

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035273	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2026
NAME OF PROVIDER OR SUPPLIER Splendido at Rancho Vistoso		STREET ADDRESS, CITY, STATE, ZIP CODE 13500 North Rancho Vistoso Blvd Tucson, AZ 85755	
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, and review of facility policy, the facility failed to ensure that staff knocked prior to entering the rooms of 4 residents (#11, #3, #13 and #29). The deficient practice could impact the resident's level of privacy and their psychosocial well-being. Findings include:-Regarding Resident #29:Resident #29 was admitted on [DATE] with diagnosis including chronic obstructive pulmonary disease, essential hypertension, major depressive disorder-recurrent, anxiety disorder, type 2 Diabetes Mellitus, shortness of breath, atrial fibrillation, use of anticoagulants, unsteadiness on feet, and muscle weakness.The annual MDS (minimum data set) dated May 22, 2026 revealed a BIMS (Brief Interview of Mental Status) score of 15, indicating that the resident was cognitively intact.An observation was conducted on July 22, 2026 at 8:06 AM in conjunction with licensed practical nurse (LPN/ staff #314) during medication administration. It was observed that staff #339 prepared the medications for resident #29, conducted hand hygiene and entered the room without knocking. -Regarding Resident #3:Resident #3 was admitted on [DATE] with diagnosis including essential hypertension, insomnia, depression, polyneuropathy, muscle weakness, unsteadiness on feet, abnormalities of gait and mobility, lack of coordination and primary osteoarthritis.The significant change MDS dated [DATE] revealed that the resident had a BIMS score of 08 indicating that the resident was moderately cognitively impaired.An observation was conducted on July 22, 2026 at approximately 8:12 AM in conjunction with staff #339 during medication administration. It was observed that staff #339 prepared the medications for resident #3, conducted hand hygiene and entered the resident's room without knocking.-Regarding Resident #13:Resident #13 was admitted on [DATE] with diagnosis including Alzheimer's disease, type 2 Diabetes Mellites, anxiety disorder, chronic pain, essential hypertension, insomnia, difficulty in walking, repeated falls and age-related osteoporosis.A review of the admission MDS dated [DATE] revealed no noted BIMS score, but indicated that the resident did present with short term and long-term memory problems.An observation was conducted on July 22, 2026 at approximately 8:19 AM in conjunction with staff #339 during medication administration. It was observed that medications were prepared for resident #13, hand hygiene was conducted and staff #339 entered the resident's room without knocking.-Regarding Resident #11Resident #11 was admitted on [DATE] with diagnosis including unspecified atrial fibrillation, essential hypertension, anxiety disorder, cerebral infarction without residual deficits and heart failure.The quarterly MDS dated [DATE] revealed that the resident had a BIMS score of 13, indicating that the resident was cognitively intact.An observation was conducted on July 22, 2026 at 8:38 AM in conjunction with staff #339 during medication administration. It was observed that the staff #339 prepared the medications for resident #11, took the medication cup, conducted hand hygiene and entered the resident's room without knocking.An interview was conducted on July 22, at (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, staff and resident interviews, and facility policy review, the facility failed to ensure that comprehensive care plans were updated, care plan conferences were conducted, and care plans were revised to reflect residents' current needs for 3 of 3 sampled residents (#11, #17, and #33). The deficient practice had the potential to result in residents and/or their representatives not participating in the development and review of the plan of care, not understanding the resident's current care needs and goals, and staff providing care that was not based on an accurate, current, and individualized care plan. Findings include: -Regarding resident #11 Resident #11 was re-admitted to the facility on [DATE], with a diagnosis that included heart failure, atrial fibrillation, anxiety disorder, and other symptoms and signs involving cognitive functions and awareness. A care plan revealed a focus area for recreational activities, and both her daughter and son are active in her care planning and, while in Tucson, offer support. When they are not in Tucson, the resident speaks with them daily. A quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating that the resident has intact cognition. During initial screening conducted on July 20, 2026 at 10:36 am, the resident stated that she could not recall being part of care plan meetings. Review of the Electronic Health Records (EHR) care plan meetings revealed an admission care plan meeting dated March 19, 2025, and a quarterly care plan meeting dated February 23, 2026. The attendees on March 19, 2025 were the resident, family, and identified staff. Attendees on February 23, 2026 were identified as family, the resident, and dietary staff. A telephonic interview was conducted with the resident's daughter on July 23, 2026 at 8:25 am. She stated that the facility did not have a care plan meeting this quarter and had not had one in a while. She stated it may have been because there were no changes with the resident. She stated they had met more often when the resident was receiving physical therapy, but not now as the resident has been stable. She further stated there has been no communication from the facility about why they have not conducted any care plan meetings. She stated, I am assuming it is because she is stable and has no concerns. An interview was conducted July 22, 2026, at 8:05 am with the administrator (Staff#725). Staff # 725 stated both she and the director of nursing were covering social services while they were on (continued on next page)		

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on staff interviews and review of facility documentation and policy, the facility failed to provide services of a registered nurse (RN) for at least eight consecutive hours a day, seven days a week. The census was 38. The deficient practice could result in resident not provided with advanced care activities to meet their needs. Findings Include: The Facility Assessment with completion date of February 7, 2026 revealed an average daily census range of 28-35 for long-term care and 2-7 for short stay. Staffing plan included one FT (full-time) Director of Nursing (DON), 1-3 Licensed nurses providing direct care, and other nursing personnel with administrative duties that would include the lead nurse, minimum data set (MDS), assistant director of nursing (ADON), and Medical Records. Per the assessment, there should be at least one RN per 24-hour period; individual nursing staff assignments were based on patient care needs and individual staff needs/training; and nursing shifts are twelve hours with a goal of consistent assignments. Review of facility punch detail for registered nurses for February and March 2026 revealed no evidence of RN coverage on the following dates: -February 7, 2026 for 24 hours-March 14, 2026 for 24 hours Review of the facility's daily posting for the following dates