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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 46Number of residents cited: 1Based on observation, interview, review of clinical record, staff interviews, review of facility's video footage, policy and procedure, the facility failed to ensure adequate supervision was provided to one resident (#27). The deficient practice resulted in the resident sustaining injury from accidental foley catheter dislodgement and a transfer to the hospital.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.A care plan dated December 5, 2025, revealed Resident #27 was at risk for functional self-care deficits and/or functional mobility limitations related to subdural hemorrhage; and, had a catheter. Goals were to safely perform functional self-care and mobility tasks; and, that the resident will be and will remain free from catheter-related trauma. Interventions included that the resident required assistance with transferring and toileting; required an assistive device to reposition and turn in bed to encourage resident to participate to the fullest extent possible with each interaction; and, to encourage resident to use call light to call for assistance.A Fall Risk Evaluation dated December 5, 2025, revealed Resident #27 had a fall risk score of 18 indicating the resident was high risk for fall.The health status note dated December 6, 2025 included that Resident #27 continued to be disoriented and at times reminded of his surroundings. According to the documentation, resident was noted pulling on his foley catheter, forgets that he has a foley catheter and required reminders.The eMAR (electronic medication administration record) note dated December 6, 2025 revealed the resident was alert and oriented x 1-2, very forgetful, was forgetting that he had a foley catheter in place and was yelling.A History and Physical physician note dated December 6, 2025, revealed the resident was agitated, confused, alert and oriented only to self; and, was pulling on his foley catheter. The documentation included that the resident needed more supervision; and that, the provider discussed with staff that resident #27 may not be appropriate for the facility because of agitation reasons.A Health Status Note dated December 7, 2025 included Resident #27 was alert, confused, forgetful, and needed reminders throughout the night. Per the documentation, the resident 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; and that, family visited and sat with the resident all evening and the resident was calmer.The eMAR note dated December 7, 2025 revealed resident was alert and oriented x3, able to make needs known to staff, required frequent redirection and frequently yelled out asking where his family was.Another eMAR note dated December 7, 2025 included that the resident did not want to move or adjust his body in the bed. The documentation included that the resident thought he could stand up by himself or move himself to the edge of the bed.An eMAR note dated December 8, 2025, revealed a change of condition for the resident's behaviors of yelling out and pulling on foley catheter.The physician progress note dated December 8, 2025 included that the resident had advanced vascular dementia with behaviors, was agitated, confused, alert and oriented only to self; was pulling on his foley catheter and needed more supervision. Further, the documentation included (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 0689 Level of Harm - Actual harm Residents Affected - Few	that the resident was very encephalopathic at this time; and that, the provider discussed with staff that resident #27 may not be appropriate for the facility because of agitation reasons.A physician order dated December 8, 2025 included to target symptoms/behaviors tracking for anxiety as evidenced by restlessness every shift.An encounter note dated December 9, 2025 included that when the resident initially arrived to the facility, he was more agitated, anxious and disoriented; and that, the resident was started on an anticonvulsant for mood lability and 1st generation antihistamine for anxiety/restlessness. Per the documentation, family reported that the resident appeared calmer since the medications were introduced. The documentation also included that staff reported resident had agitation. Assessments included dementia with behavioral disturbances and recent behavioral concerns of agitation and restlessness with difficulties adjusting to facility. Recommended nonpharmacologic strategies included environmental modifications to ensure safety, structured activities to reduce triggers for wandering and agitation and consistent sleep routine.The physician progress note dated December 9, 2025 included that the resident was agitated, confused, alert and oriented only to self; was pulling on his foley catheter and needed more supervision. Further, the documentation included that the resident was very encephalopathic at this time; and that, the provider discussed with staff that resident #27 may not be appropriate for the facility because of agitation reasons.The eMAR note dated December 10, 2025 included the resident was yelling throughout the night.The skilled needs review dated December 10, 2025 revealed that following comprehensive review, the IDT (interdisciplinary team) attested that resident met all criteria for skilled services.The daily skilled evaluation dated December 10, 2025 included that the resident was disoriented x 4.