STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035207	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springdale Village Healthcare	7255 East Broadway Road Mesa, AZ 85208

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on clinical record review, resident and staff interviews, and policy review, the facility failed to ensure two of three sampled residents (#15 and #43) reviewed for advance directives right to formulate an advance directive. The deficient practice could result in residents not receiving proper care according to their preferences or potential harm to the resident ' s life. Findings Include: -Regarding Resident #15 Resident #15 was admitted to the facility on [DATE] with diagnoses that included pneumonia, COVID-19, chronic obstructive pulmonary disease, hypoxemia, type 2 diabetes, protein-caloric malnutrition, anxiety, and dysphagia (difficulty swallowing). A physician ' s order dated February 6, 2023 was written for full code. A care plan initiated on February 6, 2023 revealed a focus on Resident #15 having an advance directive of full code with an intervention to call for help immediately and begin basic life support if the resident became unresponsive. A Medicare 5-Day Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score was 13, which indicated no cognitive impairment. There was no electronic or physical evidence in Resident #15 ' s clinical record of a signed advance directive or acknowledgement. Additionally, there was no evidence of a discussion with the resident or his representatives regarding his code status. -Regarding Resident #43 Resident #43 was admitted to the facility on [DATE] with diagnoses that included local infection of the skin and subcutaneous (fatty tissue just below the skin) tissue, sepsis (the body's overwhelming and life-threatening response to infection that can lead to tissue damage, organ failure, and death), pneumonia due to streptococcus (bacterial) pneumoniae, COVID-19, acute systolic heart failure, history of traumatic brain injury, type 2 diabetes, hypertension, depression, and morbid obesity. A physician ' s order dated January 27, 2023 was written for full code. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A care plan initiated on January 27, 2023 revealed a focus on Resident #43 having an advance directive of full code with an intervention to call for help immediately and begin basic life support if the resident became unresponsive. There was no electronic or physical evidence in Resident #43 ' s clinical record of a signed advance directive or acknowledgement. Additionally, there was no evidence of a discussion with the resident or his representatives regarding his code status. An interview was conducted on April 9, 2025 at 8:15 a.m. with a Registered Nurse (RN/Staff#111) who stated that the facility ' s process for advance directive paperwork was to complete the physical form right away. The RN stated that the document would ultimately be uploaded and located in the Electronic Medical Record (EMR), but there should always be a copy of it in the building. An interview was conducted on April 9, 2025 at 8:28 a.m. with a Certified Nursing Assistant (CNA/Staff#115) who stated that if a resident were found unresponsive, she would need to find the full code or do not resuscitate (DNR) paperwork in the EMR or report sheet at the nurses station. An interview was conducted on April 9, 2025 at 9:58 a.m. with a Licensed Practical Nurse (LPN/Staff#201) who stated that on admission, staff needed to have residents or representatives sign a lot of paperwork that included advance directives. The LPN stated that they would input the code status into the EMR and physically store the paperwork with the Director of Nursing (DON). The LPN stated that the facility did not store hard charts at the nurses station, and if there was a refusal to sign paperwork it would need to be documented in the medical record. The LPN stated that the risk of not having physical or electronic documentation in the EMR would be that residents may not have their wishes honored, and it could be a problem in case of an emergency. An interview was conducted on April 9, 2025 at 10:46 a.m. with the Director of Nursing (DON/Staff#123) who stated that it was her expectation on admission for staff to complete the advance directive paperwork with the residents or their families. The DON stated that a copy of the advance directives should be maintained as a physical copy at the nurses stations, and there should always be something filled out on the forms. The DON stated that the risk of not filling out the advance directive paperwork would be that residents may not have their preferences honored, and they could be rehospitalized . The DON also stated that she could not find evidence of advance directives in the physical or electronic charts of Resident #15 or Resident #43. Review of a policy titled, Advance Directives, revealed that the facility needed to inform and provide written information to all residents regarding their right to accept or refuse medical treatment. The policy also revealed that a copy of the resident ' s advance directive was required to be included in the medical record after the advance directive had been issued.