STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465186	A. Building B. Wing	12/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Springs Senior Living	350 East 2200 North North Logan, UT 84341

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 0805 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined for 1 of 5 sampled residents, that the facility failed to provide each resident with a safe diet that met the special dietary needs of each resident. Specifically, a resident had a diet order for moist and minced texture and was given a cheese stick and pretzels for a snack which resulted in the resident choking and passing away. Resident identifier: 1It was determined the provider's noncompliance with this rule caused harm. However, based on the facility's corrective actions and a review of its current compliance, the deficiency was determined to be past noncompliance. The facility developed and implemented a corrective action plan before the survey start date. The facility's corrective action plan, which was developed and implemented by December 3, 2025, included the following measures. The Director of Nursing (DON) added a column on the Nurse report sheet to identify textures and diets for all current residents. The DON audited diets and textures to ensure that all residents were appropriately documented. Online training was completed by all nursing staff. The facility's corrective action plan included additional future training and weekly audits. The surveyor reviewed the facility's investigation involving an incident with Resident 1 dated November 29, 2025 which revealed the followingOn November 29, 2025, Nurse 1 had taken Resident 1's blood sugar and it was 59, so Nurse 1 proceeded to give her juice, cheese, and pretzels in order to raise her blood sugar. Nurse 1 stayed in the room while Resident 1 took a few bites of food and swallowed with no problems. Nurse 1 left the room with the door open and told Resident 1 that she would come back in 10 minutes to recheck her blood sugar. Resident 1 had started choking, and staff began the Heimlich maneuver, but after several minutes of back slaps and Heimlich, Resident 1 went unresponsive. Nurse 1 noted that Resident 1's code status was DNR, and Nurse 1 called Resident 1's Power of Attorney (POA) to confirm, and the POA confirmed DNR. The facility's investigation included a statement from Nurse 1, I was training a new nurse [Nurse 2] on my shift. Around 1600 I had asked him to go check [Resident 1]'s blood sugar prior to dinner. When he returned he told me her blood sugar was 59. I grabbed a few snacks that included: Orange Juice, a Slice of Cheese and some pretzels for some consistent carbs. In the past when [Resident 1]'s blood sugar was this low she has become tired/lethargic. She was laying in her bed. I did not want to transfer her with the [NAME]-Steady to avoid a possible fall due to weakness from her low blood sugar. I spoke with her and she replied to her name. I let her know her blood sugar was low and she needed to have a snack. She agreed. I sat the head of the bed up 90 degrees. I sat next to her on the bed and opened the piece of cheese first. I watched her chew and swallow a few bites with no problems. She was alert and oriented. I told her I would be back to reassess her blood sugar. I left her door open so we could check on her in passing. It had been maybe 5-10 minutes. CNA working the swing shift radioed me to come to her room as soon as possible. I ran to her room and saw she was choking. She was not coughing or responding to her name. She had gone unconscious. At this time I helped lay the head of her bed down. Started (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0805 Level of Harm - Actual harm Residents Affected - Few	CPT [Manual Chest Physiotherapy] on her back. Had [staff names redacted] help me lower her to the ground where I sat her up and performed the heimlich 5 times. I tried multiple times to use the sweep method to see if the object could be dislodged. I was unsuccessful. I asked [CNA] to go check the report sheet to see what her POLST was. She radioed me and let me know she was DNR. At this time I left the room to call her advanced directive [name redacted] to clarify he did not want CPR performed. Before I left [Nurse 2] had checked to see if [Resident 1] had a pulse and she still did. She had gasped twice. [Staff] continued to perform the [NAME]. Once i got a hold of the [POA] he said not to perform CPR. When I entered back into the room she was pulseless. At this time I notified the local authorities due to the nature of the incident. Once the paramedics arrived they had pronounced her deceased . After talking with [the] DON and [the] Administrator, Resident 1 had her diet order changed on 11/5/25 to moist and minced this was not placed on the nurses report sheet or in the TAR/MAR. But in PCP orders only. I received no information in the report that morning of changes to her diet or new/increased difficulties to swallow. The facility's investigation included a Root Cause Analysis Tool which revealed that the incident had occurred because the nurse was unaware of the texture restrictions, the nurses report sheet only documented how residents took their pills, and it did not have information about the diet texture. Therefore, the texture order was not easily accessible when staff were in the residents' room or in an urgent situation. The surveyor reviewed Resident 1's medical record. Resident 1 had diagnoses that included type 2 diabetes and vascular dementia. The Minimum Data Set (MDS) dated [DATE] revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderately impaired cognition. A physician's order dated November 5, 2025 indicated, Minced and Moist texture, thin consistency for diet orders. The surveyor interviewed the Speech Language Pathologist (SLP) on December 8, 2025. The SLP stated that Resident 1 had her diet order changed due to recent swallowing complications, including coughing and vomiting up food. The SLP confirmed that Resident 1 had received string cheese and a small bag of mini pretzels, and that both food items were not appropriate for a minced and moist diet. The SLP stated that a new process for diet order changes had been put in place to ensure staff had easy access to identify a resident's diet orders and texture. The surveyor interviewed the DON on December 8, 2025. The DON stated that prior to this incident involving Resident 1, the nurse report sheets did not include information about the resident's diet order. The DON stated that the diet texture order was not readily available for nursing staff. The DON stated that a column had been added to the nurse report sheet to include a resident's diet order.