STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035253	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookdale Santa Catalina	7500 North Calle Sin Envidia Tucson, AZ 85718

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interviews, the State Agency's (SA) complaint portal, and review of the facility's policies and procedures, the facility failed to ensure their Neglect policy was implemented in that an allegation of neglect was not reported to the SA within the required timeframe and the investigation of the alleged neglect was not documented. The deficient practice could lead to residents feeling unsafe and/or having their needs unmet while receiving care at the facility.Findings include:A facility self-report was submitted to the SA on April 20, 2026 at 11:51 A.M., which revealed that a Nursing Student had voiced an allegation of neglect to Registered Nurse (RN/Staff #2). The report further revealed that a Certified Nursing Assistant (CNA/Staff #13) neglected the residents in her unit when she failed to provide cares to them.Review of the facility's 5-day report revealed that a Nursing Student had initially made an allegation of neglect on March 27, 2026 to Staff #2. The report indicated that upon receiving the initial allegation, Staff #2 then reported it to the facility's former Administrator (Staff #9). The report further indicated that the facility made initial report of neglect to the SA on April 17, 2026, approximately 21 days after the allegation was made, and then initiated an investigation.An interview was conducted on May 29, 2026 at 9:19 A.M. with RN/Staff #2. Staff #2 described neglect as a delay of care, staff isolation of residents, not giving residents their medications, or not implementing resident interventions. Staff #2 explained that suspected neglect is reported to the abuse coordinator, who was formerly the facility Administrator (Staff #9), and is now reported to the Social Services Director (SSD/Staff #41). Staff #2 shared that towards the end of her shift, a Nursing Student approached her and reported that several nursing students were upset because the CNA (Staff #13) had not changed the residents on her unit. Staff #2 stated she then called Staff #9 to notify him of the neglect allegation; however, he did not answer his phone. Staff #2 stated she then instructed the Nursing Student to fill out the complaint/grievance form, took a picture of the completed form, and texted it to Staff #9. Staff #2 stated that she received a call from Staff #9 that same night at 10:45 P.M. and relayed to him what was reported by the Nursing Student. Staff #2 also recalled that Staff #9 had told her that he was in the building earlier that day and had spoken with Staff #13 and had observed her entering and leaving resident rooms. Staff #2 indicated that after speaking with Staff #9, she did not receive status updates on the outcome of the facility's investigation and stated that she does not typically receive that type of information.An interview was conducted on May 29, 2026 at 10:07 A.M. with SSD/Staff #41. Staff #41 stated that suspected cases of neglect is reported to the abuse coordinator which currently is herself. She explained that a complaint/grievance form is completed and is assigned to either herself, the Director of Nursing (DON), or the Administrator to investigate depending on the nature allegation. Staff #41 further explained that allegations of neglect are to be reported to the SA within 24 hours. Staff #41 further explained that allegations of neglect are to be reported to the SA within 24 hours. She added that complaint/grievance forms are maintained in a binder in her office and recalled a grievance form being completed in March 2026. Upon retrieving the binder, Staff #41 stated she was unable to locate the specific grievance form alleging neglect. She recalled Staff #2 placing the form under her office door and noted that they only individuals with access to her office were the maintenance person, the former Administrator (Staff #9) and herself. Staff #41 stated that she was aware of the (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035253	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookdale Santa Catalina	7500 North Calle Sin Envidia Tucson, AZ 85718

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	complaint/grievance form because it was sent via text message from Staff # 2 to herself, Staff #19, and Staff #9. Staff #41 further stated that she was not assigned to investigate alleged neglect, as Staff #9 had indicated he would conduct the investigation. Staff #41 explained that she did not hear anything further regarding the alleged neglect until several weeks later, when corporate office staff arrived at the facility and began interviewing her. It was at that time that she raised the alleged neglect issue, and the incident was subsequently reported to the SA by the corporate office. An interview was conducted on May 29, 2026 at 10:49 A.M. with the DON/Staff #19. Staff #19 acknowledged that a complaint/grievance form was sent via text message from Staff #2 to herself, Staff #41 and Staff #9 in March 2026 indicating that residents were