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 the resident had moderate cognitive impairment. The assessment also included the resident had no evidence of acute change in mental status, had no potential indicators of psychosis such as hallucinations and delusions, and the resident's current behavior status, care rejection of wandering was worse in comparison to prior assessment. Active diagnoses included CVA (cerebrovascular accident), non-Alzheimer's dementia, anxiety, depression, and altered mental status. An eMAR note dated December 11, 2025, revealed the resident was yelling and screaming throughout the night, and that as needed (PRN) anxiety medication was not effective.The psychiatry progress note dated December 11, 2025, revealed Resident #27 was seen near the nursing station resting in wheelchair. The note revealed that according to the chart, the resident had been yelling and screaming throughout the night, did not sleep, and had been given PRN (as needed) anti-anxiety medication with no effect.A physician order dated December 11, 2025 included for change of condition monitoring for yelling out every shift for 6 days. The documentation included that physician was notified.A care plan initiated on December 11, 2025 revealed the resident had a behavior problem related to impaired cognitive function, impaired safety awareness and verbal behavior (yelling out and banging on table instead of using call light). The goal was that resident safety will be maintained. Interventions included anticipating and meeting the resident's needs; for caregivers to provide opportunity for positive interaction, attention and to stop and talk with the resident as passing by; explaining all procedures to the resident before starting and allow the resident time to adjust to changes; identifying behavior triggers; intervening as necessary to protect the rights and safety of others, and approach/speak in a calm manner, diverting attention, and removing from situation and taking to alternate location as needed; and, administering medications as ordered, monitoring/documenting for side effects and effectiveness.An eMAR note dated December 12, 2025 included the resident woke up intermittently, called out for his family, and was redirected as needed.Another eMAR note dated December 12, 2025 revealed the resident called out for his family 4 times; and that, the resident stopped calling out when he was informed that his family was at home.The physician progress note dated December 12, 2025 revealed the resident was agitated, confused, alert and oriented only to self; was pulling on his foley catheter, needed more supervision; and, the provider discussed with staff that Resident #27 may not be appropriate for the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	facility because of agitation reasons.The eMAR notes dated December 13, 2025 included the resident continued to yell out even after needs had been met. Per the documentation, the resident was confused, was redirected as needed, and still continued to yell out.A daily skilled evaluation dated December 14, 2025 revealed the resident was oriented x1 and had Foley catheter in place.The eMAR notes dated December 14, 2025 included that resident was yelling and screaming, and that anti-anxiety medication was administered. It also included that after administration, the resident was calm and rested for short periods of time, and continued to yell out and scream at intervals.An eMAR note dated December 16, 2025 revealed Resident #27 continued to yell out at intervals throughout the night; and that, episodes of yelling and screaming had decreased.A psychiatry progress note dated December 16, 2025 included Resident #27 remained confused and continued with intermittent moments of yelling out at night. The documentation included that it seemed to lessen when PRN anti-anxiety medication was administered.The physician progress note dated December 17, 2025 revealed the resident was agitated, confused, alert and oriented only to self; was pulling on his foley catheter, needed more supervision; and, the provider discussed with staff that resident #27 may not be appropriate for the facility because of agitation reasons.Another eMAR note dated December 16, 2025 revealed the resident was yelling and agitated.A psychiatry progress note dated December 18, 2025 included resident was still having moments of yelling and calling out for his family. The documentation included that staff reported the resident had agitation; and, review of systems included resident had poor insight, limited judgment, and slow processing, tangential thought process. Assessment included Dementia with behavioral disturbance. 