STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035301	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skilled Nursing Unit at Oro Valley Hospital	1551 E Tangerine Rd Oro Valley, 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, staff interviews, and policy review the facility failed to ensure that medications were not left at bedside for 1 (Resident #32) out of 56 sampled residents. The deficient practice could lead to the medication being incorrectly administered or accidentally ingested by a resident.Findings include:Resident #32 was admitted on [DATE] with diagnoses including fracture of part of neck and right femur, encounter for neck and right femur orthopedic aftercare, and chronic kidney disease.A MDS (minimum data set) assessment dated [DATE], revealed a BIMS (brief interview of mental status) score of 14, which revealed intact cognition. Further MDS assessment revealed that the resident had occasional pain.Physician orders from April 29, 2026 through May 13, 2026, revealed no evidence of orders for medication self-administration. Physician orders, dated May 13, 2026, included Voltaren Arthritis Pain External Gel 1% (Diclofenac Sodium (Topical)) to apply to affected areas topically every 6 hours as needed for Arthritis pain, max 4 applications in 24 hours.A care plan initiated April 29, 2026 and May 5, 2026, revealed no evidence that Resident #32 related to medication self-administration.A review of IDT (interdisciplinary team) notes dated April 29, 2026 through May 13, 2026, revealed no evidence that resident #32 was authorized to self-administer medications.A review of assessments within the electronic health record revealed no evidence that resident #32 was assessed to self-administer medications.During an observation conducted in Resident #32's room on May 12, 2026 at 11:14 a.m., a boxed medication of Diclofenac Sodium 1% gel (topical non-steroidal anti-inflammatory drug) was observed to be present on the bedside table of the resident. Resident #32 was not present in the room. The call light button was pressed to alert facility staff to the medication being present at the resident's bedside. Activities Director (staff #73) responded to the call light and opened the medication box discovered on Resident #32's bedside table; which revealed a tube of medication labelled Diclofenac Sodium 1% gel with approximately 50% of the contents remaining. The Activities Director removed the medication from the resident's bedside table at this time.Following this observation, an interview was conducted with the Activities Director (staff #73) in room [ROOM NUMBER] at 11:16 a.m. Staff #73 stated facility policy is that medications should not be left in a resident's room, she further stated that the medication being present in a resident's room did not meet facility expectations. The Activities Director stated a potential outcome from leaving medications at a resident's bedside is that another resident could ingest the medication and have an allergic reaction.An interview was conducted on May 12, 2026 at 11:25 a.m. with a Certified Nursing Assistant (CNA/staff #51). The CNA stated that if she were to find a medication present at a resident's bedside, she would immediately report it to a nurse. She stated that potential outcomes to a medication being left at a resident's bedside included another resident could take the medication or keep it for themselves. The CNA further stated that medications left at a resident's bedside does not meet facility expectations.An interview was conducted on May 14, 2026 at 10:49 a.m. with the Director of Nursing (DON/staff #113). The DON defined a medication as something used to treat an underlying disease process. She stated that various routes of medication administration included oral, (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	IV (intravenous), subcutaneous, and topical. The DON stated that the facility policy included that no medication should be left at a resident's bedside. She stated potential outcomes of a medication being left at bedside included a resident could harm themselves by administering the medication incorrectly or another patient could come in contact with the medication. The DON performed a record review and stated there was no evidence of physician orders for the resident to self-administer medications. She further stated that medications left at bedside did not meet her or the facility's expectations.The facility's policy titled, Medication Storage and Labelling, dated July 1, 2025, revealed in accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature control. The Medication Storage and Labelling policy further revealed that drugs shall be stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications shall be assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents.The facility's policy titled, Self-Administration Medications, revealed residents have the right to self-administer medications if the interdisciplinary care team has determined that it is clinically appropriate and safe for the resident to do so. If a resident requests to self-administer medication(s), it is the responsibility of the interdisciplinary team (IDT) (as defined in S483.21 (b), F657, Comprehensive Care Plans) to determine that it is safe before the resident exercises that right.