soaking wet all day and remained unchanged. Staff #19 recalled speaking with Staff #9 and informing him that she was unable to follow up with the complaint/grievance due to a personal matter, and that he assumed responsibility for the follow-up. When asked to produce the original complaint/grievance form, Staff #19 stated it was located in Staff #41's office and went to retrieve it. Upon returning, Staff #19 reported that the original complaint/grievance form was missing; however, she retained the original text message on her cell phone and shared the image with the surveyor. Staff #19 described the picture as a statement from a Nursing Student indicating that residents were left soaking wet all day. Staff #19 recalled contacting Staff #2 for additional information regarding the complaint/grievance form, at which time Staff #2 had told her that the Nursing Students had provided cares to residents throughout the shift because Staff #13 was on her phone. Staff #19 added that upon returning to the facility the following Monday, she did not follow up on the incident.A telephonic interview was conducted on May 29, 2026 at 12:01 P.M. with the facility's former Administrator (ADM/Staff #9). Staff #9 described neglect as services not being provided to residents and gave the example of not changing them. Staff #9 stated that he was not notified of an allegation of neglect in March of 2026 and denied receiving a text message with a picture of the complaint/grievance form. Staff #9 stated that he was traveling at the time the incident allegedly took place; however, he did acknowledge that he was the abuse coordinator even while traveling and was expected to be available if neglect or abuse situations arose. Staff #9 stated there was no alternate abuse coordinator in place at that time. When surveyor read aloud the following statement written on the complaint/grievance form - multiple patients went their whole shift without being changed and properly cared for - Staff #9 stated that it did sound like an allegation of neglect.A telephonic interview was conducted on May 29, 2026 at 12:15 P.M. with the Senior Director of Clinical Services for Skilled Nursing (Staff # 44). Staff #44 stated that on April 16, 2026 the facility received an anonymous complaint via the company's Integrity Phone Line, alleging that facility management staff were not taking action regarding allegations of neglect. Staff #44 indicated that management staff were placed on suspension while an investigation was conducted. Staff #44 explained that during an interview with Staff #9, he shared a complaint/grievance made by a Nursing Student alleging that a CNA was not providing cares and services to residents. Staff #44 stated that Staff #9 indicated he had investigated the incident by speaking with residents and staff members, who raised no concerns regarding the cares provided by Staff #13, and therefore concluded that the alleged neglect had not occurred. However, Staff #9 did not provide documentation of his investigation. Staff #44 stated that the standard process requires the investigation to be documented. Staff #44 explained that once she became aware of the allegation of neglect, it was reported to the SA on April 17, 2026. Staff #44 also shared that the facility's policy on neglect requires that allegations of suspected neglect must be reported to the SA, and it that this requirement not followed.Review of the facility's policy and procedures titled, Abuse, Neglect, & Exploitation Policy, last revised in October 2022, revealed the policy defines neglect as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The policy further identifies the Administrator being responsible to ensure the policy is implemented, and describes the following steps to be taken should an allegation of neglect be made:The administrator or supervisor, on duty, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035253	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookdale Santa Catalina	7500 North Calle Sin Envidia Tucson, AZ 85718

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	are to take necessary steps to ensure residents are protected from continued neglect, suspend the staff member pending the outcome of the investigation.Investigate the potential neglect incident as soon as practicable by interviewing residents and staff members, and maintain a written record of the investigation.Report the alleged neglect incident externally to the SA.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035253	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookdale Santa Catalina	7500 North Calle Sin Envidia Tucson, AZ 85718

