STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035059	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Scottsdale	3293 North Drinkwater Boulevard Scottsdale, AZ 85251

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, interview, review of clinical record, and review of facility policy and procedure, the facility failed to ensure a resident (#27) was treated with dignity and respect. The deficient practice could lead to psychosocial harm of a resident.-Findings include:Resident #27 was re-admitted on [DATE], with diagnoses of acute on chronic congestive heart failure, cardiomyopathy, pneumonia, unspecified dementia, anxiety disorder, and retention of urine.An admission minimum data set (MDS) assessment dated [DATE], revealed Resident #27 had a brief interview for mental status (BIMS) assessment score of 9, indicating moderate cognitive impairment.A care plan focus dated December 5, 2025, revealed Resident #27 was at risk for functional self care deficits and / or functional mobility limitations, with a goal to safely perform functional self care and mobility tasks. Interventions included: -The resident required assistance with transferring-Encourage resident to participate to the fullest extent possible with each interaction -Encourage resident to use call light to call for assistance.A Health Status Note dated December 6, 2026, revealed Resident #27 continued to be disoriented at times and needed reminded of his surroundings, and that the resident was noted to pulling on his foley catheter, and that the resident forgot he had a foley catheter, requiring reminders.A Health Status Note dated December 7, 2025, revealed Resident #27 had confusion and was forgetful, and liked to sit with someone, so the resident sat at the nurse station with a staff part of the morning. The note revealed the resident's urine was noted to be bloody due to the resident pulling on his foley catheter yesterday.An eMAR Medication Administration Note dated December 8, 2025, revealed a change of condition for the resident's behaviors of yelling out and pulling on foley catheter.A Physician Progress Note dated December 9, 2025, revealed the resident had advanced dementia with behaviors.An Activity Progress Note dated December 9, 2025, revealed the resident enjoyed teaching people how to do new things, playing games, sports, attending social gatherings, watching movies, photography, playing bingo, dominos, and being with his family.A physician order dated December 11, 2025, included for change of condition monitoring every shift for 6 days, due to resident yelling out, and that the physician was notified.A care plan focus initiated on December 11, 2025, revealed Resident #27 had a behavior problem related to impaired cognitive function, impaired safety awareness, verbal behavior (yelling out and banging on table instead of using call light), with a goal that safety would be maintained. Interventions included:-Administer medications as ordered, and monitor / document for side effects and effectiveness-Allow resident to make decisions about plan of care-Anticipate and meet the resident's needs -Caregivers to provide opportunity for positive interaction, attention. Stop and talkwith the resident as passing by.-Encourage as much participation / interaction as possible during care activities-Encourage me to follow the plan of care, but respect the resident's choices.-Explain all procedures to the resident before starting and allow the resident time to adjust to changes-Give a clear explanation of all care activities prior to and as they occur duringeach (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	contact-Identify behavior triggers-If the resident resists with ADLs, reassure the resident, leave, return and try again-If issues arise, remove from situation-If reasonable, discuss the resident's behavior, and explain / reinforce why the behavior isinappropriate and/or unacceptable-Intervene as necessary to protect the rights and safety of others, and approach / speakin a calm manner, divert attention, and remove from situation and take to alternatelocation as needed-Refer to psychiatric provider for consultation as orderedThere was no evidence of updates, additions, or revisions to the care plan focus' interventions since December 11, 2025.A psychiatry provider encounter note dated December 18, 2025, revealed the resident was still having moments of yelling and calling out for his wife.A care plan focus initiated December 18, 2025, revealed Resident #27 had impaired cognitive function / dementia or impaired thought processes due to impaired decision making. Interventions initiated on December 18, 2025, included:-Administer medications as ordered-Keep routine consistent and try to provide consistent caregivers as much as possible to decrease confusion-Monitor, document, and report to the physician any changes in cognitive function, and to use task segmentation to support short term memory deficits.There was no evidence of updates, additions, or revisions to the care plan focus' interventions since December 18, 2025.A Physical Therapy (PT) Progress Note dated December 22, 2025, revealed Resident #27 presented with poor sequencing of tasks during walking, and that poor execution of walking technique resulted in decreased safety with walking, and that fall risk was noted. Resident #27 required minimum assistance for chair to / from bed transfers and for walking, and required cues for safe sequencing of tasks.An Occupational Therapy (OT) daily note dated December 24, 2025, revealed the resident required frequent redirection throughout the session due to poor cognition.A Speech Therapy (ST) Daily Note dated December 26, 2025, revealed Resident #27 was able to answer orientation questions with 0% accuracy despite max cueing from the therapist. The resident had continued confusion, stating this is my home, why are you here? where is my wife?. The note revealed the therapist attempted to orient the resident to place and situation, but the resident started to yell out for help.A psychiatry provider encounter note dated December 26, 2025, revealed Resident #27 yelled for help or for his wife, and settled down when talked to but then began yelling out intermittently. The note revealed that per staff, the resident appeared more anxious recently and continued with intermittent yelling out.An ST Daily Note dated December 28, 2025, revealed Resident #27 constantly yelled out and with poor immediate recall, and that the resident began to yell out again as therapist walked away.A Physician Progress Note dated December 28, 2025, revealed the resident constantly yelled I need help repeatedly, and appeared to be about the same. The plan included for mobilization with staff assistance, and safety / fall precautions per facility protocols.A PT Daily Note dated December 30, 2025, revealed that the resident required minimum to moderate assistance for transfers.A neurology provider encounter note dated December 30, 2025, revealed Resident #27 was seen lying in bed while yelling for help and unable to verbalize needs when asked about what he needs. The note revealed the resident could not be redirected, and was intermittently yelling, and that per staff, the resident was constantly yelling and shouting all night as well.A Pulmonary Progress Note dated December 30, 2025, revealed the resident remained confused, alert and oriented to self only, and was yelling out for his wife.An eMar Medication Administration Note dated December 30, 2025, revealed the resident continued to yell out and refused medication.A Daily Skilled Evaluation note dated December 31, 2025, revealed the resident had verbal behavior directed at others requiring frequent redirection, and frequently yelled out instead of using call light.A care plan focus dated December 31, 2025, revealed Resident #27 was admitted to hospice with diagnosis of senile degeneration of brain, effective January 1, 2026. Interventions included:-Nutrition and hydration to maintain (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	comfort-Provide activities to meet needs-Routine position changes and exercise to comfort and relieve pressure-1 to 1 visits and provide support to family as needed, and to document one to one support-Activities of daily living (ADL) needs per facility protocol and existing plan of care-Medication as ordered to ensure comfortA psychiatry provider encounter note dated January 1, 2026, revealed the resident was seen intermittently yelling for help, and calmed down with redirection. The note revealed that staff reported continuation of the resident's same behaviors of yelling out despite frequent reminders to use the call light, and that the resident presented with limited attention and ability to maintain logical / linear thought. The note revealed the resident's speech was yelling out, short- and long-term memory were poor, concentration was tangential, insight was poor, and judgment was limited, and the resident was confused and required frequent re-orientation. Recommendations included for nonpharmacological strategies such as environmental modifications to ensure safety, structured activities to reduce triggers for wandering and agitation, and consistent sleep