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 that food items were stored, dated, labeled, and maintained at an appropriate temperature to prevent food borne illnesses in accordance with professional standards. The deficient practice could lead to food borne illnesses. The census was 33 residents. Findings include:A kitchen observation was conducted on April 12, 2026 at 10:28 a.m. with the Dietary Supervisor (Staff #62) who is currently ServSafe certified. In refrigerator 7, a styrofoam cup containing chopped cilantro and two stainless steel size 6 bins containing scallions and red onion were observed without an open or use by date.A follow up interview with the Dietary Supervisor (Staff #62) was conducted April 12, 2026 at 10:32 a.m., who stated that extra/unused food items should be covered and dated. The Dietary Supervisor stated that a dietary aid had just used the chopped cilantro, scallions, and red onion for the breakfast tray line, however, the items should have been covered and dated. She also stated that the risks of not dating and labeling food items left in the refrigerator could result in food borne illnesses and uncertainty of the date the items were opened or used. An observation of the meat refrigerator conducted April 12, 2026 at 10:50 a.m., revealed a stainless-steel bin on the bottom shelf containing 15 raw sausages that were not fully covered with saran wrap and were exposed to air. Further observation revealed a sheet pan containing 4 smaller sheet pans with 11 blueberry crisp desserts, 40 peeled and cut mandarin oranges, and 35 salads, all in individual cups, which were not covered.An interview was conducted with the Dietary Supervisor (Staff #62) on April 12, 2026 at 10:52 a.m., who stated that she expected meat stored in the refrigerator to be fully covered with saran wrap, and that the identified sausages should have been covered. The Dietary Supervisor stated that the items in the sheet pan rack observed in the refrigerator should have been covered. The Dietary Supervisor further stated that the dietary aid had just prepped the salads and desserts before entering the items into the refrigerator. The Dietary Supervisor also stated that the risks of not covering the raw sausages and prepped desserts and salads could result in food borne illnesses. The Dietary Supervisor removed the sheet rack and sausage container and asked the Head Chef (Staff # 102) to dispose of the uncovered raw sausages. An additional observation on April 12, 2026 at 11:10 a.m. of the fruit and vegetable refrigerator was conducted with the Dietary Supervisor, which revealed a stainless-steel container containing whole unpeeled oranges that had fuzzy blue-green patches on the outside peels, and were soft and mushy to the touch. The unpeeled oranges with fuzzy blue-green patches were touching other unpeeled oranges that also had fuzz patches on its surface. Further observation revealed cut mixed fruits in a stainless-steel container size 6 with no date or label sticker on the container. An open three-pound spinach bag, was observed with more than half of its contents used, with a received date sticker but no open date observed on the bag. A follow-up interview was conducted on April 12, 2026 at 11:13 a.m. with the Dietary Supervisor (Staff #62), who stated that the facility's expectation is that fresh foods are not expired or spoiled, that all items are checked by the stock clerk daily, and by those who use the items daily to ensure that foods are not expired or spoiled. The Dietary Supervisor took the container with oranges and instructed the Head Chef (Staff #102) to dispose of the oranges and cleanse the remaining oranges, a total of 11 oranges were affected and disposed of. The Dietary Director stated that the bins should have been labeled and dated with an expiration date, and disposed of the spinach bag with no open sticker. The Dietary Supervisor stated that the risk of not providing an opened date sticker on a used item, could result in food borne illness.An interview was conducted with the Dietary Supervisor (Staff #62) on April 14, 2026 at 1:52 p.m., who stated that she is the Dietary Supervisor and stated that the facility currently did not have a Dietary Director and that she was the interim manager. She stated that as soon as a container or box of food items is received, a received date is placed on the items, and when an item is opened, a new label must be put on the item to show the open date and new expiration date. She further stated that if a food item is (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	opened and not fully used and is not to be used again, then staff should dispose of the food item. The Dietary Supervisor also stated that the sausages discovered to not be fully wrapped in saran wrap two days prior, should have been properly covered but they were not and the facility had to dispose of those sausages. The Dietary Supervisor further stated that all items should have a new labeled date or opened date if the item is to be used again, otherwise the facility will dispose of the items. She stated that food borne illnesses are a risk when items are not fully covered and exposed to air. The Dietary Supervisor stated that the stock clerk is responsible for ensuring food items are not beyond their use date or unspoiled, and that after the first kitchen observations the Stock Clerk (Staff #109) was terminated, as he had not perform his job duties on multiple occasions. The Dietary Supervisor stated that the Head Chef and the Dietary Supervisor are responsible for ensuring all job duties are performed correctly, including those responsibilities of the stock clerk. She also stated that the molded oranges should have been caught ahead of time, as eleven oranges had to be thrown out. The Dietary Supervisor stated that the sheet pan rack discovered uncovered with the prepped salads and desserts, should have been covered and that the risk of not being covered could result in food borne illness. A policy titled, Scope of Nutritional Service Department Policy, revised February 12, 2026, revealed that foods, non-foods, and supplies related to and used food preparation are stored/handled/distributed in such a manner as to prevent chemical and bacteriological contamination. All food items stored in the cooler are covered and all opened food supplies are labeled and dated.