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interviews, the State Agency's (SA) complaint portal, and review of the facility's policies and procedures, the facility failed to ensure an allegation of neglect was reported to the SA within the timeframes required by the facility's policy and federal regulation. The deficient practice could lead to residents feeling unsafe and/or having their needs unmet while receiving care at the facility.Findings include:A facility self-report was submitted to the SA on April 20, 2026 at 11:51 A.M., which revealed that a Nursing Student had voiced an allegation of neglect to Registered Nurse (RN/Staff #2). The report further revealed that a Certified Nursing Assistant (CNA/Staff #13) neglected the residents in her unit when she failed to provide cares to them.Review of the facility's 5-day report revealed that a Nursing Student had initially made an allegation of neglect on March 27, 2026 to Staff #2. The report indicated that upon receiving the initial allegation, Staff #2 then reported it to the facility's former Administrator (Staff #9). The report further indicated that the facility made initial report of neglect to the SA on April 17, 2026, approximately 21 days after the allegation was made, and then initiated an investigation.Review of the SA's complaint portal found no other facility self-report alleging neglect around the alleged timeframe of March 27, 2026.An interview was conducted on May 29, 2026 at 9:19 A.M. with RN/Staff #2. Staff #2 described neglect as a delay of care, staff isolation of residents, not giving residents their medications, or not implementing resident interventions. Staff #2 explained that suspected neglect is reported to the abuse coordinator, who was formerly the facility Administrator (Staff #9), and is now reported to the Social Services Director (SSD/Staff #41). Staff #2 shared that towards the end of her shift, a Nursing Student approached her and reported that several nursing students were upset because the CNA (Staff #13) had not changed the residents on her unit. Staff #2 stated she then called Staff #9 to notify him of the neglect allegation; however, he did not answer his phone. Staff #2 stated she then instructed the Nursing Student to fill out the complaint/grievance form, took a picture of the completed form, and texted it to Staff #9. Staff #2 stated that she received a call from Staff #9 that same night at 10:45 P.M. and relayed to him what was reported by the Nursing Student. Staff #2 also recalled that Staff #9 had told her that he was in the building earlier that day and had spoken with Staff #13 and had observed her entering and leaving resident rooms. Staff #2 indicated that after speaking with Staff #9, she did not receive status updates on the outcome of the facility's investigation and stated that she does not typically receive that type of information.An interview was conducted on May 29, 2026 at 10:07 A.M. with SSD/Staff #41. Staff #41 stated that suspected cases of neglect are reported to the abuse coordinator which currently is herself. She explained that allegations of neglect are to be reported to the SA within 24 hours. Staff #41 recalled a grievance form being completed in March 2026 alleging neglect; however, upon retrieving the binder, where complaint/grievance forms are maintained, she was unable to locate the specific grievance form. Staff #41 stated that she was aware of the complaint/grievance form because it was sent via text message from Staff #2 to herself, Staff #19, and Staff #9. Staff #41 further stated she was not assigned to investigate the alleged neglect, as Staff #9 had indicated he would conduct the investigation, and that she had the impression that Staff #9 had also reported the incident to the SA. Staff #41 explained that she did not hear anything further regarding the alleged neglect until several weeks later, when corporate office staff arrived at the facility and began interviewing her. It was at that time that she raised the alleged neglect issue, and the incident was subsequently reported to the SA by the corporate office. An interview was conducted on May 29, 2026 at 10:49 A.M. with the DON/Staff #19. Staff #19 acknowledged that a complaint/grievance form was sent via text message from Staff #2 to herself, Staff #41 and Staff #9 in March 2026 indicating that residents were soaking wet all day and remained unchanged. Staff #19 recalled speaking with Staff #9 and informing him that she was unable to follow up with the complaint/grievance due to a personal matter, and that he assumed responsibility for the follow-up. Staff #19 added that upon returning to (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035253	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookdale Santa Catalina	7500 North Calle Sin Envidia Tucson, AZ 85718

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	the facility the following Monday, she did not follow up on the incident.A telephonic interview was conducted on May 29, 2026 at 12:01 P.M. with the facility's former Administrator (ADM/Staff #9). Staff #9 stated that he was not notified of an allegation of neglect in March of 2026 and denied receiving a text message with a picture of the complaint/grievance form. Staff #9 stated that he was traveling at the time the incident allegedly took place; however, he did acknowledge that he was the abuse coordinator even while traveling and was expected to be available if neglect or abuse situations arose. Staff #9 stated there was no alternate abuse coordinator in place at that time. When surveyor read aloud the following statement written on the complaint/grievance form - multiple patients went their whole shift without being changed and