revealed no RN coverage for the 6 am-6 pm shift or the 6 pm- 6 am shift; -February 7, 2026 for 24 hours-March 14, 2026 for 24 hours An interview was conducted on July 24, 2026, at 10:01 am with Staffing Coordinator (Staff # 291). Staff #291 stated he staffs the facility with 3 nurses, including an RN and 5 certified nursing assistants, daily. He stated he will occasionally utilize registry staff to cover staffing needs. He stated he feels there is enough staff to complete their job duties and no issues filling vacant staffing areas. He stated staff is usually cooperative in filling call-offs. He stated there have been some identified issues with RN coverage on the weekends and that the facility is hiring staff to meet RN needs. Staff #291 reviewed the facility sign-in sheets, punch details, and the daily postings and confirmed there were no RN assigned on February 7, 2026, and March 14, 2026 for both the 6a-6p and 6 pm-6 am. An interview was conducted on July 24, 2026, at 10:18 am with the Director of Nursing (Staff#181) and Staffing Coordinator (Staff #291). Regarding the facility's staffing process and responsibilities. The DON stated that when identifying staffing needs for the facility, she will review staffing daily with the Staffing Coordinator (Staff #291). During check-in and check-out. She further stated she participates in the facility's on-call rotation and would begin on-call responsibilities the following Monday. The DON explained there is a monthly rotation in which she and the administrator alternate clinical on-call responsibilities, and there is a separate rotation for staffing coverage. The DON stated staffing needs are based on reviewing the schedule, noting that staffing ratios are generally adequate unless there is a staff call-off. The DON stated the facility can utilize agency staff when needed and had recently begun using a new staffing agency that has been more effective. The DON stated the facility addresses staff call-offs or additional staffing needs, including one-to-one resident supervision, by reviewing the staffing schedule and census to determine whether resident assignments can be adjusted or whether additional staff need to be called in. She stated the facility may contact available employees, request assistance from agency staff, or utilize certified nursing assistants from the independent living or assisted living units if appropriate. Regarding one-to-one resident supervision, the staff member stated the facility first determines whether the resident has an assigned caregiver and, if so, contacts the agency to determine whether coverage is available. The DON further stated the facility may reassign staff based on credentials, redistribute resident assignments to maintain floor coverage, request additional staff to report to work, or obtain agency staff when necessary. The DON stated in the event of a weekend call-off, the (continued on next page)		

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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** Based on observations, clinical record reviews, staff interviews and facility documentation and policy review, the facility failed to ensure there were no expired items readily available for resident use; failed to ensure that that medications were not left at bedside during medication administration; and, failed to provide for safe and secure storage for medication for two residents (#29, #1). The deficient practice could result in placing residents at risk for medication errors, unauthorized access, and potential adverse health outcomes. Findings include: Resident #1 was admitted to the facility on [DATE], with diagnoses including severe vascular dementia without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, difficulty swallowing (oropharyngeal dysphagia), a cognitive communication deficit, and generalized muscle weakness. A comprehensive Minimum Data Set assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 9, indicating moderately impaired cognition. The assessment further identified that the resident exhibited verbal behavioral symptoms directed toward others and received an antipsychotic, antidepressant, and anticoagulant medication during the lookback period. A physician's order dated June 15, 2026, directed staff to monitor the resident for hallucinations every shift and document the findings in a progress note. The resident's active medication regimen included multiple high-risk psychotropic medications, specifically quetiapine (an antipsychotic), hydroxyzine (an antianxiety medication), and sertraline (an antidepressant). A review of the clinical record revealed no self-administration assessment or orders for medication self-administration. During initial screening, an observation was conducted on July 20, 2026, at 12:30 p.m. in Resident #1's room. A tube of 2% miconazole nitrate (an antifungal ointment) was observed lying unsecured on the resident's bedside table. The resident was seated in his wheelchair next to the bedside table, with the medication within his reach. An interview was conducted on July 20, 2026, at 12:30 p.m. with Resident #1. The resident stated that a fire had occurred in his room that morning. He further stated he did not know where the antifungal ointment came from, and that he did not have a fungal infection. An interview was subsequently conducted with Licensed Practical Nurse (Staff #339/LPN) regarding fires. Staff #339 stated that no fire had occurred in the resident's room and stated that the facility was actively monitoring the resident for hallucinations A psychiatric follow-up assessment dated [DATE], at 9:15 a.m. also documented that the resident demonstrated ongoing confusion regarding his room location. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A second observation was conducted on July 20, 2026, at 1:53 p.m. The tube of miconazole nitrate ointment remained unsecured and accessible on the resident's bedside table. A review of Resident #1's active physician orders revealed no physician's order for miconazole nitrate ointment. Furthermore, a review of the resident's clinical progress notes and comprehensive care plan revealed no documented history of a fungal infection, no active treatment for a fungal infection, and no care plan interventions addressing fungal treatments. On July 21, 2026, at 8:49 a.m., during a third observation conducted in the resident's room with a Certified Nursing Assistant (Staff #754/CNA), the miconazole nitrate ointment was still observed unsecured on the bedside table. The CNA immediately removed the ointment from the room, stating it should not be kept at the bedside. During an interview conducted on July 21, 2026, at 8:49 a.m., CNA (Staff #754) defined a medication as any substance used to alter conditions orally, intravenously, rectally, or topically, and confirmed that an antifungal ointment is a medication. She stated that medications should never be kept at the bedside because residents with cognitive impairment or dementia could accidentally ingest them. An interview was conducted on July 21, 2026, at 8:56 a.m. with a Licensed Practical Nurse (Staff #240/LPN), who reviewed the resident's record and confirmed there were no orders or active diagnoses for a fungal infection, and she had never applied an antifungal ointment to the resident. She stated that topical medications must be stored in the treatment cart and are never allowed