

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035291	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER The Center at Val Vista, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3744 South Rome Street Gilbert, AZ 85297	
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 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. Based on observations, staff interviews, and facility policy and procedure, the facility failed to ensure food items were properly stored, labeled, dated and handled in accordance with professional standards and sanitary food service practices. The deficient practice had the potential to result in food contamination and place residents at risk for foodborne illness. Findings include: An initial walk-through of the kitchen was conducted on June 16, 2026, at 8:20 A.M with the Dietary Manager (Staff #119). Observations were made in the large walk-in refrigerator, freezer, and dry storage. The following food items were observed to be improperly stored:- Approximately two pounds of Mozzarella cheese dated 5/31 with no use-by date.- One open package of ham with no use-by date.- One-eighth pan of carrots past due date.- One-eighth pan of green beans past due date.- One opened bag of lettuce exposed to air.- Three 8-ounce cartons of TruMoo milk with expiration date of June 15, 2026.- Ten Peeled hard-boiled eggs open to the air.- One Container of strawberries with mold and past the storage date.- Ten ground beef hamburger patties opened and exposed to air.- Open opened bag of French fries with no opened or use-by date.- One 70-ounce bag of hash browns with no opened or use by date.- Seven slider burgers opened to air and no open or use by date - Seven fish patties with no opened or use-by date.- Fourteen slices of garlic bread with no opened or use-by date.- Eight Chicken patties exposed to air with no opened or use by date.- Eleven Italian chicken breasts exposed to air with no use by date.- One Pan of apple crumble with no use-by date.- Approximately one-half pound of potato wedges exposed to air with no opened or use by date.- One 20-ounce package of Chuck Wagon corn with no opened or use by date.- Twelve Blueberry pancakes with no opened or use by date.- Twenty-five frozen Chicken Kiev breasts exposed to air with no opened or use by date.- Six Chicken tenders with no opened or use-by date.- One Tub of tapioca pudding with no opened or use-by date.- One container of Folgers coffee with no cover.- One case of No Preservative Fruit with dirt and plastic particles on the top of the lid. During a kitchen walkthrough on June 16, 2026, at 8:20 A.M., the Dietary Manager (Staff #119) stated that all food items should be dated upon opening. He emphasized that food kept past its use-by date could cause foodborne illness. Staff #119 stated he had previously discussed these protocols with staff members. He further stated that kitchen staff members possess food handler's cards and are aware of food storage policies. He stated that food left exposed to air develops frostbite, resulting in a bland taste and a leather-like texture. An Observation conducted on June 16, 2026, at 8:30 A.M., revealed that Dietary Aid (Staff #111) was preparing food with long braids outside of her hair net. An interview conducted with the Dietary Manager (Staff #119) on June 16, 2026, at 8:38 A.M. He stated that Dietary Aid (Staff # 111) should have braids secured within the hairnet. He further stated that staff #111's braids could contaminate the food. An interview with Dietary Aid (Staff #111) was conducted on June 16, 2026, at 8:40 A.M. who stated that the risk of having hair exposed while preparing food could introduce bacteria and contamination into the food. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 035291	If continuation sheet Page 1 of 6

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	She further stated she was unaware that her braids were extending outside of the hairnet. Sanitary bucket testing was conducted on June 17, 2026, at 8:14 A.M. The kitchen had 9 sanitary buckets throughout the kitchen. Three of nine buckets tested did not meet safety guidelines for required parts per million (ppm) for sanitizer concentrations. Staff #119 tested the 3 of 9 buckets, revealing no parts per million (ppm). The Registered Dietitian (Staff #98) was observed emptying the other buckets while testing was in progress, after she was informed not to do so while the testing was in progress. Observation on June 17, 2026, at 12:18 PM, revealed Activities assistant (Staff#6) pulled the tray cart and delivered meal trays to residents without performing hand hygiene after touching the tray cart. Staff #6 stated she was not aware she needed to sanitize her hands after pushing the tray cart before delivering trays. She further indicated she works in the activities department and was just trying to help. An interview with the dietary manager, staff #119, was conducted on June 17, 2026, at 8:24 P.M. Staff #119 stated that staff #6 did not know she needed to sanitize her hands after touching the tray cart; she usually does not pass trays. He further stated that not sanitizing hands after touching the cart could lead to the introduction of bacteria to the food trays being delivered to residents. On June 18, 2026, at 9:30 AM, an interview was conducted with Dietary Manager staff #119, who stated he has been the dietary manager for the facility for four years. He emphasized the importance of dating food items when opened, as well as their use-by dates. He noted that dry storage should be rotated based on the dates and declared the need to discuss proper dating and labeling practices with his staff. The Dietary manager (#119) presented a staff meeting sign-in sheet dated June 6, 2026, to discuss the identified concerns, however the meeting was not