routine, and to consider pharmacologic intervention if there was concern for safety of patient/others.A BIMS assessment dated [DATE], revealed Resident #27 had a score of 6, indicating severe cognitive impairment.A Behavior Note dated January 2, 2026, revealed Resident #27 continued to have behaviors of yelling throughout the day, and that redirection had no effect.A Progress Note dated January 4, 2026, revealed Resident #27 was noted walking toward nurses' station while yelling, and that the resident's foley catheter was lying on the floor under his chair. The note revealed a certified nursing assistant (CNA) was trying to assist the resident back to the chair. The provider was notified the resident had pulled his catheter out, and the resident was taken to his room, where he was placed on the toilet. The note revealed the nurse instructed a CNA to place the resident in bed after toileting so the catheter could be replaced. Upon entering the room, the resident was standing by his bed, with brief noted with large amount of bright red blood and large clots present. The documentation revealed the provider was updated of the resident's bleeding and clots, and gave an order for the resident to be sent to the emergency department.An observation was conducted on January 4, 2026, at 7:03 a.m. by a team of state surveyors who observed Resident #27 sitting in a reclining wheelchair (gerichair) in the hallway in front of the nurses' station. There was no call light or call bell present for the resident. There was no staff visible nearby the resident. There was no evidence that the resident was set up with any sort of activity or TV show for the resident to watch. The resident was yelling out loudly and frequently for help.Another observation was conducted on January 4, 2026, at 7:42 a.m. of Resident #27 sitting in the gerichair in the hallway in front of the nurses' station. The resident stood up from the gerichair and started to take small unsteady steps forward toward the nurses' station and was yelling out very loudly. No staff were observed near the resident. The resident continued to take small steps forward, which pulled his foley catheter tube taught, and the catheter bag was attached to the gerichair. The resident then was observed to yell out loudly and repeatedly in pain, and the foley catheter tube and balloon were then observed on the floor. The resident continued to yell out loudly in pain, and a CNA (Staff #17) then approached the resident quickly and called out Resident #27's first name. Without re-assuring the resident or explaining what she was doing, Staff #17 grabbed the resident's right arm with both of the staff's hands and arms, and attempted to pull the resident by his arm toward the gerichair. At the same time, Resident #27 stated No and was trying to walk in the opposite direction that Staff #17 was pulling him by the arm. The floor nurse (Staff #9) who was down the hall, called out don't pull on him, and Staff #17 let go of the resident and walked over to the gerichair and brought it over to Resident #27. The resident stated that he had a bowel movement on himself, and Staff #9 approached the resident and instructed Staff #17 to assist the (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident in the bathroom to get him cleaned up, and then Staff #9 would re-insert the catheter. The CNA positioned the gerichair directly in front of Resident #27 and said in a rude tone of voice, sit down here. The CNA did not explain further, and stated again in a rude tone of voice for the resident to sit. The resident was still standing in front of the gerichair, and Staff #17 stated again firmly and rudely sit in there. The resident was taken to the bathroom in the gerichair, and Staff #17 assisted the resident with the toileting task. The observation was continued from outside the door of the resident's bathroom, and the resident's and Staff #17's voices could be overheard from outside the bathroom door. Staff #27 continued to speak to Resident #27 in a firm and rude tone of voice. Resident #27's voice was overheard to say to Staff #17 please don't be rude.A follow-up observation was conducted with the Administrator (Staff #55) on January 6, 2026, at 1:02 p.m. of the facility's video camera footage from January 4, 2026, at 6:00 a.m. of the nurses' station area, revealing the following: -6:00 a.m.: Resident #27 was sitting in a gerichair with the legrest of the chair in the elevated position and the chair back reclined. A foley catheter bag was observed hanging under the legrest portion of the chair. -6:45 a.m.: Resident #27 called out that he needed to use the bathroom. A staff responded to the resident and stated that the resident had a catheter in. The resident replied to the staff and stated that he needed to use the men's room and needed help to use it. The staff did not assist the resident. -6:47 a.m.: The staff was observed leaving the nurses' station area. The resident yelled out for help. No staff responded. The resident called out again why won't you help me, and please help me repeatedly. A nurse was observed standing at a medication cart in the hallway approximately 30 feet away. The resident continued to yell please water and give me water, and no staff responded. -6:49 a.m.: The resident continued to yell out for help and for water. A staff responded and the resident asked the staff to sit him upright so that he could drink water. The staff stated I want you to sit like this for a little longer until breakfast is served. The resident stated he could not drink water reclined like that. -6:50 a.m.: The staff adjusted the resident's gerichair backrest to a more upright position and poured the resident a cup of water. The staff stated to the resident there's no reason for that and you are waking everybody up. The resident stated to the staff, I need to talk to someone who is in authority. The staff stated to the resident that his family was in bed. The staff left the nurse's station area. -6:53 a.m.: Resident #27 continued to yell for help. A male staff walked past the resident, did not attend to the resident, and left the area. No staff was observed nearby the resident, and a nurse was passing medications at a medication cart approximately 30 feet away. No staff had assisted the resident with going to the bathroom as requested. -6:55 a.m.: The resident stated to the nurse that he had a bowel movement, and the nurse stated to the resident to wait until she could find a staff to assist with changing the resident. -6:57 a.m.: A nurse walked past the resident and the resident stated he needed to use the bathroom. The nurse did not address the resident. -6:58 a.m.: Resident #27 continued to yell out loudly help, and that he needed to use the bathroom, and help me. -7:00 a.m.: No staff were observed in sight and the resident continued to yell out loudly and repeatedly for help and that he needed to use the men's room. -7:05 a.m.: A nurse approached the resident and stated to the resident that his family would arrive in a couple hours, and that she needed the resident to stop yelling, and that his family had already been contacted and would be here in a couple hours and then walked away. Neither the nurse nor any other staff addressed the resident's request to use the bathroom. -7:05 a.m.: Resident #27 continued to call out loudly for help repeatedly over 20 times without staff attending to the resident. -7:12 a.m.: a nurse was at the nurse's station. The resident stated that he was going to try to walk and that he might hurt himself doing it. No staff responded to the resident. -7:13 a.m.: The resident (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, facility documentation and policy review, the facility failed to implement their policy on abuse reporting and investigation for allegations of abuse for 2 of 9 sampled residents (#77 and #72). The deficient practice could result in allegations of abuse not reported, not investigated and residents not protected from continued abuse.Findings include: -Resident #77 was admitted on [DATE] with diagnoses of displaced intertrochanteric fracture of the left femur, osteoporosis and chronic pain. The ADL (activities of Daily Living) care plan dated August 1, 2023 included the resident was at risk for ADL self-care performance deficit. Intervention included to encourage resident to participate to the fullest extent possible with each interaction. The progress note dated August 1, 2023 revealed the resident was admitted after a GLF (ground level fall) at home and presented with left hip fracture. The IDT (interdisciplinary team) fall review dated August 7, 2023 included that the resident sustained a fall on August 7, 2023 at 5:00 a.m. The documentation included that resident was found on the floor by the toilet sit facing sideways on the right side; and that, resident reported that he fell. According to the documentation, the resident was alert and oriented x 3 and able to verbalize what happened, was assisted to the wheelchair with a gait belt and 3 person assist assist x3. The alert note dated August 7, 2023 revealed the resident was found on the floor by the toilet sit facing sideways on the right side; and the resident reported that he