to be left at a resident's bedside. She stated that the risks associated with leaving medications unsecured at the bedside include misuse, application to the incorrect body part, or accidental oral ingestion. An interview was conducted on July 23, 2026, at 8:36 a.m. with the Interim Director of Nursing (Staff #191/DON), who stated that all topical medications must be stored in the medication cart unless there is a specific physician's order for self-administration. She reviewed Resident #1's record and confirmed he did not have any physician's orders for self-administration or bedside storage of medications. She stated that family members sometimes bring items into the facility and leave them in rooms. She stated that the risks of leaving medications unsecured at the bedside are heightened by the resident's severe cognitive impairment and his active hallucinations, as he could easily mistake the medication and ingest it. - Regarding Expired items: An observation of the main medication room was conducted with Licensed Practical Nurse (LPN/Staff #240) on July 21, 2026, at 11:15 a.m. During the observation, the following expired nutritional supplements were found in the bottom drawer of the refrigerator located in the medication room at the main nurses' station: Three unopened 237 mL cartons of Boost with a use-by date of October 2025. Each carton had 729 handwritten in black ink; Two unopened 237 mL cartons of Boost with a use-by date of July 2025. Each carton had 729 (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	handwritten on it; One 237 mL bottle of Ensure High Protein Shake with a use-by date of May 2026. The bottle had 729 handwritten on it; and, Two unopened 237 mL cartons of Nepro with a use-by date of October 2025. Each carton had a yellow facility barcode label on the front and 729 handwritten on it. The LPN (staff #240) stated that the supplements belonged to the resident in room [ROOM NUMBER]. She stated that the two cartons of Nepro were supplied by the facility because they had yellow stickers with facility barcode. She stated that the remaining supplements were provided by the resident's family. The LPN further stated that each nurse is responsible for checking that medications and supplements are not expired before administering them to a resident. However, she stated she did not know who was responsible for ensuring that expired items were removed from the medication room refrigerator. An interview was conducted with another LPN (staff #314) on July 21, 2026 at 12:03 p.m. The LPN said that at the beginning of each shift, she checks her medication cart. She stated there is a form at the main nurses' station that nurses sign to document that the medication cart was checked for expired medications and supplies and that no expired items were available for resident use. She further stated that she does not check the medication room for expired items because she believed that responsibility belongs to the central supply department. In an interview with the nurse concierge (staff #291) conducted on July 21, 2026 at 12:13 p.m., the nurse concierge stated that he was responsible for staffing and ordering supplies, including nutritional supplements and liquid protein products, but not medications. He stated that nursing staff would notify him when supplies, supplements, or liquid protein products were running low, and he places the orders. He said that when the supplies arrive, he checks the expiration dates before storing them. He stated that he would place some supplements in the medication room refrigerator and checks the expiration dates each time to ensure they were not expired. However, he stated that some residents' families provide nutritional supplements, and he does not check those items for expiration dates. An observation of the medication room at the main nurse station was conducted with the nurse concierge (staff #291) on July 21, 2026 at 12:20 p.m. The eight expired nutritional supplements previously identified that had been removed from the refrigerator and was found in the trash inside the medication room. He stated that he had not checked those items because they were brought in by the family of the resident in room [ROOM NUMBER]. he also stated that the expired supplements found in the medication room should have been discarded before that day. During an interview with the Director of Nursing (DON) conducted on July 21, 2026 at 12:45 p.m., the DON stated that the nurse concierge (staff #291) was responsible for ordering facility supplies, including nutritional supplements. The DON stated that, at least weekly, nurses and staff #291 would check the medication room for expired medications, supplements, and supplies; and, any expired items identified during these checks are discarded. The DON further stated that nurses check their medication carts at least weekly, or more often as needed, to ensure expired medications, (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	supplements, and supplies were removed and were not available for resident use. The DON stated that staff had been routinely checking the medication room for expired items and that she did not know how the expired supplements found during the observation had been missed. -Regarding Resident #29: Resident #29 was admitted on [DATE] with diagnosis including chronic obstructive pulmonary disease, essential hypertension, type 2 diabetes mellitus, major depressive disorder-recurrent, anxiety disorder, shortness of breath, atrial fibrillation, hereditary and idiopathic neuropathy, presence of cardiac pacemaker, chronic kidney disease-stage 3, and dysphagia. A review of the annual MDS (minimum data set) dated May 22, 2026 revealed a BIMS (brief interview of mental status) score of 15, indicating that the resident was cognitively intact. A review of the physician orders revealed an active order dated April 16, 2026 noting that the resident may self-administer creams and gels. The physician orders revealed no evidence that the resident had an order in place to self-administer oral medications. A review of the care plan revealed no evidence that the resident was authorized to self-administer oral medications A review of the electronic health record revealed no evidence that the resident was assessed for oral medication self-administration. An observation was conducted on July 22, 2026 at 8:06 AM in the room of resident #29. A licensed practical nurse (LPN/ staff 339) was observed during medication administration. Staff #339 was observed to sanitize her hands and entered the room of resident#29 with a medication cup containing the resident's morning medication as well as the glucometer. Staff #339 placed the medication cup on the tray table and took the resident's blood sugar values. The LPN then took the glucometer and 'sharps' out of the resident's room leaving the medication cup with the medications still in the cup unattended on the tray table. Staff #339 disposed on the sharps at the medication cart in the hallway, which was observed to be outside of the view of the resident's tray table. After disposing of the 'sharps', Staff #339 then re-entered the room. An interview was conducted on July 22, 2026 at 8:56 AM with licensed practical nurse (LPN/ staff#314). Staff #314 stated that nursing staff are required to stay in the room until all medications are taken during medication administration to ensure that the resident