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	03/30/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - 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 interviews, review of the clinical record, review of facility documentation, and review of facility policy and procedures, the facility failed to ensure that physician orders for weekly weights were followed for two residents (#77 and #14) in accordance with professional standards. The deficient practice could result in a lack of monitoring of weight changes and malnutrition. -Regarding Resident #77 Resident #77 was admitted to the facility on [DATE], with diagnoses that included displaced trimalleolar fracture of the right lower leg, muscle weakness, lobar pneumonia, coccidioidomycosis, type 2 diabetes, schizophrenia, depression, chronic kidney disease, polyneuropathy, hyperlipidemia, and a history of transient ischemic attack and cerebral infarction. A physician's order dated February 5, 2026, revealed weekly weights for 4 weeks, every day shift, every 7 days for 4 weeks. An admission nutrition evaluation dated February 6, 2026, revealed that the resident was at risk for malnutrition with a mini nutrition assessment (MNA) score of 8.0. A progress note dated February 6, 2026, at 10:24 a.m. revealed that an MNA was conducted, and found the resident to be at risk for malnutrition with a score of 8.0. A weight summary revealed a weight taken on February 6, 2026, at 1:22 p.m. of 219.6 Lbs on a mechanical lift scale. A weight summary revealed a weight taken on February 22, 2026, at 2:25 p.m. of 219.6 Lbs on a mechanical lift scale. An admission Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. A care plan focus revised on March 13, 2026, revealed a focus on the resident's nutritional problem or potential problem, and revealed that she was at risk on the Mini Nutritional Assessment with interventions to monitor and report to the doctor as needed for signs and symptoms of decreased appetite or unexpected weight loss. The care plan also revealed an intervention initiated on February 10, 2026, to complete weekly weights for 4 weeks and then monthly if stable. Review of the electronic medication and treatment administration record (eMAR/eTAR) revealed that a weight value was taken on February 6, 2026, and February 13, 2026, and the resident refused to be weighed on February 27, 2026. The eMAR/eTAR revealed no evidence that a weight was taken or refused by the resident on February 20, 2026. -Regarding Resident #14 Resident #14 was admitted to the facility on [DATE], with diagnoses that included metabolic encephalopathy, muscle weakness, cognitive communication deficit, asthma, and hypothyroidism. A physician's order dated March 2, 2026, revealed weekly weights for 4 weeks, every day shift, every 7 days for 4 weeks. A care plan focus initiated on March 2, 2026, revealed a focus on the resident's nutritional problem or potential problem, and revealed that she was at risk on the Mini Nutritional Assessment with interventions to monitor and report to the doctor as needed for signs and symptoms of decreased appetite or unexpected weight loss. A progress note dated March 5, 2026, at 12:43 a.m. revealed that an MNA was conducted, and found the resident to be at risk for malnutrition with a score of 9.0. A progress note dated March 10, 2026, at 5:53 p.m. revealed that they were unable to obtain a weight. A progress note dated March 17, 2026, at 5:32 p.m. revealed that the Restorative Nursing Assistant (RNA) was scheduled to obtain the resident's weight the next day. A weight summary revealed a weight taken on March 5, 2026, at 10:29 a.m. of 156.6 Lbs on a wheelchair scale. A weight summary revealed a weight taken on March 20, 2026, at 5:51 p.m. of 156 Lbs on a standing scale. A Medicare (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5-Day Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 07, which indicated severe cognitive impairment. An admission nutrition evaluation dated March 9, 2026, revealed that the resident was at risk for malnutrition with an MNA score of 9.0. Review of the eMAR/eTAR revealed no evidence that a weight value was taken on March 3, 2026, or March 24, 2026. It was also revealed that on March 10, 2026, and March 17, 2026, weight values were not taken with an indication to see the nursing notes. An interview was conducted on March 30, 2026, at 1:47 p.m. with a Restorative Nursing Assistant and Certified Nursing Assistant (RNA/CNA/Staff#40), who stated that it was the facility's process to weigh every resident at least monthly, but that they do weekly weights for residents who have orders from the doctor for weekly weights. The CNA stated that weights were documented in the CNA tasks in the electronic health record (EHR), and that if she noticed changes in a resident's meal consumption or weight changes, she would communicate with the dietician and nursing staff, and they would request weights for the resident. The CNA stated that she could recall Resident #77, and that she only remembered weighing her once. The CNA further stated that Resident #77 did not eat well, and they often had to feed the resident because she wouldn't eat on her own. The CNA stated that she was sure the resident lost weight because of