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, to consider pharmacologic intervention if there was concern for safety of the resident / others, and to continue to monitor for mood, anxiety, or behavioral concerns.A care plan initiated December 18, 2025 revealed Resident #27 had impaired cognitive function/dementia or impaired thought processes related to impaired decision making. Goal was that the resident will be able to communicate needs on a daily basis. Interventions included to administer medications as ordered; to keep routine consistent and try to provide consistent caregivers as much as possible to decrease confusion; and, to monitor, document, and report to the physician any changes in cognitive function, and to use task segmentation to support short term memory deficits.The physical therapy (PT) progress note dated December 22, 2025, revealed Resident #27 had poor sequencing of tasks during walking, had poor execution of walking technique that resulted in decreased safety with walking, and was a fall risk. Per the documentation, the resident required minimum assistance for chair to/from bed transfers and for walking, and required cues for safe sequencing of tasks.A psychiatry progress note dated December 22, 2025 included Resident #27 was yelling out when needing assistance and often required frequent reorientation. It also included that the resident became restless and yelled out at times.The daily skilled evaluation December 23, 2025 revealed the resident had a foley catheter in place, had verbal behavior directed at others, required frequent redirection, and frequently yelled out and asking [NAME] occupational therapy (OT) daily note dated December 24, 2025 included the resident required frequent redirection throughout the session due to poor cognition.The daily evaluation note dated December 24, 2025 revealed the resident had a foley catheter in place, had verbal behavior directed at others requiring frequent redirection, and frequently yelled out instead of using the call light.The pulmonary progress note dated December 24, 2025 included the resident was confused and thought that his family was not aware of his location.The physician progress note dated December 24, 2025 revealed the resident was agitated, confused, alert and oriented only to self; was pulling on his foley catheter and needed more supervision; and, the provider discussed with staff that resident #27 may not be appropriate for the facility because of agitation reasons.A speech therapy (ST) daily note dated December 26, 2025 included the resident was able to answer orientation questions with 0% accuracy despite max cueing from the therapist. Per the documentation, the resident had continued confusion (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	behavior directed at others, required frequent redirection, and frequently asking for his family and frequently yelled out instead of using the call light.Review of the clinical record revealed that the resident was admitted to hospice on December 31, 2025.The care plan dated December 31, 2025 included that Resident #27 was admitted to hospice with diagnosis of senile degeneration of brain, effective January 1, 2026. Interventions included to 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, and, medication as ordered to ensure comfort.A psychiatry progress note dated January 1, 2026, revealed the resident was in a chair intermittently yelling for help and assistance to use the bathroom, and was calmed down with redirection. The note included that revealed that staff reported continuation of the behaviors of yelling out despite frequent reminders to use the call light, agitation and, had started to refuse medications. Per the documentation, staff reported difficulties in medication administration; and that, the resident remained forgetful and confused. The documentation also included that the resident presented with limited attention and ability to maintain logical/linear thought. Mental status examination included poor short- and long-term memory were poor, tangential concentration, poor insight, and limited judgment. It also included that 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.The pulmonary progress note dated January 1, 2026 included the resident remained confused and was yelling out.The daily skilled evaluation dated January 1, 2026 revealed resident was oriented x 1, had verbal behavior directed at others, required frequent redirection, and frequently asking for his family and frequently yelled out instead of using the call light.A BIMS assessment dated [DATE], revealed Resident #27 had a score of 6 indicating severe cognitive impairment.The behavior notes dated January 2, 2026 included that Resident #27 was alert and oriented to self, was refusing medications, continued to have behaviors of yelling throughout the day, and had multiple attempts to self-ambulate to leave the facility, and was assisted back to his chair before he could exit the building. Continued re-assurance was offered and redirection were not effective. The note included that the resident was administered with an antianxiety medication and a narcotic opioid in his cheek. The documentation also included that hospice was notified to have nurse come to the facility for assessment and assistance.The physician progress note dated January 2, 2026 continued to document that the resident was agitated, confused, alert and oriented only to self; was pulling on his foley catheter and needed more supervision. It also continued to document that the provider discussed with staff that resident #27 may not be