took all the prescribed medications. Staff #14 stated that the only time medications might be left in a room is if the resident was assessed to safely be able to self-administer medications. Staff #314 stated that if a nurse did not stay in the room with a resident, who is not authorized to self-administer medications, she would not know if the resident took the medication or threw it away. An interview was conducted on July 22, 2026 at 9:04 AM with LPN/ staff #339. Staff #339 stated that when administering medications, she would take the medications into the room and wait to leave until the resident had taken the medication. She stated that she recalled going into the room of resident (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#29 and exiting the room with the medication cup still on the tray table in order to throw away the 'sharps'. Staff #339 stated that resident #29 has not been assessed to self-administer oral medications. She further stated that she had not observed the resident taking the medication. Staff #339 stated that she should have held on to the sharps and watched the resident take the medications before she stepped out of the room. The LPN further stated that the risk of not having observed the resident take the medications could include that the resident could have thrown away the medications or accidentally spilled the cup. An interview was conducted on July 22, 2026 at 9:15 AM with registered nurse (RN/ staff #656). Staff #656 stated that a medication cup should never be left at bedside, even for a short time. The RN stated that eyes should never be taken off the medication cup, to ensure that the medication is taken. Staff #656 stated that the risk for leaving a medications in a residents room without observing that they actually took the medication could include that the resident might 'toss' or 'pocket' the medications, instead of taking them. An interview was conducted on July 22, 2026 at 9:19 AM with the director of nursing (DON/ staff #191). Staff #191 stated that the expectation is that nursing staff stay in the room while the resident takes their prescribed medications. Staff #191 further stated that it is never okay, even for a short time, to leave a medication cup unattended. Staff #191 stated that the risk could include a resident choking or a resident forgetting to take the medication. A review of the procedural guidelines that the facility provided from [NAME] Healthcare for Clinical Procedures for Long-Term Care it was noted under the section titled Medication Administration, General, under number 6, the following: Never leave any medication with the resident to take later. Always observe the resident swallowing the medication then record that it was administered on the MAR. A review of the Medication/ Treatment Management policy revised on May 2025 and reviewed on May 2026 revealed that medications are to be kept in a locked cabinet, medicine cart or storage area. The policy further revealed that self-administration of medications/ treatments is permitted only upon the written order of the primary healthcare provider and that an assessment of the resident's ability to self-administer medications must be completed using an approved tool. It further documented that only if the resident is identified as able to self-administer medications may they do so. The policy further included that medications/treatments administered by team members are centrally stored. Centrally stored medications/treatments are stored according to directions on the label. Discontinued medications, medications with damaged labels or those medications that have expired, treatment supplies and medications that have expired or discontinued, are disposed of in accordance with regulations.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and the facility policy and procedures, the facility failed to ensure that food was properly stored, dated and labeled. The deficient practice could result in a loss of freshness, freezer burn, taste, and loss of nutritive value. Findings include: During the initial tour of the kitchen conducted on July 20, 2026, at 10:04 a.m. with the Chef de Cuisine and Interim Food Service Director (Staff #43), the following observations were made of the refrigerators, freezer, and dry storage: The following observations were made of the refrigerators and freezer: sheet pan of arancini balls - prep date- 7/13- use by date-7/19 3 sheet pans of bread pudding- x3 prep date- sheet pan of biscotti no use by date- prep date 7/14 sheet pan of coffee cake no use by date - prep date 7/3 sheet pan of strawberry cake no use by date- prep date-5/12 expired sheet pan of chocolate cake. prep date-2/19-use by date-5/29 sheet pan of chocolate chunk cookie no use by date- prep date-7/15 sheet pan of carrot cake no use by date- prep date-7/2 sheet pan of carrot cake no use by date- prep date-6/2 19 muffins prep date-6/9. no use by date #6 pan [NAME] cheese no prep or use by date #6 pan of tartar sauce no prep or use by date 1lb shredded beef no dates 2 lbs shrink-wrapped chicken wings- no defrost date #6 pan of hummus no prep or use by date #6 pan of kalamata olives expired 7/17 9 cooked chicken breasts expired 7/17 sheet pan of arancini balls, expired. prep date 7/13- use by date 7/19 cookie dough open to air in freezer #9 shredded cheddar cheese open, exposed to air/no covering salami slices 2lbs - prep date-7/16- no use by date #9 1lb pan of mozzarella cheese no use-by date 2lb chicken tenders - no open or use by date one loaf of gf bread- no open or use by date 9 hot dog buns -no open or use by dates Yuzi flakes 50 grams packaging states refrigerate after opening (not refrigerated) No open date 1lb of Matcha tea -no open date 5lbs of forbidden rice- no use-by dates tempura flour 1lb - no open or use-by date [NAME] tea no open or use-by date Staff #43 stated the cooks are responsible for ensuring that not only the prep dates are on the food labels, but also the use-by dates. An interview was conducted on July 23, 2026 at 9:29 am with (Staff #43) and Chef De Cuisine (Staff # 164). Staff #43 stated the expectation is that the cooks, [NAME] sous chefs, and himself are responsible for checking the dates on all food items. Staff #164 stated she oversees the front and back of the life center, including the satellite kitchen, but that all food items are prepared in the main kitchen. Staff #43 stated that improper dating, labeling, and storing of food items can impact the health of residents, team members, and visitors, leading to food poisoning or stomach issues. Review of the facility policy titled Food Storage, Disposal and Refrigeration Management Revised June 2026 states Purpose: This policy reviews the process for food storage, disposal, and refrigeration management in the life plan communities.1. Team members who receive and store food maintain the storage areas, including dry, refrigerated, and freezer storage, and should adhere to food storage guidelines.6. Packages should be dated with receiving date and use-by date.6.1 Ready-to-eat foods are discarded seven (7) days after it is prepared/opened. Open date is considered day one (1).Storeroom sanitation:2. Dispose of items that are beyond the expiration or use by dates. The expiration date should be written on the container as well as the opened or prepared date.9. Food DisposalFood items that are at the expiration date should be discarded.		