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews with staff, and facility policies, the facility failed to ensure that 2 residents (#23 & #62) representatives were informed after a change in condition. Findings include: Resident #23 was admitted on [DATE] with diagnoses of metabolic encephalopathy, Parkinson's disease, and cerebral infarction. A care plan initiated on December 28, 2022 included that this resident was at risk for falls related to weakness and/or debility. A 5-day scheduled assessment Minimum Data Set (MDS) dated [DATE] included that this resident was moderately cognitively impaired and that this resident required extensive assistance for most activities of daily living including transfers. A narrative note dated January 15, 2023 included that this resident experienced a fall and that provider was notified of the fall however, family not notified. An interview was conducted on April 10, 2025 at 10:02 A.M. with a Registered Nurse (RN/staff #23) who said that a soon as a resident falls, staff do an assessment, perform a head to toe skin check, start neurological monitoring, and once the resident is deemed safe to move, the staff will get the resident back in bed, and then do a risk management assessment and start monitoring for a change in condition. This nurse said that staff will inform the Director of Nursing, the resident's family members and the resident's provider. An interview was conducted on April 10, 2025 at 10:24 A.M. with the Director of Nursing (DON/staff #200) This DON said that her expectations for a fall would be that staff would do a head to toe to make sure there were no injuries, check vitals, then make the Medical Doctor, the resident's family and herself aware, and then fill out risk assessment out. This DON said that it does not meet her expectation that a family was not notified and said that there's the risk of the family no knowing and getting upset, and there's a risk of harm if the resident is confused and is unable to provide an accurate history when family would know. An interview was conducted on April 10, 2025 at 10:24 A.M. concurrently with a clinical resource (staff #240) who reviewed resident #23's clinical record and said that there was nothing in the record regarding notification of the family. Regarding Resident #62: Resident #62 was admitted on [DATE] with dysphagia, hemiplegia, hemiparesis, cognitive communication deficit, and depression. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated April 5, 2023 revealed Resident #62 was discovered walking outside the front door of the facility around 7:00 p.m. to 7:30 p.m. The resident was redirected by staff to his room and the nurse notified a corporate nurse. A progress note dated April 7, 2023 at 4:02 p.m., revealed that the resident was found outside the building, and that a social worker reported that per the Administrator, the resident was to be sent to an emergency room, and a case manager would notify family. A progress note dated April 8, 2023 indicated that Resident #62 was transported from the facility at 7:00pm and that the outgoing nurse had reported that a case manager was to call family. The clinical record dated April 7, 2023 through April 8, 2023, revealed no evidence that the family was notified. An interview was conducted with a Licensed Practical Nurse (LPN/Staff # 201) on April 10, 2025 at 10:21 a. m., stated that if an elopement takes place, the Director of Nursing (DON) or Executive Director (ED) can delegate contacting the family to the nurses. who would document in the Electronic Medical Record (EMR) in our progress notes any contacts or attempted contacts to family. An interview was conducted with the DON (Staff # 9) stated family, physician, and all other appropriate agencies would be notified when a resident elopes. The DON reviewed Resident #62's clinical record and stated that when Resident #62 left the building the first time all notifications and assessments were not appropriately made as well as no care plans indicating the resident's risk for elopement. A review of the facility's policy on Elopement/Unsafe Wandering dated September, 2024 included that when the resident has been located and/or returns to the facility, the attending physician and resident representative will be notified of the resident's return and the resident status. A policy titled Fall Management system reviewed March, 2025 included that the attending Physician and family/responsible party shall be notified of the fall and the resident status.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews with staff, and facility policies, the facility failed to ensure that professional standards were followed in regards to care planning and an interdisciplinary review of the fall regarding one resident (#210). Findings include: Resident #210 was admitted on [DATE] with diagnoses of encephalopathy, aphasia, and depression. An admission Minimum Data Set (MDS) dated [DATE] included that this resident was severely cognitively impaired and that this resident required partial/moderate assistance for transfers from chair to bed and toilet transfers. A care plan initiated on March 19, 2025 included that this resident was at risk for falls related to to a history of falls and cognitive impairment. This care plan's latest update was on March 20, 2025. A nursing note dated March 21, 2025 included that the resident was observed on the floor by the Certified Nursing Assistant (CNA) and that the resident said that she slid off the bed. This note included that the nurse assessed the resident and the resident has stable VS. BP 131/85, 86 bpm, 98.3, 96% RA, 20rr. This note included that the resident denied pain and had no loss of mobility and that the provider, the Director of Nursing and family member were notified. A nursing note dated April 1, 2025 included this nurse heard a CNA calling for help, went