conducted. He outlined expectations for the freezer, stating that staff should ensure all bags are closed and clearly marked with open and use-by dates to prevent cross-contamination, foodborne illness, and frostbite. He further stated that without proper labeling and dating, it would be difficult to determine whether food items remained within their use-by dates. A third observation was conducted on June 18, 2026, at 9:53 A.M. Three sanitary buckets were tested in the food prep area; two of the three buckets failed with a reading of 100 ppm and 200 ppm. An interview was conducted on June 18, 2026, at 1:10 P.M. with the Administrator (staff #117), who emphasized the importance of labeling and dating all food items. He further stated that the uncertainty of food items when opened could lead to spoiled food and potential health risks for residents. A review of the facility policy titled Food Storage Policy dated September 4, 2028, with a revision dated February 8, 2021, states that on the same day that food products are delivered to the facility, they are to be inspected for safety and quality. Each item is to be accurately dated upon receipt. When items are opened for use, use-by-dates are to be labeled upon them, followed by storing the item in the proper area, such as the Refrigerator, Freezer, or Dry Storage area located in the kitchen. All outdated, expired, or damaged food products are to be discarded immediately. Proper food sanitation guidelines are to be followed. Food from outside sources is to be stored in the refrigerators located on floors two and three with the correct date.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on facility observations, staff interviews, record review, and a review of facility policies, the facility failed to ensure that dumpsters were maintained in a clean and sanitary condition. This deficient practice has the potential to increase pest infestations and contribute to the spread of disease-causing microorganisms throughout the facility environment. Findings included: An initial observation was conducted on June 16, 2026, at 8:14 a.m. of the dumpsters located outside the facility. During the observation, one dumpster lid was observed to be left open. Sixteen pairs of used gloves were scattered on the ground around the dumpsters. Oil traps were covered with dirt and leaves. In addition, a bag containing eight (8) used IV bags with attached connectors and tubing, along with other medical supply items, was observed on the ground. A grease trap containing accumulated landscaping debris was also observed in the dumpster area. A subsequent observation conducted on June 17, 2026, at 8:14 a.m. revealed the presence of an IV flush syringe, IV tubing, used gloves, and landscaping debris around the dumpsters. At the time of the observation, Staff #119 was observed using a shovel to clean the area surrounding the dumpsters. Staff #119 stated that he would clean the debris around the dumpsters. A third observation conducted on June 18, 2026, at 2:59 p.m. revealed that the dumpster area had not been completely cleaned, as landscaping debris remained present and one dumpster lid continued to be left fully open. An interview with the Maintenance Manager, Staff #123, was conducted on June 18, 2026, at 11:57 a.m. Staff #123 stated that the maintenance department collaborated with the kitchen staff to clean the dumpster area. Staff #123 explained that, at times, refuse collection trucks spilled trash while emptying the dumpsters and that the drivers did not clean debris that fell onto the ground. Staff #123 stated that the maintenance team typically cleaned the spilled trash but acknowledged that the department did not maintain a cleaning log to document routine cleaning activities and ensure accountability. A subsequent interview with the Kitchen Manager, Staff #119, was conducted on June 18, 2026, at 1:54 p.m. Staff #119 stated that the dumpsters located behind the facility were used by the entire facility and further stated that individuals from outside the facility also disposed of trash in those dumpsters. Staff #119 stated that the kitchen staff were responsible for cleaning the dumpster area and that his kitchen staff members were routinely reminded to keep the dumpsters clean. Staff #119 further stated that the dumpster area was cleaned once per week and acknowledged that no cleaning log was maintained. Staff #119 stated that the used gloves and other medical supply items observed during the initial observation may have been discarded by overnight staff while leaving the facility. Staff #119 acknowledged that the unsanitary conditions observed around the dumpsters could attract pests and increase the potential for the spread of pathogenic microorganisms. Staff #119 further stated that dumpster lids should remain closed at all times, biohazardous materials should not be disposed of in the dumpsters, and the dumpster enclosure should be secured with a coded lock accessible only to facility staff. An interview with the Director of Nursing Services, Staff #113, was conducted on June 18, 2026, at 10:35 a.m. Staff #113 stated that IV bags were disposed of in the regular trash after they had been emptied. Staff #113 stated that IV bags should have been properly disposed of and expressed surprise that they had been found outside the dumpsters. Staff #113 explained that the facility maintained separate disposal procedures for different categories of waste, including designated containers for biohazardous materials, which were collected and disposed of according to facility protocol. Staff #113 stated that facility staff did not dispose of biohazardous materials in the dumpsters. A request for the facility's policy regarding environmental cleanliness was made on June 17, 2026. A review of (continued on next page)		