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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 advance directives were completed and maintained for one sampled resident (#17). The deficient practice could result in residents not receiving proper care according to their preferences or in potential harm to residents' lives. Findings include: Resident #17 was admitted to the facility on [DATE], with a diagnosis that included a wedge compression fracture of the second lumbar vertebra, a wedge compression fracture of the third lumbar vertebra, and repeated falls. An active physician's order dated June 30, 2026, was written for DO NOT RESUSITATE -DNR without hold or end date. An admission Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderate cognitive impairment. A Care Plan date revised June 29, 2026, revealed a full code status. Interventions included Advanced Directives located in the medical record. Family and medical doctor will be notified of any condition change. Nursing Staff will initiate basic life support (BLS) and call an ambulance for transport to the hospital as needed. An observation was made on July 20, 2026 at 3:43 pm of the resident's medical chart, revealing a Pre-Hospital Do Not Resuscitate (DNR) form, with no witness signature. An interview was conducted on July 22, 2026, at 7:59 am with the administrator (Staff #725). The administrator stated both she and the Director of Nurses were sharing the social services role while the social services director was on vacation. Staff #725 stated the process for DNR forms is that they should be taken on admission and that the orange form should be filled out completely with the doctor and resident's information and a witness signature. She further stated that the facility conducts audits of resident code statuses and should be followed up if there is any missing information or concerns. Staff #725 reviewed the DNR form and identified there was no witness signature, stating there should be a witness signature on the form. She stated the risks associated with not thoroughly completing the DNR form is staff would be unable to determine if that is what the resident wanted, and if the resident is unable to communicate, staff would not know what their desire was. No witness signature would then take over and invalidate the DNR. She stated she would hope the nurse would call the family for clarification. An interview was conducted on July 22, 2026 at 12:32 pm with registered nurse (Staff/RN #656). She stated that if the resident is a new admission, the facility have the orange form and staff go through it with the resident or their family or representative. And then it is placed in the Go Book. She reviewed the DNR form located in the Go Book located at the nurse's station and identified there was no witness signature; she stated the DNR form is incomplete and there is a possibility the resident's wishes would not be honored. She stated she would need to reach out to family to confirm, which could delay or initiate a full code in an emergent situation, due to uncertainty regarding the resident's code status. An interview was conducted on July 22, 2026 at 12:43 pm with the Director of Nursing (DON/Staff #181). She reviewed the DNR form in the resident's electronic health record and confirmed the DNR form did not have a witness signature. The DON stated the risks of an incomplete DNR form are that the resident's wishes could possibly not be honored in an emergent situation. Review of the facility policy titled Advance Directive Protocol, revised December 2025, states [NAME] respects the resident's right to make decisions relating to his or her own medical treatment, including the right to accept, reject, or limit any life-sustaining treatment, including cardiopulmonary resuscitation. Advance Directives may be revoked or changed by the resident or the resident representative at any time. This may be done either verbally or in writing.1. Residents who (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wish to have a DNR order may do so based on their right to manage their health care decision(s).2. The resident's primary healthcare provider writes the DNR orders. 2.1. The primary healthcare provider documents in the progress notes the discussion between him/her and the resident, the resident's representative and/or DPAH related to their wishes for healthcare management and end-of-life treatment decisions.2.2. Residents may change their DNR status at any time by letting a team member know. The team member will contact the healthcare provider of the residents wishes		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and the Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123, the facility failed to ensure the resident's signature and date on the NOMNC form was legibly signed and dated for one of three sampled residents (#44). The deficient practice could result in inaccurate NOMNC forms. Findings include: Resident #44 was admitted to the facility on [DATE], with a diagnosis that included tubulo-interstitial nephritis, depression, and lack of coordination. A care plan dated January 13, 2026 revealed a focus for discharge, with stay projected to be a short duration. Interventions included social services, which will involve appropriate community resources for follow-up to ensure resident safety. A physician's order dated January 29, 2026 revealed the resident to be discharged to home on January 30, 2026 with home health skilled nursing for medication management and safety evaluation, Physical and Occupational Therapy evaluation and treatment, and home health aide for showers and Master of Social Work (MSW) services. A Resident and Interdisciplinary Discharge summary dated [DATE] indicated discharge was a facility-initiated discharge, and the resident was to return to a private residence in the community. A Discharge Summary Progress Note dated January 30, 2026 stated the patient was discharged to go home with home health. Patient discharged in stable condition with medications and paperwork. A review of the NOMNC CMS-10123 form revealed the Medicare skilled services would end January 30, 2026. Further review of the NOMNC form under additional comments revealed illegible writing, and the signature and date line were also identified as illegible. An interview was conducted on July 22, 2026, at 11:37 am with the Director of Nursing (DON/Staff #181). The DON stated that the process for NOMNC's is that social services or the therapy director, as backup, reviewed the NOMNC with the resident. The DON reviewed the NOMNC in the resident's electronic health record (EHR) and confirmed that the resident was discharged from the facility on January 30, 2026, but there was no documentation that the resident waived her rights for an earlier discharge. The DON stated, after further review of the EHR, that there was no documentation that the resident was issued the NOMNC, no documentation of who provided the form to the resident, and that she was unable to read the date written on the form, stating that the date looked like February 28, 2027, which would be incorrect. The DON stated she expected that when residents signed anything, whoever was assisting the resident and would need to make sure everything was signed and that the dates were correct and document that the resident has waived their 72-hour notification. The DON stated the risks were that the NOMNC is a legal document and could be nullified if the document was not accurately filled out; further stating Medicare could not pay or would not accept the form and could void the document entirely. The Form Instructions for the NOMNC CMS-10123 revealed the resident or the resident's representative must sign the signature line and must fill in the date that he or she signed the document. Review of the facility policy titled Beneficiary Notices, revised July 2025, states This policy establishes guidelines for the administration of beneficiary notices including the Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN), Notice of Medicare Non-Coverage (NOMNC) and Detailed Explanation of Non-Coverage (DENC) in [NAME] skilled nursing care venues. Skilled nursing facilities (SNFs) issue beneficiary notices to help honor resident rights to make an informed decision about whether to get services and accept financial responsibility for those services that Medicare may no longer pay for or does not pay for at all. The notices serve as proof that the beneficiary knew prior to getting the service that Medicare does not cover the service or will no longer cover the service. If a valid notice is not issued to the beneficiary per Medicare requirements, the beneficiary cannot be billed for the service, and the care venue may be financially liable.