fell. According to the documentation, the resident was alert and oriented x 3 and able to verbalize what happened, was assisted to the wheelchair with a gait belt and 3 person assist assist x3. A progress note dated August 7, 2023 included that while the resident was observed during smoking break, the resident stated that he was unhappy with facility; and that, the resident did not go into detail about the reasons why he was unhappy,. A late entry incident note dated August 7, 2023 revealed the resident reported that he was treated roughly, and does not want further care from a CNA (certified nurse assistant) that worked for the morning shift on this day. According to the documentation, skin assessment was completed and there were no new findings. It also included that the ED (executive director), DON (director of nursing), physician and the family were notified. The initial facility report submitted to the SA (State Agency) on August 7, 2023 revealed that the resident reported to the unnamed therapist that he did not want care from a CNA assigned to him on August 7, 2023; and that, he had at least 3 broken bones from the CNA who was going to kill him and was out to get him. The report included that the resident was able to describe the CNA as a younger female about 24-[AGE] years old, had a lighter brown hair with glasses, had tattoos and was wearing blue and black; but the resident did not know the CNA's name. The documentation included that later, the resident reported that the CNA wore dark grey clothes and had tattoos on the left arm; and that, there was a CNA that best fits this description. According to the report, the resident reported that the CNA wheeled him around too fast, bumped his feet on walls and he felt like a horse while being showered; and, while being turned during cares by the CNA, he hit his face on the wall. The report included that the CNA was immediately suspended and at the time of the report submission, the facility was contacting other agencies. However, review of the clinical record and facility documentation, there was no evidence found that this allegation was reported to law enforcement and APS (Adult Protective Services); and that, the results of the investigation of the alleged abuse was submitted to the SA within 5 working days of the incident. There was also no evidence that this allegation was thoroughly investigated by the facility. -Resident #72 was admitted on [DATE] with diagnoses of chronic embolism, hemiplegia and hemiparesis, restless leg syndrome and other specified disorders of the brain. The ADL care plan dated July 26, 2023 included (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the resident was at risk for ADL self-care performance deficit. Interventions included to praise efforts at self care and to encourage resident to participate to the fullest extent possible with each interaction. The health status note dated August 12, 2023 revealed the resident was alert and oriented x 3-4. The late entry NP (nurse practitioner) progress note dated August 30, 2023 included that the resident had been smoking since she was [AGE] years old; and that the resident smokes every day. The psychology progress notes dated September 13, 2023 revealed that observations of and conversations with resident revealed no evidence of psychological harm related to incident last week. The documentation did not include details of the incident. Per the documentation that after speaking with resident, there were no concerns or changes noted since the occurrence; and that, the resident has had no other incidents of conflicts. The psychology progress notes dated September 14, 2023 revealed that observations of and conversations with resident revealed no evidence of psychological harm related to incident last week. The documentation did not include details of the incident. Per the documentation that after speaking with resident, there were no concerns or changes noted since the occurrence. The initial facility report submitted to the SA on September 14, 2023 included that resident #72 reported to the ED (staff #54) that on September 11, 2023 at 2:00 p.m., another resident made sexual comments towards resident #72 while she was sitting on the smoking patio last week. However, review of the clinical record and facility documentation, there was no evidence found that this allegation was reported to law enforcement; and that, the results of the investigation of the alleged abuse was submitted to the SA within 5 working days of the incident. There was also no evidence that this allegation was thoroughly investigated by the facility. The email correspondence from the Director of Nursing (DON/staff #19) dated January 5, 2026 revealed that the investigation/incidents and/or complaints requested for resident #77 and #72 were not available because they were outside the guidelines. An interview with the DON (staff #19) was conducted on January 6, 2026 at 1:47 p.m. The DON stated she does not know where the investigations for the incident related to residents #77 and #72 because both residents as in her email were outside the guideline. She said that outside the guideline was their policy which dictates what and for how long documents including incidents/investigations were maintained for X number of years. An interview with a registered nurse (RN/staff #25) was conducted on January 6, 2026 at 3:17 p.m. The RN stated that different types of abuse included financial, physical, sexual, verbal and emotional abuse; and, when there is an allegation of abuse and/or neglect, staff ensures the resident was safe, the alleged aggressor is separated from the resident/victim. The RN stated that if the allegation involved a staff member, the staff is sent home so there is no access to the resident/victim or anyone else that may be put in danger. The RN also said that allegations of abuse and/or neglect is reported to the administrator immediately; and the Ombudsman, police, physician, family were also notified. In an interview with another RN (staff #32) conducted on January 6, 2026 at 3:28 p.m., the RN stated that if an allegation of abuse was to reported to her, she would ensure that the resident was secured, safe and would separate the resident from the perpetrator. She stated that she would also notify the ED, DON or the assistant DON so they could work together to resolve the situation. The RN said that if the perpetrator was a staff member, that staff member would be sent home and she would call the ED. An interview was conducted on January 6, 2026 at 3:40 p.m. with the social services director (SSD/staff #56) who stated that different types of abuse included sexual, physical, emotional and financial abuse; and if there were allegations of abuse, it would immediately be reported directly to the ED. He stated that if the ED was not available, the incident will be reported either to the DON or the ADON. The SSD stated that when there was an allegation of abuse, the first thing to do was to ensure the resident was safe; and if the perpetrator (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was a staff member, they were immediately suspended until the investigation was concluded. The SSD further stated that his role in abuse investigation was to help with the facility's self-report and assist the ED with investigation. During an interview with the administrator (staff #55) conducted on January 7, 2026 at 8:30 a.m., he stated that he could not any evidence of the investigation the facility conducted regarding resident #77 and #72. The administrator further stated that he follows the facility policy on record retention which stated that incident reports and self-reports must only be retained for a period of 12 months after the date of report or posting; and, grievances must only be retained for a period of 3 years. In another interview with the DON (staff #19) conducted on January 7, 2026 at 12:13 p.m., the DON stated that staff will follow their policy on abuse, when there was an allegation of abuse. She stated that when there was an allegations of abuse, staff would ensure that residents were safe; and if it involved a staff, the staff would be suspended until the facility's investigation was over. She stated that the allegation of abuse is reported to the abuse coordinator; and, investigation will be conducted by the abuse coordinator who will then send a preliminary report to the SA, APS, Ombudsman, police and family. She stated the allegation of abuse will be reported to the SA, APS, Ombudsman and police within the 2 hour window for suspected abuse. The DON also said that investigation of the allegation of abuse conducted by the abuse coordinator involved conducting interviews with the victim, the alleged perpetrator and possible witnesses; and, the abuse coordinator would then submit the 5-day report of the investigation to the SA. The policy on Abuse, Neglect, Exploitation and Misappropriation Prevention Program with effective date of January 1, 2024 included that residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives:-Develop and implement policies and protocols to prevent and identify: a. abuse or mistreatment of residents; b. neglect of residents; and/or c. theft, exploitation or misappropriation of resident property;-Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property;-Investigate and report any allegations within timeframes required by federal requirements; and, -Protect residents from any further harm during investigations.