to a resident room to the CNA and observed the resident sitting on the floor with her back to the bathroom door. This note included that the resident said that she walked into the door and fell and has a bruised and small hematoma to her forehead. This note included that an assessment was performed, the resident helped back into bed and that the resident's family and providers were notified. However, no care plan update or interdisciplinary meeting was found in the clinical record for these falls. An interview was conducted on April 10, 2025 at 10:02 A.M. with a Registered Nurse (RN/staff #23) who said that a soon as a resident falls, staff do an assessment, perform a head to toe skin check, start neurological monitoring, and once the resident is deemed safe to move, the staff will get the resident back in bed, and then do a risk management assessment and start monitoring for a change in condition. This nurse said that staff will inform the Director of Nursing, the resident's family members and the resident's provider. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on April 10, 2025 at 10:24 A.M. with the Director of Nursing (DON/staff #200) This DON said that her expectations for a fall would be that staff would do a head to toe to make sure there were no injuries, check vitals, then make the Medical Doctor, the resident's family and herself aware, and then fill out risk assessment out. This DON said that it does not meet her expectation that a family was not notified and said that there's the risk of the family no knowing and getting upset, and there's a risk of harm if the resident is confused and is unable to provide an accurate history when family would know. An interview was conducted on April 10, 2025 at 10:24 A.M. concurrently with a clinical resource (staff #240) who reviewed resident #23's clinical record and said that there was nothing in the record regarding notification of the family. A policy titled Fall Management System reviewed March, 2025 included that it is the policy of this facility to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs. This document included that a resident's existing care plan will be updated. The care plan interventions will address those elements determined by investigation as probable causal factors that contributed to the fall.

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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	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 one resident's (#110) medication was administered according to physician orders. The deficient practice could result in medication errors that could harm residents. Findings include: Resident #110 was admitted to the facility on [DATE]. 2023 with a diagnosis of anemia in chronic kidney disease, chronic obstructive pulmonary and type 2 diabetes. Review of the MDS (Multiple Date Set) dated February 24. 2023 reveals a BIMS (Brief Interview for Mental Status) score of 15, indicating no cognitive impairment. Review of the discharge instructions and medication orders from the hospital state cyclobensaprine 10 mg oral tablet, 1 tab oral three times a day as needed for spasms. Review of the orders upon admission to the facility, that were transcribed from the hospital discharge sheet show the same order states cyclobenzaprine HCl oral tablet 10 mg, give 3 tablet by mouth every 8 hours as needed for spasms. Review of the MAR TAR (Medication Administration Record and Treatment Administration Record) for February 2023 reveal Resident #110 received the incorrect dose of cyclobenzaprine on the following dates: February 1, 2023 in the AM, February 24, 2023 in the AM, February 25, 2023 in the AM and PM, February 26, 2023 in the AM and February 27, 2023 in the AM. Review of the MAR TAR for March 2023 reveal Resident #110 received the incorrect dose of cyclobenzaprine on the following dates: March 1, 2023 in the AM, March 2, 2023 in the AM, March 3, 2023 in the AM and the PM, March 5, 2023 in the AM and March 7, 2023 in the AM. On March 7, 2023 at 7:00 PM the order was changed to read cyclobenzaprine HCl oral tablet 10 mg, give 1 table by mouth every 8 hours as needed for spasms. Review of the MAR TAR from March 8, 2023 through March 23, 2023 reveal the medication was given according to physician orders. An interview was conducted on April 10, 2025 at 11:01 AM with Director of Nursing (staff #200). She stated the orders are transcribed from the discharge instruction from the hospital when a resident admits. Pharmacy reviews the medication and so does staff #200 to ensure doses are accurate and then they are verified with the physician. When asked to review the cyclobenzaprine order, staff #200 stated oh, that is wrong, She was overmedicated. I cannot speak to what happened because the facility had different owners at that time. Review of the facility's policy for Nursing Services/Physician Orders dated May 2021 and reviewed on (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	August 2021, August 2022, August 2023 and August 2024 states admission orders are reviewed with the physician upon admission based on the discharge instructions from the discharging facility and are transcribed accordingly.