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, facility documentation, and policies and procedures, the facility failed to develop and implement a comprehensive care plan that addressed one resident's (resident #1) current psychotropic medication regimen, including individualized interventions and monitoring. The deficient practice could result in inadequate monitoring and interventions, placing the resident at risk for adverse medication outcomes. The universe was 38, and the sample size was 5. Findings include: Resident #1 was admitted on [DATE], with diagnoses including severe vascular dementia without behavioral disturbance, paroxysmal atrial fibrillation, hypertension, pneumonia, cognitive communication deficit, dysphagia, history of falling, generalized muscle weakness, and anxiety. A baseline Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 8, which indicated moderate cognitive impairment. The assessment indicated that the resident was receiving antidepressant medications. A physician progress note dated February 10, 2026, revealed the resident was receiving Remeron, an antidepressant also known as mirtazapine, for decreased appetite. The note further revealed the resident's daughter requested the dose be decreased from 15 mg (milligram) to 7.5 mg, and the provider documented the medication would be continued at the reduced dose. A psychiatric progress note dated March 30, 2026, revealed the resident was evaluated for agitation and verbal aggression toward staff. The provider documented the resident was receiving Remeron 15 mg by mouth at bedtime for depression, recommended continuation of the medication without changes, and noted no medication side effects were observed or reported. A physician order dated April 7, 2026, revealed directions for staff to monitor the resident for the presence of anxiolytic medication side effects, including drowsiness and sedation, every shift. A physician order dated April 7, 2026, further directed staff to complete behavior monitoring every shift by documenting the presence of target behaviors, including agitation and calling out, and to document non-pharmacological interventions used to redirect the resident. A physician's order dated April 25, 2026, revealed a discontinued order for Remeron, an antidepressant also known as mirtazapine. The order revealed a previously prescribed half dose of a 15 mg tablet by mouth at bedtime for depression, as evidenced by an inability to sleep and reduced appetite. A physician order dated May 4, 2026, revealed an order for Hydroxyzine HCl, an antianxiety medication, 50 milligrams (mg) by mouth every six hours as needed for anxiety and agitation related to confusion and calling out for 14 days, and one tablet by mouth at bedtime for anxiety and agitation related to confusion and calling out. A comprehensive MDS assessment dated [DATE], revealed a BIMS score of 9, indicating moderately impaired cognition. The assessment further revealed the resident exhibited verbal behavioral symptoms directed toward others one to three days during the assessment period and received an antipsychotic, antidepressant, and anticoagulant during the lookback period. A physician order dated May 6, 2026, revealed an order for Sertraline HCl, an antidepressant medication, 25 mg by mouth daily for depression as evidenced by verbalized sadness. The resident's comprehensive care plan dated May 15, 2026, revealed a focus initiated February 4, 2026, identifying the resident as taking Remeron related to appetite stimulation and insomnia, with interventions to administer the medication as ordered, monitor food intake, and observe for antidepressant side effects including sedation, weight gain, dizziness, and dry mouth. Further review of the care plan revealed no focus, goals, or interventions addressing the resident's current psychotropic medication regimen, including Quetiapine for dementia-related behavioral symptoms, Sertraline for depression, or Hydroxyzine for anxiety and (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	agitation. The care plan had not been revised to reflect the discontinuation of mirtazapine or the initiation of the resident's current psychotropic medications. A physician order dated June 24, 2026, revealed an order for Quetiapine Fumarate, an antipsychotic medication, 50 mg by mouth at bedtime for dementia-related behavioral symptoms. A physician order dated June 25, 2026, revealed an order for Quetiapine Fumarate 25 mg by mouth every morning for dementia-related behavioral symptoms. An interview was conducted on July 21, 2026, at 11:51 AM with a Certified Nursing Assistant (Staff #876/CNA). The CNA stated that when residents exhibit behaviors, staff provide interventions such as taking the resident to activities, checking on the resident more frequently, changing the subject, redirecting the resident, and providing pictures or memory-related items. He stated that he assisted residents with ADLs (Activities of Daily Living) and reported changes to the nurse. An interview was conducted on July 21, 2026, at 12:54 PM with a Licensed Practical Nurse (LPN/Staff #339). The LPN reviewed the resident's electronic health record and stated the resident was receiving Quetiapine, Hydroxyzine, and Sertraline and confirmed these medications were not reflected in the resident's care plan. She stated the resident's previous mirtazapine remained in the care plan even though it had been discontinued. She stated the care plan should have been revised and that failure to update the care plan could result in medications being withheld or placed on hold until further review. An interview was conducted on July 23, 2026, at 8:36 AM with the Interim Director of Nursing (DON/Staff #191). The DON reviewed the resident's care plan and medication profile and stated the resident was prescribed Quetiapine, Sertraline, and Hydroxyzine. She stated Quetiapine was the only psychotropic medication addressed within the care plan and acknowledged the resident's Sertraline and Hydroxyzine should also have been care planned. However, at the time of clinical record review on July 21, 2026, at 9:55 A.M., the resident's comprehensive care plan did not include Quetiapine, Sertraline, or Hydroxyzine. The DON stated the care plan is what drive care for the resident. The DON stated it was her expectation that all three psychotropic medications should be reflected in the resident's comprehensive care plan. The DON further stated that although medication monitoring occurs through physician orders and medication administration records, the risk associated with the omission of these medications from the care plan could result in staff missing required interventions. Review of the facility policy titled Documentation and Assessment, Standards in Skilled Nursing, revised April 2026, stated this policy defines standards of assessment and documentation used in the Skilled Nursing care venues in Illinois and Arizona by the team members. 3. The following areas are re-assessed every quarter and with a significant change of condition and a return from a hospital stay of 24 hours or more: Review and revise care plan as appropriate. Review of the facility policy titled Comprehensive Personalized Plan of Care (Care Plans), revised December 2025, stated the purpose of this policy is to define the process for creating, reviewing, revising, and evaluating comprehensive personalized plans of care in the skilled nursing care venues. 1.4 Comprehensive personalized plans of care address the following components of the resident's plan of care: Description of the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.		