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, facility documentation and policy review, the facility failed to ensure an allegations of abuse were reported to APS and law enforcement; and failed to ensure that the results of the investigations of the alleged violation for 2 of 9 sampled residents (#77 and #72) were submitted to the SA within 5 working days of the incident. The deficient practice could result in allegations of abuse not investigated and residents not protected from continued abuse.Findings include: -Resident #77 was admitted on [DATE] with diagnoses of displaced intertrochanteric fracture of the left femur, osteoporosis and chronic pain. The ADL (activities of Daily Living) care plan dated August 1, 2023 included the resident was at risk for ADL self-care performance deficit. Intervention included to encourage resident to participate to the fullest extent possible with each interaction. The progress note dated August 1, 2023 revealed the resident was admitted after a GLF (ground level fall) at home and presented with left hip fracture. The IDT (interdisciplinary team) fall review dated August 7, 2023 included that the resident sustained a fall on August 7, 2023 at 5:00 a.m. The documentation included that resident was found on the floor by the toilet sit facing sideways on the right side; and that, resident reported that he fell. According to the documentation, the resident was alert and oriented x 3 and able to verbalize what happened, was assisted to the wheelchair with a gait belt and 3 person assist assist x3. The alert note dated August 7, 2023 revealed the resident was found on the floor by the toilet sit facing sideways on the right side; and the resident reported that he fell. According to the documentation, the resident was alert and oriented x 3 and able to verbalize what happened, was assisted to the wheelchair with a gait belt and 3 person assist assist x3. A progress note dated August 7, 2023 included that while the resident was observed during smoking break, the resident stated that he was unhappy with facility; and that, the resident did not go into detail about the reasons why he was unhappy,. A late entry incident note dated August 7, 2023 revealed the resident reported that he was treated roughly, and does not want further care from a CNA (certified nurse assistant) that worked for the morning shift on this day. According to the documentation, skin assessment was completed and there were no new findings. It also included that the ED (executive director), DON (director of nursing), physician and the family were notified. The initial facility report submitted to the SA (State Agency) on August 7, 2023 revealed that the resident reported to the unnamed therapist that he did not want care from a CNA assigned to him on August 7, 2023; and that, he had at least 3 broken bones from the CNA who was going to kill him and was out to get him. The report included that the resident was able to describe the CNA as a younger female about 24-[AGE] years old, had a lighter brown hair with glasses, had tattoos and was wearing blue and black; but the resident did not know the CNA's name. The documentation included that later, the resident reported that the CNA wore dark grey clothes and had tattoos on the left arm; and that, there was a CNA that best fits this description. According to the report, the resident reported that the CNA wheeled him around too fast, bumped his feet on walls and he felt like a horse while being showered; and, while being turned during cares by the CNA, he hit his face on the wall. The report included that the CNA was immediately suspended and at the time of the report submission, the facility was contacting other agencies. However, review of the clinical record and facility documentation, there was no evidence found that this allegation was reported to law enforcement and APS (Adult Protective Services); and that, the results of the investigation of the alleged abuse was submitted to the SA within 5 working days of the incident. -Resident #72 was admitted on [DATE] with diagnoses of chronic embolism, hemiplegia and hemiparesis, restless leg syndrome and other specified disorders (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of the brain. The ADL care plan dated July 26, 2023 included the resident was at risk for ADL self-care performance deficit. Interventions included to praise efforts at self care and to encourage resident to participate to the fullest extent possible with each interaction. The health status note dated August 12, 2023 revealed the resident was alert and oriented x 3-4. The late entry NP (nurse practitioner) progress note dated August 30, 2023 included that the resident had been smoking since she was [AGE] years old; and that the resident smokes every day. The psychology progress notes dated September 13, 2023 revealed that observations of and conversations with resident revealed no evidence of psychological harm related to incident last week. The documentation did not include details of the incident. Per the documentation that after speaking with resident, there were no concerns or changes noted since the occurrence; and that, the resident has had no other incidents of conflicts. The psychology progress notes dated September 14, 2023 revealed that observations of and conversations with resident revealed no evidence of psychological harm related to incident last week. The documentation did not include details of the incident. Per the documentation that after speaking with resident, there were no concerns or changes noted since the occurrence. The initial facility report submitted to the SA on September 14, 2023 included that resident #72 reported to the ED (staff #54) that on September 11, 2023 at 2:00 p.m., another resident made sexual comments towards resident #72 while she was sitting on the smoking patio last week. However, review of the clinical record and facility documentation, there was no evidence found that this allegation was reported to law enforcement; and that, the results of the investigation of the alleged abuse was submitted to the SA within 5 working days of the incident. An interview with a registered nurse (RN/staff #25) was conducted on January 6, 2026 at 3:17 p.m. The RN stated that allegations of abuse and/or neglect is reported to the administrator immediately; and the Ombudsman, police, physician, family were also notified. In an interview with another RN (staff #32) conducted on January 6, 2026 at 3:28 p.m., the RN stated that if an allegation of abuse was to reported to her, she would ensure that the resident was secured, safe and would separate the resident from the perpetrator. She stated that she would also notify the ED, DON or the assistant DON so they could work together to resolve the situation. An interview was conducted on January 6, 2026 at 3:40 p.m. with the social services director (SSD/staff #56) who stated that different types of abuse included sexual, physical, emotional and financial abuse; and if there were allegations of abuse, it would immediately be reported directly to the ED. He stated that if the ED was not available, the incident will be reported either to the DON or the ADON. The SSD further stated that his role in abuse investigation was to help with the facility's self-report and assist the ED with investigation. During an interview with the administrator (staff #55) conducted on January 7, 2026 at 8:30 a.m., he stated that he could not any evidence of the investigation the facility conducted regarding resident #77 and #72. The administrator further stated that he follows the facility policy on record retention which stated that incident reports and self-reports must only be retained for a period of 12 months after the date of report or posting; and, grievances must only be retained for a period of 3 years. In another interview with the DON (staff #19) conducted on January 7, 2026 at 12:13 p.m., the DON stated that staff will follow their policy on abuse, when there was an allegation of abuse. She stated that allegation of abuse is reported to the abuse coordinator; and, investigation will be conducted by the abuse coordinator who will then send a preliminary report to the SA, APS, Ombudsman, police and family. She stated the allegation of abuse will be reported to the SA, APS, Ombudsman and police within the 2 hour window for suspected abuse. The DON also said that investigation of the allegation of abuse conducted by the abuse coordinator involved conducting interviews with the victim, the alleged perpetrator and possible witnesses; and, the abuse coordinator (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	would then submit the 5-day report of the investigation to the SA. The policy on Abuse, Neglect, Exploitation and Misappropriation Prevention Program with effective date of January 1, 2024 included that residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: -Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property; and, investigate and report any allegations within timeframes required by federal requirements.