blood sugar results in the resident's clinical record and stated that the blood sugars should have been rechecked after the initial result but there was no evidence showing that it had been completed. She also stated that the physician should have been notified. The LPN (staff #82) stated that the risks to the resident of not rechecking the blood sugar or notifying the physician could result in the resident passing out. She further stated that not following the physician's order for insulin lispro did not meet facility expectations. An interview was conducted on November 21, 2024 at 8:57 AM with the Director of Nursing (DON/staff #7) who stated that the process for administering insulin would be based off of the physician's order and nursing assessment. She stated that the physician orders regarding insulin would be followed. The DON (staff #7) reviewed the above dates and documented blood sugars in the resident's (#215) clinical record, and stated that the blood sugars should have been rechecked. She further reviewed the resident's clinical record and stated that there was no evidence of the blood sugars being rechecked after the initial result according to physician's orders, or that the physician was notified. The DON stated that the risks to the resident of not rechecking the blood sugar or notifying the physician could include that the resident's blood sugar could stay elevated and that they would not be addressing his diabetes. She further stated that not following physician orders did not meet facility expectations. - Regarding resident #46: Resident #46 was admitted on [DATE] with diagnosis that included Type 2 Diabetes Mellitus with Diabetic Neuropathy. (continued on next page)

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	035106	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tempe Post Acute	6100 South Rural Road Tempe, AZ 85283

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the physician's order dated October 29, 2024, revealed an order for, Insulin Lispro solution 100 unit/milliliter (ml), inject as per sliding scale: if 0 - 60 =0 units asymptomatic or symptomatic blood sugar (BS) 60 and below; see as needed orders; 61 - 150 = 0 Units;151 - 200 = 0 Units;201 - 250 = 2 Units;251 - 300 = 4 Units;301 - 350 = 6 Units;351 - 400 = 8 Units;401+ = 10 Units RECHECK, IF STILL ELEVATED IN 60 MINUTES CALL MD, subcutaneously before meals and at bedtime. The care plan for Diabetes Mellitus initiated on October 30, 2024 included an intervention of diabetes medication as ordered by doctor; monitor/document for side effects and effectiveness. The Minimum Data Set (MDS) assessment dated [DATE] included a brief interview for mental status (BIMS) score of 15 signifying the resident had no cognitive impairment. Review of the Medication Administration Record (MAR) dated November 2024 revealed that on November 04, 2024, resident's BS was 407 and 10 units of insulin was administered. A review of the clinical record revealed no evidence that the BS was rechecked or that the physician was notified for the above date regarding blood sugar. An interview was conducted on November 21, 2024 at 10:14 AM with the Director of Nursing (DON/staff #7) who reviewed the MAR/TAR for November 2024. The DON (staff #7) reviewed the November 04, 2024 and documented blood sugars in the resident's (#46) clinical record, and stated that the blood sugars should have been rechecked. She further reviewed the resident's clinical record, she stated that the blood sugar was first checked at 10:53 and then it was checked at 15:38 and she stated that it should been as physicians order. She further stated that not following physician orders did not meet facility expectations. The facility's policy, Physician Orders, revised in September of 2024 revealed to accurately implement orders in addition to medication orders, only upon the order of a person duly licensed and authorized to do so in accordance with the resident's plan of care.