STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035121	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Boswell Transitional Care of Cascadia	10601 West Santa Fe Drive Sun City, AZ 85351

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** -Regarding Resident #82: Resident #82 was admitted on [DATE], diagnosis included chronic systolic congestive heart failure, pleural effusion, Hypo-osmolality, Hyponatremia, hypertension, and hyperlipidemia. The Admissions Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating that resident is cognitively intact. Resident #82 ' s care plan did not address that resident is able to self-administer medication. Review of the physician ' s orders revealed no orders to self-administer medications. Further review of the Physicians orders revealed no orders for Estradiol 0.01% vaginal cream 42.5gm or Betamethasone Dipropionate Ointment, USP 0.05%. A health status note dated May 6, 2025 at 12:26PM revealed that the resident's family was noted to bring ointments from home prescribed by her gynecologist. The nurse educated residents and residents' families about not bringing in home medications without notifying the facility staff. Education was provided for risks of medication at bedside without the nurse or physicians awareness. Residents and Residents' family verbalized understanding back to this Nurse and will not bring medication into this facility without permission. Provider notified. Resident stated she does not need the ointments at this time as it was for vaginal itching and she has no symptoms at this time An observation was conducted on May 6, 2025 at 12:12PM in Resident #82 room and revealed that there was unopened Estradiol Vaginal Cream (vaginal estrogen) on the table which had Walgreen sticker on it with resident #82 names on it. Also observed was Betamethasone Dipropionate (Corticosteroid) unopened laying on the table in a red box and immediately calling the nurse on the floor. An interview was conducted on May 6, 2025 at 12:20PM with Licensed Practical Nurse (LPN/staff #43), who identified the medications Estradiol 0.01% Vaginal Cream 42.5gm and Betamethasone Dipropionate Ointment, USP 0.05%. He stated that these ointments are not allowed to be on bedside and was not aware of these the resident #82 had them. Staff #43 also stated that no over the counter medication should be left on the bedside. He mentioned that there are risks of having these medications left on bedside such as drug interactions and over medication. -Regarding resident #47: (continued on next page)

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #47 was admitted on [DATE], diagnosis included metabolic encephalopathy, Pneumonia, epilepsy, anemia, major depressive disorder, and anxiety disorder. A significant change in admissions Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 09 indicating cognitively impaired. Resident #47 ' s care plan did not address that resident is able to self-administer medication. Review of the physician ' s orders revealed no orders to self-administer medications. Further review of the Physicians orders revealed no orders for CryoDose Topical Anesthetic Spray or Zinc Oxide Ointment Skin Protectant 2 ounces. A health status note dated May 6, 2025 at 12:52 PM revealed that the resident wife at bedside brought over the counter zinc oxide cream and an aerosol topical antiseptic. The writer asked the resident's wife if the medication was specifically for her or the residents. The wife said, Give it to me, it ' s mine. The resident's wife snatched it out of the writer's hand. Zinc oxide cream was immediately discarded. The resident's wife was educated of the risks and benefits, and per facility protocol outside medication was not permitted. Patient with rash to buttocks and is currently being addressed by nursing. MD notified, no new orders. An observation was conducted on May 6, 2025 at 12:38 PM in Resident #47 room, revealed a resident eating his meal by himself in the room and observed a small bottle with the secured cap on named CryoDose (topical anesthetic spray) on the residents table as well as a tube laying on the table named Zinc oxide cream (skin protectant).A nurse on the hallway was immediately called. An interview was conducted on May 5, 2025 at 12:41 PM with Certified Nurse Assistance (CNA/staff #222), who identified the medications as CryoDose Anesthetic Topical Spray and Zinc Oxide Cream skin protectant. She stated they are not supposed to be on the table and there are risks posed to it such as the resident accidentally grabbing it thinking it is something else, getting sick, or hurt. Observed the wife entering the room. An interview was conducted on May 5, 2025 at 12:43 PM with the Licensed Practical Nurse (LPN/staff #61), who also identified the medication as CryoDose Anesthetic Topical Spray and Zinc Oxide Cream skin protectant. Staff #61 stated that these are not supposed to be on the table. He stated there are risks to having these medications left at bedside such as infection control and wrong medication taken by the resident. LPN was trying to take medication from the CNA, the resident ' s wife aggressively took the CryoDose Anesthetic Topical Spray from his hand and stated that it is her medication. An interview was conducted on May 09, 2025 at 12:43 PM with the Chief Nursing Officer (CNO/staff#220), who stated that the process for outside medication is to write them on inventory list upon admission and follow the policy. She stated that staff need to call the physician, send the medication home, and check with the pharmacy. CNO also stated that if they see medication left on the bedside where the family is educated, they call the physician if the physician will allow them to authorize the resident self administrator . She stated that if they see any topicals they follow their policy. She stated if medication is left at bedside she hopes not have a negative outcome. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A further interview was conducted on May 09, 2025 at 01:35PM with the Chief Nursing Officer (CNO/staff#220), who stated that the facility process for self-administrating medication is to assess the resident if they are eligible to take medication on their own, to plan that, and the physician will have to write an order to self-administer medication. Reviewed the policy Self-Administration of Medications Release date 11/28/2017 revealed that the resident may self-administer drugs if the interdisciplinary team has determined that this practice is safe. Review of the policy Medication Management, revision date October 15, 2022 revealed that if medications are found at the bedside the staff will remove the medication immediately and the physician is notified immediately. Based on observations, staff interviews and policy review, the facility failed to ensure that medications were not left at the bedside for three residents (#193, #47, #82). The facility census was 78 and the sample was 3 residents. The deficient practice could result in harm to the residents, and/or visitors who have access to medications. Findings include: Resident #193 was admitted on [DATE], with the diagnoses of concussion with loss of consciousness, fall, pain in right hip, type 2 diabetes mellitus, transient ischemic attack, cerebral infarction, unspecified difficulty in walking, dysphagia, oropharyngeal phase. The minimum data set (MDS) was in progress for Resident #193, however the brief interview for mental status (BIMS) was conducted with a score of 15 which indicated the resident was cognitively intact. Resident #193's care plan did not address resident as able to self-administer medications. An observation took place on May 6, 2025 at 09:15 a.m. in Resident #193's room and revealed a small white round object on the resident's personal cell phone. An interview was conducted on May 6, 2025 at 09:16 a.m. with Resident #193 and revealed that the small white round object was a pill. Resident #193 believed it was Tylenol. The pills were left in a medicine cup and they leave them all the time. They do it all the time. An interview was conducted on May 6, 2025 at 09:19 a.m. with certified nursing assistant (CNA) Staff #99 and revealed that it is a pill and should not be there. Staff #99 then left the room to notify the nurse. An observation was conducted on May 6, 2025 at 09:20 a.m. in Resident #193's room with licensed and revealed Licensed Practical Nurse (LPN) Staff #212 asking why Resident #193 did not take her Tylenol. Resident #193 responded by stating she could not swallow the pill. An interview was conducted on May 6, 2025 at 09:21 a.m. with Staff #212 and revealed that the small round white object was a pill, Tylenol. If the pill was not taken, then it would not have been effective. Another patient could take the pill and it could contraindicate other medications and they should not take what is not prescribed to them. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on May 9, 2025 at 12:43 p.m. with Chief Nursing Officer (CNO) Staff #220 and revealed that the medication cup is handed to the resident and nurse stands there and watches the residents take their medications. When asked if there was any time that they leave the medications in the cup and leave the room, the response was, I would hope not. If medications are left at the bedside, hoping that a negative outcome would not happen if a resident used it. If a medication was found, a med cup would be brought in to collect the medication and the physician would be notified.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, staff interviews, facility recipes, and policy review, the facility failed to ensure the nutritive value of puree food. The deficient practice could result in residents receiving food with altered nutritive value. Findings include: During an observation conducted on May 8 2025 at 10:57 AM in the kitchen, the cook (staff #75) was observed preparing puree food for one resident (#314). Staff (#75) placed one portion size of turkey into the blender, adding 20 ounces of apple juice with one ounce of thickener and proceeded to blend. Staff (#75) removed the pureed content from the blender, placing into a container. Stated it was ready to be heated and served. Staff #75 stated he is able to determine when a pureed mixture is at the right consistency, based on his years of experience and by visual observation. A taste test was conducted of the pureed turkey by the surveyor, staff #75, Culinary Manager (Staff #17) and Registered Dietitian (Staff #258, the flavor of the turkey puree tasted of apple juice, sweet and no longer tasted of turkey this was confirmed by all. Culinary Manager (Staff #17) stated the use of apple juice is used for all pureed meals to decrease the salt content in the resident's food. Resident #258 had an order for regular, puree consistency. Culinary Manager (Staff #17) further stated once the gravy is added to the pureed turkey, it would then taste like turkey. Culinary Manager (Staff #17) stated she was unaware that an observation should be made of the entire pureed meal; and stated, that's the first time that has ever been done. Staff (#75) proceeded to place the stuffing into the blender without washing the container from the turkey. Staff (#258) intervened the process and washed the container. Staff (#75) added one #12 scoop of stuffing to the container and an unmeasured amount of apple juice, blended and removed to be heated and served. The result was a gritty, sweet texture. Staff #75 asked, do you want me to blend it again? and was informed to follow his process. Staff removed the pureed stuffing placing on a plate to be heated and served. The third item for puree was green beans. Staff #75 placed a #12 scoop of green beans, two ounces of apple juice and 2 ounces of thickener. Staff #75 proceeded to blend the mixture, stopping twice to added unmeasured apple juice and unmeasured amounts of thickener to the blender. When adding the unmeasured amount of thickener, Staff #75 would dip the cup into the container of thickener, each time placing the cup back on the table surface. A request was made to taste the green bean mixture, again tasted by staff #75 and staff #258. The texture was a smooth, thick consistency, and the flavor of apple juice. An interview was conducted on May 9, 2025 11:10 AM with Registered Dietitian Staff (Staff # 258). Staff #258 stated the cook (staff #75) did not follow the recipe for the meal puree and did note that the turkey did have a sweet taste. Staff # 258 stated maybe once gravy was poured over the turkey, it would make it taste better. An interview was conducted on May 9, 2025 11:48 AM with the Culinary Manager (Staff #17), who stated. Staff # 75 stated he had become frustrated and nervous with being observed and with the surprise of having to puree all portions of the meal. Staff #258 reviewed the recipes for the meal, resident #258 and cross contamination of the thickener. Staff #258 stated, while the turkey was slightly sweet, the added gravy would have made it taste more like turkey. Stated would not add apple juice to a regular meal for a resident; and that, placing the cup into the thickener container with his hands did not cause any cross contamination because, the surface of the table had been cleaned before the meal prep. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Therapeutic Diets and Meal Plans states the facility provided therapeutic diet/meal plans as nutrition intervention when resident's medication/nutrition diagnosis has identified the need for modification in the resident's meal plan. 5. Diet orders are written to match the terminology in the approved diet manual and therapeutic menu.