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, facility documentation and policy review, the facility failed to ensure allegations of abuse for 2 of 9 sampled residents (#77 and #72) were thoroughly investigated. The deficient practice could result in residents not protected from continued abuse and appropriate corrective action not taken.Findings include: -Resident #77 was admitted on [DATE] with diagnoses of displaced intertrochanteric fracture of the left femur, osteoporosis and chronic pain. The ADL (activities of Daily Living) care plan dated August 1, 2023 included the resident was at risk for ADL self-care performance deficit. Intervention included to encourage resident to participate to the fullest extent possible with each interaction. The progress note dated August 1, 2023 revealed the resident was admitted after a GLF (ground level fall) at home and presented with left hip fracture. The IDT (interdisciplinary team) fall review dated August 7, 2023 included that the resident sustained a fall on August 7, 2023 at 5:00 a.m. The documentation included that resident was found on the floor by the toilet sit facing sideways on the right side; and that, resident reported that he fell. According to the documentation, the resident was alert and oriented x 3 and able to verbalize what happened, was assisted to the wheelchair with a gait belt and 3 person assist assist x3. The alert note dated August 7, 2023 revealed the resident was found on the floor by the toilet sit facing sideways on the right side; and the resident reported that he fell. According to the documentation, the resident was alert and oriented x 3 and able to verbalize what happened, was assisted to the wheelchair with a gait belt and 3 person assist assist x3. A progress note dated August 7, 2023 included that while the resident was observed during smoking break, the resident stated that he was unhappy with facility; and that, the resident did not go into detail about the reasons why he was unhappy,. A late entry incident note dated August 7, 2023 revealed the resident reported that he was treated roughly, and does not want further care from a CNA (certified nurse assistant) that worked for the morning shift on this day. According to the documentation, skin assessment was completed and there were no new findings. It also included that the ED (executive director), DON (director of nursing), physician and the family were notified. The initial facility report submitted to the SA (State Agency) on August 7, 2023 revealed that the resident reported to the unnamed therapist that he did not want care from a CNA assigned to him on August 7, 2023; and that, he had at least 3 broken bones from the CNA who was going to kill him and was out to get him. The report included that the resident was able to describe the CNA as a younger female about 24-[AGE] years old, had a lighter brown hair with glasses, had tattoos and was wearing blue and black; but the resident did not know the CNA's name. The documentation included that later, the resident reported that the CNA wore dark grey clothes and had tattoos on the left arm; and that, there was a CNA that best fits this description. According to the report, the resident reported that the CNA wheeled him around too fast, bumped his feet on walls and he felt like a horse while being showered; and, while being turned during cares by the CNA, he hit his face on the wall. The report included that the CNA was immediately suspended and at the time of the report submission, the facility was contacting other agencies. However, review of the clinical record and facility documentation, there was no evidence found that the allegation of abuse for resident #77 was thoroughly investigated by the facility. -Resident #72 was admitted on [DATE] with diagnoses of chronic embolism, hemiplegia and hemiparesis, restless leg syndrome and other specified disorders of the brain. The ADL care plan dated July 26, 2023 included the resident was at risk for ADL self-care performance deficit. Interventions included to praise efforts at self care and to encourage resident to participate to the fullest extent possible with each interaction. The health status note dated August 12, 2023 revealed the resident was alert and (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	oriented x 3-4. The late entry NP (nurse practitioner) progress note dated August 30, 2023 included that the resident had been smoking since she was [AGE] years old; and that the resident smokes every day. The psychology progress notes dated September 13, 2023 revealed that observations of and conversations with resident revealed no evidence of psychological harm related to incident last week. The documentation did not include details of the incident. Per the documentation that after speaking with resident, there were no concerns or changes noted since the occurrence; and that, the resident has had no other incidents of conflicts. The psychology progress notes dated September 14, 2023 revealed that observations of and conversations with resident revealed no evidence of psychological harm related to incident last week. The documentation did not include details of the incident. Per the documentation that after speaking with resident, there were no concerns or changes noted since the occurrence. The initial facility report submitted to the SA on September 14, 2023 included that resident #72 reported to the ED (staff #54) that on September 11, 2023 at 2:00 p.m., another resident made sexual comments towards resident #72 while she was sitting on the smoking patio last week. However, review of the clinical record and facility documentation, there was no evidence found that the allegation of abuse for resident #72 was thoroughly investigated by the facility. The email correspondence from the Director of Nursing (DON/staff #19) dated January 5, 2026 revealed that the investigation/incidents and/or complaints requested for resident #77 and #72 were not available because they were outside the guidelines. An interview with the DON (staff #19) was conducted on January 6, 2026 at 1:47 p.m. The DON stated she does not know where the investigations for the incident related to residents #77 and #72 because both residents as in her email were outside the guideline. She said that outside the guideline was their policy which dictates what and for how long documents including incidents/investigations were maintained for X number of years. An interview was conducted on January 6, 2026 at 3:40 p.m. with the social services director (SSD/staff #56) who stated that different types of abuse included sexual, physical, emotional and financial abuse; and if there were allegations of abuse, it would immediately be reported directly to the ED. He stated that if the ED was not available, the incident will be reported either to the DON or the ADON. The SSD further stated that his role in abuse investigation was to help with the facility's self-report and assist the ED with investigation. During an interview with the administrator (staff #55) conducted on January 7, 2026 at 8:30 a.m., he stated that he could not any evidence of the investigation the facility conducted regarding resident #77 and #72. The administrator further stated that he follows the facility policy on record retention which stated that incident reports and self-reports must only be retained for a period of 12 months after the date of report or posting; and, grievances must only be retained for a period of 3 years. In another interview with the DON (staff #19) conducted on January 7, 2026 at 12:13 p.m., the DON stated that staff will follow their policy on abuse, when there was an allegation of abuse. She stated that when there was an allegations of abuse, staff would ensure that residents were safe; and if it involved a staff, the staff would be suspended until the facility's investigation was over. She stated that the allegation of abuse is reported to the abuse coordinator; and, investigation will be conducted by the abuse coordinator who will then send a preliminary report to the SA, APS, Ombudsman, police and family. She stated the allegation of abuse will be reported to the SA, APS, Ombudsman and police within the 2 hour window for suspected abuse. The DON also said that investigation of the allegation of abuse conducted by the abuse coordinator involved conducting interviews with the victim, the alleged perpetrator and possible witnesses; and, the abuse coordinator would then submit the 5-day report of the investigation to the SA. The policy on Abuse, Neglect, Exploitation and Misappropriation Prevention Program with effective date of January 1, 2024 included that (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property; and, investigate and report any allegations within timeframes required by federal requirements. The facility memo on Retention of Records dated November 1, 2025 revealed that pursuant to the Federal [(2 CFR S483.70 and 42 CFR S483.35(i)(4)] and State (A.A.C. R9-10-404 and A.R.S. 12-2297) regulations, a skilled nursing facility in the State of Arizona is only required to keep or retain records, staffing records, personnel records and quality manager and incident records for the period indicated in the regulation. The greatest period of retention required is 6 years after the date of discharge and that is the period of which pertains only to retention of resident medical records. Incident reports and self-reports must only be retained for a period of 12 months after the date of report or posting. grievances of the facility must only be retained for a period of 3 years after the grievance decision is issued. As a federally and state regulated skilled nursing facility, it follows the retention requirements mentioned above and therefore, requests for documents spanning time periods prior to said retention requirements are outside of the scope and ask for the production of records is not required to meaintain due to time passed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035059	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Scottsdale	3293 North Drinkwater Boulevard Scottsdale, AZ 85251