how little she was eating. An interview was conducted on March 30, 2026, at 1:58 p.m. with Licensed Practical Nurse (LPN/Staff#26), who stated that newly admitted residents were weighed once a week at least, and that weights were documented in the medical chart. The LPN stated that the doctor would be notified of weight changes and that she would reach out to the doctor if a resident experienced a weight loss greater than 2 pounds a week. The LPN stated that the physician would put in an order for weekly weights for select residents, and that the importance of following the physician's order for weekly weights was to ensure that residents were getting proper nutrients and that there was no concern with their intake. The LPN stated that the risk of not following the physician's order for weekly weights was malnutrition. The LPN opened the medical record for Resident #77 and stated that she was admitted on [DATE], and was discharged on March 21, 2026. The LPN further stated that Resident #77 had a physician's order initiated on February 5, 2026, for weekly weights on the day shift, every 7 days, and for 4 weeks, but that the physician's order was not followed because Resident #77 only had 2 weights taken from February 5, 2026, to March 21, 2026. The LPN stated that she was Resident #77's nurse a few times, she did not think that she had weight orders for her, and she could not tell the resident was losing weight because she would not get out of bed despite the nursing staff's attempts to get her up. An interview was conducted on March 30, 2026, at 2:22 p.m. with a Dietetic Technician (DT/Staff#31), who stated that weights should have been done weekly for residents who were at risk for malnutrition on admission and for newly admitted residents. The DT stated that the doctor would put in the order for weekly weights for 4 weeks, even if it was a readmission, and that her process for ensuring that residents were eating a sufficient amount was by looking at their weekly weights and meal intake, as it was documented in the medical chart. The DT stated that concerns were communicated to the Director of Nursing (DON/Staff#87), and that the RNA/CNA, Staff #40, would take the resident's weights. The DT stated that she remembered Resident #77, and she could recall that the resident had a decreased meal intake. The DT looked at the medical chart and stated that the resident was admitted on [DATE], and was discharged on March 21, 2026, and that during her stay, she was only weighed 2 times, both at 219.6 pounds, and that 2 weights were struck out in the medical chart. The DT stated that she struck out the resident's final weight of 200.6 pounds, 2 days after the resident was discharged . The DT further stated that she struck it out because she wanted her to be reweighed, but that if the resident was already gone when she struck it out, she would say the resident's final weight in the facility would be 200.6 pounds, despite her striking it. The DT stated that Resident #77 should have been weighed weekly because it was part of their protocol, and that based on the medical chart, the physician's orders were not followed for the 4 weekly weights. An interview was conducted on March 30, 2026, at 2:44 p.m. with the Director of Nursing (DON/Staff#87), who stated that their (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	long-term care residents were expected to be weighed monthly, and that newly admitted residents would be on weekly weights for 4 weeks. The DON stated that weights were documented under the eMAR and eTAR, and that refusals would also be documented. The DON stated that the importance of following physician orders for weekly weights was to identify if there was a major loss or gain, so they could understand why there was a weight change. The DON further stated that the risk of not following the physician's orders for weekly weights would be that they wouldn't be able to identify the weight changes. The DON opened resident #77's medical chart and stated that she only had two weights taken while she was at the facility, and that she had an order initiated on February 6, 2026, for weekly weights for 4 weeks. The DON opened the eMAR and stated that, according to the documentation, the physicians' order was not followed, and that there was a hole in the documentation on the eMAR. The DON further stated that it was his expectation that staff would document a reason for the weight not being done, and that if there was a refusal, they would circle back with the resident. Review of a policy titled Physician Orders, with a revision date of March 2026, revealed that the facility's policy was to accurately implement orders, including medication orders, treatments, and procedures. The policy further revealed that treatment or related procedure orders would be transcribed in the eMAR and eTAR. Review of a policy titled, Vital Signs - Weight and Height, with a revision date of March 2025, revealed that a resident's height and weight would be recorded as the physician's orders indicate, and should be documented in the health record. The policy also revealed that if the resident was unable to be weighed, the reason should have been recorded, and other provisions should be taken to monitor the resident's size.