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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, staff interviews, observations, and facility policies, the facility failed to ensure that X-ray treatment orders were faxed in a timely manner in accordance with professional standards of practice for one resident (#36) , and failed to implement resident-directed care consistent with physician orders related to a swallowing deficit and use of a straw when drinking from a cup for one resident (#1). The deficient practice could result in the resident choking or aspirating fluids, pain or further injury. The universe was 38, and the sample size was 2. Findings Include: -Regarding Resident #36: Resident #36 was admitted on [DATE] and discharged to the hospital on May 6, 2026 with diagnosis including Parkinson's disease, difficulty walking, orthostatic hypotension, pain in left hip, unspecified lack of coordination and muscle weakness. The MDS (minimum data set) dated April 22, 2026 revealed a BIMS (brief interview of mental status) score of 5 indicating severe cognitive impairment. THE MDS further noted that the resident had a fall prior to admission, no falls since admission were noted and that the resident was on PRN (as needed) pain medication for frequent pain with a noted intensity of 9 out of 10. The physician orders revealed an order dated May 1, 2026 for an x-ray of the left leg, 2 views, pelvis-2 views, one time only. An additional order was observed for the same date adding an x-ray of the lumbar spine, one time only for left leg pain. The care plan revealed a focus area noting that the resident required assistance with ADL's (activities of daily living) related to a recent hospitalization due to a fall, which was initiated on April 16, 2026 and that it was further noted under interventions that the resident was non-ambulatory. The care plan further revealed a focus area of pain related to the recent fall initiated on April 16, 2026 with noted interventions including pain assessment, non-pharmacological interventions, evaluating the need for additional interventions if pain is not eliminated or at acceptable level. The progress notes revealed an entry on May 1, 2026 documenting that the nurse practitioner ordered an x-ray to the lower left extremity and pelvic area. A progress note on May 2, 2026 revealed that the resident had no complaints of pain overnight but had significant pain during the day. An additional note on May 2, 2026 revealed that the resident reported a 7 out of 10 pain level to his lower extremities. Another entry on May 2, 2026 revealed that the x-ray company had been called and the entry further noted that there was no time when exam was to be completed. An entry on May 3, 2026 revealed that the resident stated that he was supposed to have an x-ray of his lower leg, pelvis and lower lumbar spine. It was documented that the writer called the x-ray company to see when they would make it out, but it was documented that the writer was waiting to hear back. It was further noted that the resident reported pain and was given tramadol. A note dated May 4, 2026 revealed that resident x-ray results were reported to the provider. An interview was conducted on July 23, 2026 at 2:40 PM with licensed practical nurse (LPN/ staff (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#339). Staff #339 stated that if an x-ray was ordered because a resident was in pain, she would make sure and check the status with the x-ray provider by the end of her shift if they had not arrived. Staff #339 stated that a STAT (immediate) x-ray should be done the same day and that she would expect a regular x-ray to be completed by the next day. Staff #339 reviewed the progress notes for resident #36 and stated that she would have expected x-ray to come out sooner. She stated that risk to the resident could include delayed services and hospitalization. An interview was conducted on July 23, 2026 at 2:50 PM with registered nurse (RN/ Staff #102). Staff #102 stated that a regular x-ray order, if placed in the morning, is often done by the afternoon depending on the x-ray companies load. Staff #102 stated he would call the x-ray company as soon as he noticed that they had not arrived and ask for an 'ETA' (estimated time of arrival). He stated that if it was nearing the end of his shift he would ensure that the next nurse knew about during report. He stated that he would further retain the fax confirmation after sending the order to the x-ray company, write any applicable notes on it, and keep it at the nurses station for the next nurse to see the status. Staff #102 stated that a delayed x-ray could include risks such as malformed healing or a more difficult surgical process if there was a misaligned fracture. An interview was conducted on July 23, 2026 at 3:01 PM with the interim director of nursing, (DON/ staff #191) and the administrator (staff #725). The administrator stated that if there was a delay in having the x-ray provider come out on a regular x-ray, then a request should be made to the provider to make it a STAT order. The interim DON stated that generally 2-4 hours would be acceptable for a regular x-ray. The DON reviewed the resident's EHR (electronic health record) and stated that she saw that the order was placed on May 1st, 2026 at 8:15 PM. The DON further stated that there were 2 x-ray orders in the record for May 1, 2026, one including the lumbar area, whereas the other only noted the left leg and pelvic area. The interim DON pulled up the radiology interpretive report from the x-ray company and stated that the results were received by the facility on May 4, 2026 at 7:14 PM noting that the resident had an acute left hip fracture. The interim DON stated that the turnaround time for the x-ray was not acceptable. She further stated that she would expect staff to notify her and leadership and they would explore the option of sending the resident to the hospital. The interim DON stated that the risks of delaying x-rays could include the resident being in pain, and delay of care for the injury. The DON further stated that the delay in service would not be acceptable. A follow-up interview was conducted on July 24, 2026 at 8:01 AM with the interim DON and the administrator. The interim DON stated that she had conducted a follow-up call with the nurse practitioner (NP/ staff #772) and that he stated that routine x-ray placed on Friday may take a few days. The interim DON provided the phone number for the NP for further follow-up. A telephone call was placed on July 24, 2026 at 8:12 AM to the x-ray provider. Dispatch/ front desk staff #407 from the x-ray provider stated that a pelvic and lumbar spine x-ray would generally be done the same day. She reviewed the company records and found the resident. She stated that she saw that the facility had obtained the order on May 1, 2026; however, it was not faxed from the facility until May 4, 2026 which is the same day that the service was completed. A telephone call was placed on July 24, 2026 at 8:21 AM to the NP, staff #772. Staff #772 stated that he recalled the resident and that he had a hips contusion when he was admitted , with pain not quite (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	controlled. He stated that he had tried the resident on narcotics but the resident was somnolent (drowsy/ sleepy). He stated that in spite of the pain there was internal rotation or lengthening/ shortening of the lower extremities observed. He stated that he recalled that he placed an x-ray order on Friday, May 1, 2026 and that the x-ray was not completed until May 4, 2026. He further stated that the hospital records prior to admission and post the fall at home noted no signs of a fracture only a contusion. Staff #772 stated that a 2-3 day wait on a routine x-ray is generally not okay, but stated that staff would have alerted him if there was any change in the resident's status, at which time he would have changed the order to a STAT order. Staff #772 stated that he would have expected the facility to send the written order for the x-ray timely. He stated that if the order was not sent timely by the facility to the