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and review of facility documentation and policy, the facility failed to ensure that the Ombudsman was provided a copy of the notice of discharge for 2 of 3 sampled residents (#76 and #70). The deficient practice could result in residents being inappropriately discharged .Findings include:-Resident #76 was admitted on [DATE] with diagnoses of metabolic encephalopathy, COPD (chronic obstructive pulmonary disease) and anxiety. The admission evaluation dated September 16, 2025 included that the resident was admitted from a short-term general hospital via a stretcher for post-op rehabilitation. The skilled needs review dated September 17, 2025 revealed that the IDT (interdisciplinary team) attested that the resident met all the criteria for skilled services and the case manager approved continued stay through September 18, 2025. According to the documentation, the resident was expected to be discharged to community. The social services progress note dated September 17, 2025 revealed that discharge planning was discussed with the resident who reported a plan to discharge back to her home. The physiatry progress note dated September 18, 2025 included discharge planning and disposition to continue discussion with the therapy team, family, and social worker in multidisciplinary team meetings and will further determine as rehab progresses. Per the documentation, the resident will be followed throughout rehabilitation course to manage rehabilitation and any barriers to therapies. The IDT care plan conference dated September 23, 2025 revealed that the resident reported that she planned to discharge back to her home. The skilled needs review dated September 23, 2025 included that the resident expected to be discharged to the community. The PT (physical therapy) daily note dated October 8, 2025 included that therapy discharge was completed and the resident was discharging to home hospice services. The Discharge summary dated [DATE] included that the resident will be discharge to the community with hospice services. The skilled needs review dated October 8, 2025 revealed the resident was expected to be discharged to the community; and, anticipated discharge date was October 9, 2025. The discharge transfer evaluation dated October 8, 2025 revealed the resident was discharging to private home with hospice services. The physician order dated October 9, 2025 revealed that the resident has completed skilled inpatient stay and will be discharged home on October 9, 2025. The discharge MDS (Minimum Data Set) assessment dated [DATE] revealed resident discharged on October 9, 2025. Despite documentation that the resident was discharged , there was no evidence found in the clinical record that the Ombudsman was notified and provided a copy of the notice of discharge of resident #76. -Resident #70 was admitted on [DATE] with diagnoses of speech language deficits and type II diabetes. A A physician order dated March 11, 2024 revealed that the resident had completed skilled inpatient stay and will discharge to home on March 14, 2024. Another physician order dated March 11, 2024 included that resident was discharging with remaining medication and narcotics. The IDT care plan conference dated March 12, 2024 revealed that the resident's plan was to be discharged to home with family. The Discharge summary dated [DATE] included a date of discharge of March 14, 2024; and that, the resident will be discharged with medications. The progress note dated March 14, 2024 revealed resident discharged home in stable condition with family and belongings. There was no evidence found in the clinical record that the Ombudsman was notified and provided a copy of the notice of discharge of resident #70. In an interview with the Director of Nursing (DON/staff #19) conducted on January 7, 2026 at 10:10 a.m., the DON stated that she had only been the DON for the facility since November 24, 2025 and the facility's social services director had only been at the facility for 3 days. The DON stated that social services usually gets notified of a resident's discharge upon discussion of the NOMNC (Notice of Medicare Non-Coverage) (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	during meeting. She stated that the resident and/or resident representative (RR) is then notified in writing regarding the reason for discharge, the effective date of discharge, the location where the resident was going, explanation to the resident's right to appeal the discharge. She also stated that the resident gets a copy of bed hold policy and contact information for the Ombudsman. The facility policy on Admissions/Transfers/Discharges: Transfer or Discharge Notice included that resident and/or representatives are notified in writing, and in a language and format they understand, at least 30 days priori to a transfer or discharge. However, the policy did not include notification of the Ombudsman.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and facility documentation and policy review, the facility failed to ensure care and services related to pressure ulcer was provided to 1 of 3 sampled residents (#64). The deficient practice could result in worsening of the resident's pressure ulcer.Findings include:Resident #64 was admitted on [DATE] with diagnoses of fracture of the upper end of the left tibia, type II diabetes with hyperglycemia and pulmonary fibrosis. The late entry admission evaluation note dated September 19, 2024 included that the resident was admitted from a short-term general hospital, had shortness of breath with lying flat, was on 2 liters of oxygen via nares to keep oxygen saturation above 90% while lying flat, and had bowel and bladder incontinence. The Braden scale dated September 19, 2024 revealed a score of 15 indicating the resident had low risk of developing pressure ulcers. The progress note dated September 19, 2024 included the resident was alert to name only and had a stage 4 ulcer to the coccyx with foul odor present. The care plan dated September 19, 2024 revealed the resident had and was at risk for skin impairment: coccyx, left ankle, left biceps, left knee and right elbow. Interventions included to administer treatments as ordered and monitor for effectiveness; to educate me/family/caregivers as to causes of skin breakdown; including: transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning; to follow facility policies/protocols for the prevention/treatment of skin breakdown; weekly skin assessment; and to monitor/document/report to MD PRN changes in skin statusA physician order dated September 19, 2024 included for weekly skin check. The weekly skin check and wound assessment note dated September 19, 2024 revealed a stage 4 ulcer on the coccyx. The documentation did not include wound descriptions such as measurements, presence/absence of odor, drainage, tunneling, description of the surrounding skin and wound edge/bed.The health status note dated September 21, 2024 included that family was concerned about the bed the resident was in because of her pressure ulcer.The weekly skin check dated September 21, 2024 revealed an unstageable pressure ulcer to the coccyx. The pressure ulcer documentation dated September 21, 2024 included an unstageable pressure ulcer, present on admission, measuring 3 cm (centimeter) x 4.2 cm, with moderate serosanguineous drainage, slight odor, necrotic tissue with surrounding slough. Per the documentation, treatment included Medihoney, alginate then foam dressing; and that, a LALM (low air loss mattress) was requested. Patient and staff educated to turn and reposition Q2.Despite the documentation that the resident had stage 4 pressure ulcer identified on admission, the clinical record revealed no evidence that treatment for the pressure ulcer was initiated until September 21, 2024.A physician order dated September 21, 2024 revealed an order for air mattress per resident's request for wound healing and prevention.Another physician order dated September 21, 2024 included to cleanse the coccyx with NS (normal saline) or wound spray, pat dry, apply Medihoney (topical wound treatment) then calcium alginate (hemostatic/adsorbent topical wound