properly cared for - Staff #9 stated that it did sound like an allegation of neglect and it would need to be reported to the SA. A telephonic interview was conducted on May 29, 2026 at 12:15 P.M. with the Senior Director of Clinical Services for Skilled Nursing (Staff # 44). Staff #44 stated that on April 16, 2026 the facility received an anonymous complaint via the company's Integrity Phone Line, alleging that facility management staff did not take action regarding allegations of neglect. Staff #44 indicated that management staff were placed on suspension while an investigation was conducted. Staff #44 explained that during an interview with Staff #9, he shared a complaint/grievance made by a Nursing Student alleging that a CNA was not providing cares and services to residents. Staff #44 stated that Staff #9 indicated he had investigated the incident by speaking with residents and staff members, who raised no concerns regarding the cares provided by Staff #13, and therefore concluded that the alleged neglect had not occurred. Staff #44 stated that Staff #9 shared that he did not report the alleged abuse to the SA because he felt that it did not take place. However, Staff #9 did not provide documentation of his investigation. Staff #44 stated that the standard process requires the investigation to be documented. Staff #44 explained that once she became aware of the allegation of neglect, it was reported to the SA on April 17, 2026. Staff #44 also shared that the facility's policy on neglect requires that allegations of suspected neglect must be reported to the SA, and it that this requirement not followed.Review of the facility's policy and procedures titled, Abuse, Neglect, & Exploitation Policy, last revised in October 2022, revealed the policy defines neglect as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The policy further identifies the alleged neglect is to be made to the SA within 24 hours and the follow-up investigation report is submitted within 5 working days of the initial report.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035253	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookdale Santa Catalina	7500 North Calle Sin Envidia Tucson, AZ 85718

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. Based on interviews, the State Agency's (SA) complaint portal, and review of the facility's policies and procedures, the facility failed to ensure an allegation of neglect was thoroughly investigated and that the investigation was documented. The deficient practice could lead to residents feeling unsafe and/or having their needs unmet while receiving care at the facility.Findings include:A facility self-report was submitted to the SA on April 20, 2026 at 11:51 A.M., which revealed that a Nursing Student had voiced an allegation of neglect to Registered Nurse (RN/Staff #2). The report further revealed that a Certified Nursing Assistant (CNA/Staff #13) neglected the residents in her unit when she failed to provide cares to them.Review of the facility's 5-day report revealed that a Nursing Student had initially made an allegation of neglect on March 27, 2026 to Staff #2. The report indicated that upon receiving the initial allegation, Staff #2 then reported it to the facility's former Administrator (Staff #9). The report further indicated that the facility made initial report of neglect to the SA on April 17, 2026, approximately 21 days after the allegation was made, and then initiated an investigation.Review of the SA's complaint portal found no other facility self-report alleging neglect around the alleged timeframe of March 27, 2026 or a 5-day investigation report.An interview was conducted on May 29, 2026 at 9:19 A.M. with RN/Staff #2. Staff #2 described neglect as a delay of care, staff isolation of residents, not giving residents their medications, or not implementing resident interventions. Staff #2 explained that suspected neglect is reported to the abuse coordinator, who was formerly the facility Administrator (Staff #9), and is now reported to the Social Services Director (SSD/Staff #41). Staff #2 shared that towards the end of her shift, a Nursing Student approached her and reported that several nursing students were upset because the CNA (Staff #13) had not changed the residents on her unit. Staff #2 stated she then called Staff #9 to notify him of the neglect allegation; however, he did not answer his phone. Staff #2 stated she then instructed the Nursing Student to fill out the complaint/grievance form, took a picture of the completed form, and texted it to Staff #9. Staff #2 stated that she received a call from Staff #9 that same night at 10:45 P.M. and relayed to him what was reported by the Nursing Student. Staff #2 also recalled that Staff #9 had told her that he was in the building earlier that day and had spoken with Staff #13 and had observed her entering and leaving resident rooms. Staff #2 indicated that after speaking with Staff #9, she did not receive status updates on the outcome of the facility's investigation and stated that she does not typically receive that type of information.An interview was conducted on May 29, 2026 at 10:07 A.M. with SSD/Staff #41. Staff #41 stated that suspected cases of neglect is reported to the abuse coordinator which currently is herself. She explained that a complaint/grievance form is completed and is assigned to either herself, the Director of Nursing (DON), or the Administrator to investigate depending on the nature allegation. Staff #41 recalled a grievance form being completed in March 2026; however, upon retrieving the binder, Staff #41 stated she was unable to locate the specific grievance form. She recalled Staff #2 placing the form under her office door and noted that they only individuals with access to her office were the maintenance person, the former Administrator (Staff #9) and herself. Staff #41 stated that she was aware of the complaint/grievance form because it was sent via text message from Staff # 2 to herself, Staff #19, and Staff #9. Staff #41 further stated that she was not assigned to investigate alleged neglect, as Staff #9 had indicated he would conduct the investigation. Staff #41 explained that she did not hear anything further regarding the alleged neglect until several weeks later, when corporate office staff arrived at the facility and began interviewing her. An interview was conducted on May 29, 2026 at 10:49 A.M. with the DON/Staff #19. Staff #19 acknowledged that a complaint/grievance form was sent via text message from Staff #2 to herself, Staff #41 and Staff #9 in March 2026 indicating that residents were soaking wet all day and remained unchanged. Staff #19 recalled speaking with Staff #9 and informing him that she was unable to follow up with the complaint/grievance due to a personal matter, and that he assumed responsibility for the follow-up. When asked to produce the original complaint/grievance form, Staff #19 stated it was (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035253	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookdale Santa Catalina	7500 North Calle Sin Envidia Tucson, AZ 85718

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	located in Staff #41's office and went to retrieve it. Upon returning, Staff #19 reported that the original complaint/grievance form was missing; however, she retained the original text message on her cell phone and shared the image with the surveyor. Staff #19 described the picture as a statement from a Nursing Student indicating that residents were left soaking wet all day. Staff #19 recalled contacting Staff #2 for additional information regarding the complaint/grievance form, at which time Staff #2 had told her that the Nursing Students had provided cares to residents throughout the shift because Staff #13 was on her phone. Staff #19 added that upon returning to the facility the following Monday, she did not follow up on the incident.A telephonic interview was conducted on May 29, 2026 at 12:01 P.M. with the facility's former Administrator (ADM/Staff #9). Staff #9 stated that he was not notified of an allegation of neglect in March of 2026 and denied receiving a text message with a picture of the complaint/grievance form. Staff #9 stated that he was traveling at the time the incident allegedly took place; however, he did acknowledge that he was the abuse coordinator even while traveling and was expected to be available if neglect or abuse situations arose. Staff #9 stated there was no alternate abuse coordinator in place at that time. When surveyor read aloud the following statement written on the complaint/grievance form - multiple patients went their whole shift without being changed and properly cared for - Staff #9 stated that it did sound like an allegation of neglect.A telephonic interview was conducted on May 29, 2026 at 12:15 P.M. with the Senior Director of Clinical Services for Skilled Nursing (Staff # 44). Staff #44 stated that on April 16, 2026 the facility received an anonymous complaint via the company's Integrity Phone Line, alleging that facility management staff did not take action regarding allegations of neglect. Staff #44 indicated that management staff were placed on suspension while an investigation was conducted. Staff #44 explained that during an interview with Staff #9, he shared a complaint/grievance made by a Nursing Student alleging that a CNA was not providing cares and services to residents. Staff #44 stated that Staff #9 indicated he had investigated the incident by speaking with residents and staff members, who raised no concerns regarding the cares provided by Staff #13, and therefore concluded that the alleged neglect had not occurred. However, Staff #9 did not provide documentation of his investigation. Staff #44 also shared that the facility's policy on neglect requires that allegations of suspected neglect be thoroughly investigated and documented, and that this requirement was not followed.Review of the facility's policy and procedures titled, Abuse, Neglect, & Exploitation Policy, last revised in October 2022, revealed the policy defines neglect as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The policy further identifies the alleged neglect is to be investigated as soon as practicable by interviewing residents and staff members, and maintain a written record of the investigation.