x-ray provider then the delay of treatment for the resident would be prolonged. A follow-up interview with the interim DON on July 24, 2026 at approximately 10:30 AM revealed that the facility had attempted to retrieve the fax confirmation to the x-ray provider and was unsuccessful. The interim DON stated that the facility had now created a order process for x-ray order submission, outlying the steps to take to ensure that x-ray is received and that the x-ray provider is scheduled to come out. It was further noted in the newly created procedure that it might be quicker to place the order directly through the x-ray providers online portal. - Regarding Resident #1: Resident #1 was admitted to the facility on [DATE], with diagnoses including severe vascular dementia without behavioral disturbance, oropharyngeal dysphagia, cognitive communication deficit, and generalized muscle weakness. A nursing shift note dated February 1, 2026, revealed the resident had a speech therapy (ST) evaluation that morning, and the Speech Therapist (ST) identified that the resident had mild cognitive impairment as well as swallowing difficulties. The resident's diet was subsequently changed to a small and bite-sized diet. A physician's order dated February 1, 2026, revealed an active order for skilled Speech Therapy (ST) two to four times a week for eight weeks for oropharyngeal dysphagia. Speech Therapy progress notes for the period of February 1, 2026, through February 7, 2026, revealed the Speech Therapist treated the resident for difficulty swallowing (oropharyngeal dysphagia) and a cognitive communication deficit. The therapist documented that on February 1, 2026, the resident's baseline status was coughing with intake. Although this coughing decreased when the resident used safe swallowing strategies, he continued to exhibit an occasional cough response with intake as of February 7, 2026. Furthermore, the therapist documented that cognitive communication treatment was completely omitted because the resident's swallowing deficit was so severe that he required the entire therapy session to focus on preventing the inhalation of food or liquid into the lungs, also known as aspiration. A nursing shift note dated February 9, 2026, revealed the resident continued to use a chin tuck for swallowing and continued with no straws at this time. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Registered Dietitian (RD) progress note dated February 13, 2026, revealed the resident's diet consisted of a general/liberalized diet, soft and bite-size texture, thin liquids, small cups, and no straws. A nursing shift note dated February 14, 2026, revealed the resident was assessed for having difficulties grasping items and drinking from a cup. A physician's order dated April 16, 2026, directed staff to provide a general, regular texture diet with thin consistency liquids, small cups, and no straws. A comprehensive care plan dated May 15, 2026 revealed a focus initiated on February 2, 2026, for an Activities of Daily Living (ADL) self-care performance deficit related to general weakness and a cognitive communication deficit. Further review of the care plan revealed it stated the resident needed a straw, conflicting with the physician's active orders. A quarterly comprehensive Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 9, indicating moderately impaired cognition. The assessment further identified the resident had an active diagnosis of oropharyngeal dysphagia and was independent with eating. The assessment included no signs or symptoms of possible swallowing disorder during the assessment period. An observation was conducted on July 21, 2026, from 12:00 p.m. to 12:45 p.m. The resident was observed drinking from a Styrofoam cup using a plastic opaque straw. The resident was positioned sitting upright and leaned over to drink from the straw and cup on the table in front of him. The resident's chin was tucked, and he was able to swallow the drink. Kitchen staff subsequently entered the room and removed the meal tray, but left the cup and straw at the table. An interview was conducted on July 21, 2026, at 12:47 p.m. with a Server (Staff #805). He stated he is responsible for setting up the tray and adding straws, and that servers check if residents have straws kept in their rooms. He stated that if straws are not present, he verifies with nursing staff who provide them, and that he checks the diet slips. An interview was conducted on July 21, 2026, at 12:53 p.m. with a Certified Nursing Assistant (CNA/Staff #754). She stated that setting up straws is the responsibility of the servers and culinary staff, and she does not set up straws. An interview was conducted on July 21, 2026, at 12:54 p.m. with a Licensed Practical Nurse (LPN/Staff #240). She stated the resident has a physician's order for small cups and no straws, and she pours his drinks into a little red cup. She confirmed she had recently observed the resident receive a cup with a straw. She reviewed the resident's record and stated that while the physician's order directed no straws, the care plan conflicted and incorrectly stated he needed a straw. She stated this conflicting documentation could cause confusion among staff, and that the risk of the resident using a straw was choking or aspirating. Following the interview, an observation was conducted with the LPN in the resident's room, who (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	removed the red cup from his bathroom. When asked, the resident stated he drank from the red cup but also drank from a large white Styrofoam cup with a straw, depending on what he felt like. An interview was conducted on July 21, 2026, at 1:15 p.m. with the Registered Dietary Manager (RDM/Staff #164). She stated the process for updating diet slips involves reviewing the resident's room number and nursing orders to update labels. She stated the dietary department does not deal with straws. She reviewed the resident's diet slip, which read general/regular/thin/short cups only/small portions, with no mention of straws. She stated the risk of the resident receiving a straw when not allowed is aspiration. An interview was conducted on July 21, 2026, at 1:24 p.m. with the RD (Staff #782). She stated she had conducted a dietary assessment but made no recommendations regarding how the resident's food and drink are served. She stated occupational therapy or speech therapy usually makes the determination for textural issues if a resident has difficulty during mealtime. She stated nobody had communicated with her regarding the resident's risk for aspiration with straw usage. An interview was conducted on July 21, 2026, at 1:35 p.m. with the Director of Rehabilitation (DOR/Staff #635). She stated that nursing staff can downgrade a diet, but speech therapy is required to upgrade a diet. She stated speech therapy regulates how a resident uses straws or drinks. She reviewed the therapy notes and stated that on April 16, 2026, the resident was evaluated and ordered a regular diet with thin consistency liquids, small cups, and no straws. She stated that when the resident was first admitted for skilled services, he was ordered no straws due to difficulty swallowing and aspirating. She stated that using a straw shoots liquid down the throat, which is a risk for aspiration or choking for someone with difficulty swallowing. An interview was conducted on July 23, 2026, at 8:36 a.m. with the Interim Director of Nursing (DON/Staff #191). She stated caregivers and family go into the room and provide straws. She stated that dietitians and dining staff are part of the interdisciplinary team, and they can coordinate with speech therapy regarding dietary needs. She stated that speech therapy evaluated the resident, identified a swallowing issue, and ordered no straws because it was not safe and placed the resident at risk of choking or aspiration. Review of the facility policy titled Healthcare Provider Order Management, revised March 2024, stated that this policy describes the process for managing healthcare provider orders in the care venues. Orders from healthcare providers are carried out as written in a timely manner.		