treatment) and cover with foam dressing every day shift and as needed if dressing is soiled or dislodged.The history & physical note dated September 21, 2024 revealed the resident was transferred from the acute care setting to continue treatment at the subacute level patient here for therapy and rehab and management of comorbidities along with the completion of treatment from the hospital. The documentation included resident had dialysis on Saturday and had been febrile, was very lethargic and was on 5 liters of oxygen via mask. Physical examination included resident was alert and oriented x 3 and skin was within normal limits. According to the documentation wound examination was deferred per wound team evaluation and descriptions. The order for the wound treatment to the coccyx was transcribed onto the wound administration record for September 2024. Review of the wound administration (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	record revealed that the treatment was marked as 6 indicating the resident was hospitalized on [DATE].The order for the air mattress was transcribed onto the TAR (treatment administration record) for September 2024. The documentation included that this was administered as ordered on September 21 and 22, 2024.The alert note dated September 22, 2024 included that the resident was admitted to hospital for sepsis.The skin care plan was revised on September 24, 2024 to include the intervention of a pressure-relieving mattress. An interview with the DON (director of nursing) was conducted on January 6, 2026 at 7:35 a.m. The DON stated that the documents regarding resident #64 that she provided were all the facility had related to the resident's pressure ulcer. An interview with the MDS (Minimum Data Set) nurse (staff #25) was conducted on January 6, 2026 at 4:15 p.m. The MDS nurse stated that upon admission, each resident receives a head-to-toe skin assessment; and, if a skin impairment or wound was identified, it is documented in the clinical record and the provider is notified for orders. He stated that treatment begins as soon as provider orders are received. The MDS nurse also said that delays in treatment do not meet facility expectations, as delays can worsen skin impairments or wounds; and, if a delay is identified, the provider, family, and supervisor are notified. Further, he stated that wound care and treatments were expected to be documented each time they were provided; and, if a nurse reported that treatment was given but there was no documentation, the treatment was considered not to have been done. In an interview with a registered nurse (RN/staff #32) conducted on January 6, 2026 at 4:24 p.m., the RN stated that a head to toe skin assessment are conducted upon admission of the resident and this assessment is documented in the electronic health record. She said that if a skin impairment was identified, the nurse was expected to contact the wound care nurse and provider for immediate directions. The RN said that it would not meet facility expectations if the treatment was delayed, especially if delayed by two or three days, as that may delay healing and cause the wound to get infected. The RN stated that documentation was required to prove that the treatment was provided; and, if there was no documentation, then, treatment was not done or provided to the resident. She further stated that if she discovers that there was no treatment for the resident's wounds, she would notify the nurse supervisor, family, and the provider. An interview with the DON (staff #19) conducted on January 7, 2026 at 12:13 p.m. The corporate resource (staff #51) was present during this interview. The DON stated that when a resident comes with an open area/wound, the nurse would assess the wound and document the assessment to include color, size or drainage; but cannot stage the wound. She stated that if the resident's wound on admission had orders, the nurse were expected to transcribe the order onto the TAR and follow the treatment as ordered by the physician. She stated that if there were no treatment orders for the wound upon resident admission, the expectation was for the nurse to notify the notify the provider at the time of assessment. She stated that the facility has a 3rd party wound provider that conducts weekly assessments of the wounds of residents at the facility; and, the nurses conduct weekly skin assessment. The DON said that when wound care was provided, documentation in the clinical record would include the type of wound care given, date/time wound care given, position the resident was placed in to provide wound care, name of the person providing wound care, how the resident tolerated the procedure. and, if there were problems encountered during the provision of care/treatment. She stated that if the resident refused treatment, the reason why the resident refused must also be documented and the nurse should notify the supervisor. Regarding resident #64, the DON stated that she had only been a DON at the facility since November 2025 and all she knew about this resident was that resident #64 went to dialysis Tuesday-Thursday and Saturdays; and that, the resident's admission on [DATE] was a dialysis day. She said that the resident had another dialysis on September 21, 2024 (Saturday) and was discharged from the (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility on September 22, 2024 (Sunday). However, the DON stated that she did not know why the resident was discharged because the facility did not facilitate the discharge; so, she can only assume that the resident went to the hospital from dialysis. Further, the DON stated that she does not know whether or not treatment was initiated or provided for resident #64. The corporate resource stated that she reviewed the clinical record of resident #64 and found no documentation that treatment was provided to resident #64. Review of the facility policy on Skin/Wound Management: Pressure Ulcers/Skin Breakdown-Clinical Protocol, effective January 1, 2024 revealed that the nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers; for example, immobility, recent weight loss, and a history of pressure ulcer(s). In addition, the nurse shall describe and document/report the following: a. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue; b. Pain assessment; c. Resident's mobility status; d. Current treatments, including support surfaces; and, e. All active diagnoses. The staff and practitioner will examine the skin of newly admitted residents for evidence of existing pressure ulcers or other skin conditions. The physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings (occlusive, absorptive, etc.), and application of topical agents. The physician will help identify medical interventions related to wound management; for example, treating a soft tissue infection surrounding an ulcer, removing necrotic tissue, addressing comorbid medical conditions, managing pain related to the wound or to wound treatment, etc.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, facility documentation and policy review, the facility failed to ensure protocols for reconciliation of controlled medications were followed by staff to prevent diversion of narcotic medications for 2 sampled residents (#73 and #74). The deficient practice could result in result in risk of harm including inadequate relief of pain and complications associated with the medication use and misuse.Findings include: -Resident #74 was readmitted on [DATE] with diagnoses of acute osteomyelitis of the right ankle and foot, infection and inflammatory reaction due to internal left hip prosthesis and pain in the left hip. The admission evaluation dated February 9, 2024 revealed the resident was admitted on [DATE] from short-term general hospital. The care plan dated February 9, 2024 included that the resident was prescribed with high risk medications and was at risk for pain. Interventions included to administer analgesia medications as per orders, observe for and report any observed adverse effects to provider when clinically significant. A physician order dated February 9, 2024 revealed an order for pain evaluation using pain scale 1-10 every shift. The late entry history & physical note dated February 10, 2024 included that the resident was transferred from the acute care setting to continue treatment at the subacute level patient here for therapy and rehab and management of comorbidities along with the completion of treatment from the hospital. Summary problem list included right foot osteomyelitis s/p (status post) right foot amputation. The physician order summary report revealed an order for oxycodone (narcotic) 5 mg (milligrams), give 1 tablet by mouth every 6 hours as needed for pain 4-10. The order for oxycodone was not transcribed onto the MAR (medication administration record) for February 2024. The narcotic card audit from January 18, 2024 through February 18, 2024 conducted by the DON (Director of Nursing) revealed the oxycodone 5 mg for resident #74 had quantity of 58 dispensed; and, was highlighted. The documentation did not have a check mark and did not indicate whether the medication in the cart or was scanned. -Resident #73 was admitted on [DATE] with