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, facility documentation and policy review, the facility failed to properly monitor one of three sampled residents (#62) who were at risk of elopement. The deficient practice could result in elopement, and physical injury. Findings include: Resident #62 was admitted on [DATE] with dysphagia, hemiplegia, hemiparesis, cognitive communication deficit, and depression. There was no evidence of a completed admission Minimum Data Set (MDS) assessment. An Elopement Screen dated April 5, 2023, revealed that the resident had a history of wandering, exhibited exit seeking behavior, and had no previous history of exiting a facility or home without supervision. The resident was determined to be at risk to elope and to be placed on elopement risk protocol. A care plan was initiated April 7, 2025, revealed there was no evidence of a focus or risk of elopement placed in the comprehensive care plan. Review of the clinical record revealed no evidence of a wander risk assessment after the elopement. A progress note dated April 5, 2023, revealed Resident #62 was discovered walking outside the front door of the facility around 7:00 p.m. to 7:30 p.m., the resident was redirected by staff to his room and the nurse notified a corporate nurse. Further review of the clinical record revealed no evidence that the provider or family were notified. A progress note dated April 7, 2023 at 4:02 p.m., revealed that the resident was found outside the building, and that a social worker reported that per the Administrator, the resident was to be sent to an emergency room, and a case manager would notify family. A progress note dated April 8, 2023 indicated that Resident #62 was transported from the facility at 7:00pm and that the out going nurse had reported that a case manager was to call family. The clinical record dated April 7, 2023 through April 8, 2023, revealed no evidence that the family was notified. An interview with a Licensed Practical Nurse (LPN/Staff # 201) on April 10, 2025 at 10:21 a.m., stated that residents are assessed for elopement risk on admission. If a resident is assessed to be an elopement risk, they wear special bands on their wrist letting us know that they are at risk. The LPN stated that when a resident elopes staff will look for the resident and notify either the Director of Nursing (DON) or the Executive Director (ED). If we locate the resident, we get the resident back into the building and assess resident for any injuries. The LPN stated that the DON or ED would be the one to inform the family. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the DON (Staff # 9) on April 10, 2025 at 11:35 a.m., stated that residents are identified as an elopement risk by doing an assessment on admission, and that the resident would be given a yellow wrist band indicating that the resident would be an elopement risk. The DON also stated that a focus of elopement would be added into the care plan to monitor resident for unsafe wandering. If an elopement occurs, a code yellow is called and the staff will start looking for resident. If we cannot find resident, we notify police and family. Once resident is found we bring back to facility and assess the resident for any injuries, then we go through notifications of family, physician, and all other appropriate agencies. The DON reviewed Resident #62's clinical record and stated that when Resident #62 left the building the first time all notifications and assessments were not appropriately made, as well as no care plans indicating the resident's risk for elopement. A review of the facility's policy on Elopement/Unsafe Wandering dated September 2024, included that the facility will assess residents with capabilities of ambulation or mobility in wheelchair to determine risks for elopement and unsafe wandering on admission and with observed behaviors of wandering or attempts to elope. The policy also revealed that residents that are at risk for elopement will have individualized care plan developed that includes measurable objectives and timeframes.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, facility policy review, State Agency complaint tracking system, the facility failed to ensure medical records were complete and readily accessible for one resident (#110). The deficient practice could result pertinent medical information being missed by staff members which could be harmful. Findings include: Resident #110 was admitted to the facility on [DATE]. 2023 with a diagnosis of anemia in chronic kidney disease, chronic obstructive pulmonary and type 2 diabetes. Review of the MDS (Minimum Data Set) assessment dated [DATE]. 2023 reveals a BIMS (Brief Interview for Mental Status) score of 15, indicating no cognitive impairment. The complaint filed at the State Agency on March 9, 2023, revealed that while the resident was admitted to the facility she did not receive the insurance authorized time for therapy. Review of the facility documentation revealed the facility ownership had changed on March 1, 2025. The clinical record revealed no documentation of any entries prior to March 1, 2025. An interview was conducted on March 8, 2025 at 1:10 PM with the Administrator, staff #100. He stated the facility could not obtain certain parts of the electronic records from the previous owners. He had contacted them and the access was denied. An interview was conducted on April 10, 2025 with the Therapy Director, (staff #800) who stated he was assisting staff members in trying to obtain the records needed but were not able to access anything previous to February 1, 2025. The State of Arizona law Statue 12-2297 states a health care provider must retain the original or copies of an adult patient's medical records for at least six years after the after the last date the patient received medical or health care services from that provider, according to the Arizona legislature.