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the policy titled Cleaning Rooms Policy, revised in February 2021, revealed that it did not provide specific guidance regarding the cleaning, maintenance, or sanitation of dumpsters. A subsequent request for the facility's homelike environment policy was made on June 18, 2026, at 1:10 p.m. A review of the policy titled Homelike Environment, last updated on March 14, 2024, revealed that it did not include guidance regarding dumpster maintenance or a routine dumpster cleaning schedule. Although both policies emphasized maintaining a safe environment for residents and staff through the prevention of healthcare-associated infections, including MRSA, Clostridioides difficile (C. difficile), and device-related infections, neither policy specifically addressed dumpster sanitation or maintenance. The Homelike Environment policy further stated that the facility recognized the importance of providing residents with an environment that closely resembled normal community living.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, staff interviews, and facility policy and procedure review, the facility failed to ensure that medications were properly stored and not left unattended at the bedside for one of one sampled resident (Resident #35). The resident census (universe) was 62. This deficient practice had the potential to result in residents who are prone to accidents, as well as visitors, having unrestricted access to medications. Findings Include: Resident #35 was admitted to the facility on [DATE], with diagnoses that included acute respiratory failure with hypoxia, acute pulmonary edema, generalized muscle weakness, dysphagia, oropharyngeal phase, and other comorbidities. A review of the Minimum Data Set (MDS) assessment dated [DATE], revealed that Resident #35 had a Brief Interview for Mental Status (BIMS) score of 11, indicating moderate cognitive impairment. An observation was conducted of Resident #35's room on June 16, 2026, at 10:13 a.m. During the observation, two tablets were noted in a medication cup on the resident's bedside table. The resident stated that the tablets were vitamin C that the nurse had given him to take. The resident further stated that he had taken these medications independently since his admission. An immediate interview was conducted with Staff #500 (Licensed Practical Nurse, LPN), the nurse assigned to the resident at the time, on June 16, 2026, at 10:20 a.m. Staff #500 stated that the tablets were vitamin C for the resident to take. Staff #500 further stated that the resident was able to take the medications independently and that no incidents related to the practice had been reported. However, Staff #500 stated that she was unfamiliar with the facility's expectations regarding resident self-administration of medications because she was a registry nurse and indicated that she would verify the resident's self-administration status with the nurse leadership. A review of the resident's Order Summary on June 16, 2026, revealed no physician's order authorizing self-administration of vitamin C. A concurrent review of the resident's care plan revealed no evidence of a medication self-administration assessment or care plan. However, a follow-up review conducted during the investigation on June 17, 2026, revealed that a new care plan for self-administration of medications, excluding narcotics, had been initiated on June 16, 2026. This care plan was not present during the initial review conducted on June 16, 2026. An additional review of a care plan originally initiated on June 8, 2026, revealed that the resident was receiving speech therapy for swallowing deficits and pain when swallowing solid foods. An interview with Staff #15 (Registered Nurse, RN) was conducted on June 18, 2026, at 10:47 a.m. Staff #15 stated that she was familiar with Resident #35 and indicated that the resident often waited for his spouse before taking his medications. Staff #15 further stated that the resident was alert and oriented and had a care plan for self-administration of medications that was initiated on June 16, 2026. A subsequent interview was conducted with the Director of Nursing Services, Staff #113, on June 18, 2026, at 12:49 p.m. Staff #113 stated that she was familiar with Resident #35 because she routinely assisted with breakfast tray service in the mornings. Staff #113 stated that resident care was provided according to the care plan, physician's orders, and the outcomes of interdisciplinary team (IDT) meetings. Staff #113 further stated that nursing staff prepared Resident #35's medications in accordance with the physician's orders, left the medications with the resident, and later returned to verify that the medications had been taken. However, Staff #113 acknowledged that the physician's order authorizing self-administration of medications, excluding narcotics, was not entered until June 16, 2026. A review of the physician's order revealed that it was signed at 11:24 a.m. on June 16, 2026, approximately one hour after the medications were observed unattended at (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #35's bedside. Staff #113 further stated that there were inherent risks associated with residents self-administering medications but believed Resident #35 was capable because he was alert, oriented, and willing to take his own medications. A review of the facility policy titled Medication Administration, last reviewed on March 14, 2024, revealed that medications were to be administered as prescribed by the attending physician. The policy further stated that medications must be administered in accordance with the written orders of the attending physician, may not be set up in advance, and must be administered within one hour before or after the prescribed administration time.		