diagnoses of atherosclerotic heart disease of native coronary artery without angina pectoris, muscle weakness, and acute hematogenous osteomyelitis of the right ankle and foot. A physician order dated February 6, 2024 revealed Oxycodone-Acetaminophen Tablet 10-325 mg Give 1 tablet by mouth every 6 hours as needed for pain level 1-10. The care plan dated February 9, 2024 included that the resident was on an opiate medication. Intervention included to administer medications as ordered. A physician order dated February 9, 2024 revealed an order for pain evaluation using pain scale 1-10 every shift. The physician progress note dated February 10, 2024 included an interim history that on February 10, 2024 resident complained of leg pain with no issues, Plan was to continue pain medication. The physician progress note dated February 11, 2024 revealed pain control was adequate. Review of the MAR for February 2024 revealed that the order for Oxycodone-Acetaminophen Tablet 10-325 mg was transcribed; and that, it was documented as administered on February 7 and 14, 2024. The late entry NP (nurse practitioner) note dated February 15, 2024 included that resident indicated that pain level was 4/10 and pai was controlled on current medication regimen. The documentation also included that nursing endorsed a goal to wean the resident off of opioid pain medications. Pain regimen included Oxycodone-Acetaminophen Tablet 10-325 mg 1 tab q6 hours PRN (as needed) for moderate to severe pain. The narcotic card audit from January 18, 2024 through February 18, 2024 conducted by the DON revealed the oxycodone-acetaminophen 10-325 mg for resident #73 had quantity of 20 dispensed. The documentation was highlighted, did not have a check mark, and was marked as n/a. The facility investigation dated February 21, 2024 revealed that on 2 nurses who worked the morning shift (6:00 a.m. - 6:00 p.m.) and the NOC shift (6:00 p.m. - 6:00 a.m.) on (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	February 14, 2024 completed medication reconciliation; and that, the bubble pack and the narcotic count sheet for the oxycodone of resident #73 were present. On February 15, 2024 the alleged registry RN (staff #52) accepted the cart from the NOC shift nurse identifying that the narcotics and the count sheet were both present. The investigation included that the alleged registry RN passed the report to the NOC shift nurse on February 15, 2024; but, the narcotic sheet and the bubble pack for the oxycodone of resident #73 were not present; and that, the alleged registry RN concealed this information and did not properly hand off that information in the report. The facility investigation included that when the NOC shift nurse for February 15, 2024 passed the report onto the oncoming morning shift nurse for February 16, 2024 and told the oncoming morning shift nurse that resident #73 was asking for his oxycodone-acetaminophen medication. According to the documentation, there was an order for this medication for resident #73 but neither the count sheet nor the bubble pack were present in the nurse's cart. Continued review of the facility investigation revealed that during the course of their investigation, the camera footage was reviewed and showed that the alleged registry RN entered the medication room and pretended to put medications into a cabinet. The documentation also included that it was clear that the alleged registry RN was stuffing medication bubble packs down the front of her scrubs. Per the documentation, during the facility's audit of all other residents on controlled medications, it was determined that the alleged registry RN removed resident #74's oxycodone 5 mg and had taken total of 58 of this medication out of the facility; and that, this was a discontinued narcotic order for resident #74 and this medication was set to be destroyed. Further review of the facility investigation included that the facility substantiated misappropriation of medications; and that, when the facility reviewed the camera footage it appeared that th alleged nurse placed 2 bubble packs into her scrubs.A review of the January 2025 narcotic log book for the Hall A and D Medication cart was conducted with the assistant Director of Nursing (ADON/staff #8) on January 4, 2026 at 2:37 p.m. The log book included two nurse signatures and the sampled resident narcotic logs matched the quantity of the resident narcotic blister pack. The ADON stated that it was the nursing staff responsibility to audit the narcotic log on each medication cart on a regular basis; and that; 2 nurse signatures were required each shift to ensure accuracy of the narcotic counts. The ADON stated that if the narcotic count was incorrect, the DON is notified and investigation is conducted immediately. Further, the ADON said that narcotic counts were taken seriously in order to prevent the risk of narcotic loss or diversion. An interview was conducted on January 5, 2025 with Registered Nurse (RN/Staff #32) at 8:03 a.m. The RN stated it was never ok to use controlled medications because the narcotic count would be off; and this was against policy to use one residents' medication for another. She stated that in order to prevent narcotic diversion, two nurses will conduct a narcotic count when the medication cart is transferred to the oncoming nurse at shift change. The RN stated that if there were any issues with the count the Director of Nursing will be notified immediately. The RN also stated that all allegations of missed narcotic dosage from a resident were taken seriously; and, possible signs of narcotic diversion included resident having worsening or uncontrolled pain and/or resident not receiving the medicationsIn an interview with a licensed practical nurse (LPN/staff #9) conducted on January 5, 2025 at 9:36 a.m., the LPN said that the oncoming nurse counts all medication cards, bottles, and syringes to verify the quantity of each medication for every resident; and two nurses were required to verify that all resident medications were accounted for in the medication cart. The LPN stated that if there was a discrepancy in the count, the two nurses review the previous three shifts to identify the issue and notify the Director of Nursing (DON). The LPN also stated that nurses were not allowed to administer one resident's medication to another resident; and that, (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	if medications have not yet been received from the pharmacy and a resident's medication was given to another resident, this may be considered drug diversion. Further, the LPN stated that such actions can result in inaccurate medication counts, and if narcotic diversion was suspected, the DON is notified.During an interview with the DON (staff #19) conducted on January 7, 2026 at 12:13 p.m., the DON stated that medication reconciliation happens during shift change and will be conducted by the oncoming nurse and the outgoing nurse. She stated that one nurse will be looking at narcotic sheet and one will be at the physical medication or bubble pack The DON said that the two nurses will verify the number of narcotics and will do card counts first to ensure the number on the reconciliation sheet matches the card count. The DON said that the two nurses would then go through the individual card and do pill count. She stated that if everything matched, the outgoing nurse hands over the keys to the oncoming nurse and it would be business as usual. However, the DON stated that if it does not match, the two nurses will figure out what was off , review the reconciliation sheet or the pill count and would notify her; and that, an investigation would be conducted to find the cause of the discrepancy. The DON stated that if there were major discrepancies (reading through the policy) she will notify the administrator and consultant pharmacy. Further, the DON stated that she only had been the DON for the facility since November 2024 and cannot give details regarding the drug diversion for residents #74 and #73.The facility policy on Medication: Controlled Substances with effective date of January 1, 2024, revealed that the facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications (listed as Schedule II-V of the Comprehensive Drug Abuse Prevention and Control Act of 1976). Only authorized licensed nursing and/or pharmacy personnel have access to Schedule II controlled substances maintained on premises. Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up. The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following: a. Records of personnel access and usage; b. Medication administration records; c. Declining inventory records; and, d. Destruction, waste and return to pharmacy records. Nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory count. The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the director of nursing services. Disposal methods are used to prevent diversion and/or accidental exposure to controlled or hazardous substances. Fentanyl patches are disposed of in one of the following ways (per state regulations): a. By folding in half, sticky sides together and flushing down the toilet; or b. Using approved drug disposal products specifically for fentanyl patches.