appropriate for the facility because of agitation reasons.A physician order dated January 2, 2026, included for Lorazepam (antianxiety) oral concentrate 2 mg (milligram)/ml (milliliters), to give 1 ml by mouth every 2 hours as needed for anxiety as evidenced by restlessness and agitation, related to anxiety disorder.The eMAR note dated January 3, 2026 revealed that Foley catheter was re-inserted on previous shift and that the resident was voiding clear yellow urine into the foley bag.A behavior note dated January 3, 2026 included the resident was yelling for his family, asked for water and when he was given fresh water, the resident threw a cup at a certified nursing assistant (CNA).The daily skilled evaluation dated January 3, 2026 revealed resident was oriented x 1, had foley catheter in place, had verbal behavior directed at others, required frequent redirection, and frequently asking for his family and frequently yelled out instead of using the call light.Despite documentation continued documentation that Resident #27 needed more supervision, may not be appropriate for the facility, behaviors of yelling out and pulling foley catheter, attempts to self-ambulate there was no evidence found that the facility placed and implemented new interventions to increase supervision for Resident #27.There was also no evidence that nonpharmacological strategies such as structured activities, environmental modifications, consistent sleep routine were put in place as recommended (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Foley catheter bag was observed hanging beneath the leg rest portion of the chair.At 6:45 a.m., Resident #27 called out that he needed to use the bathroom. A staff member responded and informed the resident that he had a catheter. The resident stated that he needed assistance to use the men's restroom.At 6:47 a.m., staff left the resident alone at the nurses' station area. The resident began yelling for help. No staff responded. A nurse was observed standing at a medication cart approximately 30 feet away but did not respond. The resident continued yelling and requested water.At 6:49 a.m., a staff member responded. The resident requested to be positioned upright so he could drink water. Staff stated they wanted him to remain reclined until breakfast. The resident stated he could not drink water while reclined.At 6:50 a.m., staff adjusted the chair to a more upright position and provided the resident with water. Staff told the resident there was no reason for yelling and that he was waking others. The resident requested to speak with someone in authority. Staff told him his family was sleeping and then left him alone.At 6:53 a.m., the resident continued yelling for help and requested assistance to use the bathroom. A male staff member walked past without responding. A nurse was observed at a medication cart approximately 30 feet away. No staff assisted the resident with toileting.At 6:55 a.m., the resident told a nurse he had a bowel movement. The nurse instructed him to wait until assistance could be found.At 6:57 a.m., a nurse walked past the resident, who again stated he needed to use the bathroom. The nurse did not respond.At 6:58 a.m., the resident continued yelling loudly for help and bathroom assistance.At 7:05 a.m., a nurse told the resident that his family had been contacted and would arrive later, and instructed him to stop yelling. The nurse then left. The resident was not assisted with toileting and continued yelling repeatedly, stating he might attempt to walk and could hurt himself.At 7:22 a.m., the resident yelled that he would start breaking things and attempted to stand. A voice was heard telling him to sit down. A nurse approached and stated it was too early to call his family.At 7:24 a.m., after the nurse walked away, the resident again attempted to stand. Two nurses were at the nurses' station facing away. As the resident partially stood, the gerichair wheels were not locked securely and rolled backward until hitting the wall. The resident landed back in the chair, and the foley catheter bag fell to the floor. A nurse then approached, rehung the catheter bag on the gerichair, and instructed the resident to remain seated.At 7:27 a.m., the nurse told the resident she would retrieve his family's phone number and return, then left the area.At 7:32 a.m., the resident yelled loudly for help approximately 35 times. No staff responded.At 7:37 a.m., a therapy staff member spoke briefly with the resident, told him his family would arrive later, and stated she would return to assist with breakfast, then left.At 7:40 a.m., the resident repeatedly yelled for help and requested the police. A staff member told him it was early and that his family lived far away, then walked away while the resident continued speaking. No staff remained in the area.At 7:42 a.m., the resident stood up from the gerichair and took several unsteady steps away while yelling. The foley catheter tubing became taut as he moved away from the chair. The catheter and balloon were then pulled out and fell onto the floor. The resident yelled loudly in pain. A staff member approached and grabbed the resident's right arm, attempting to pull him back toward the gerichair.An interview with a random alert and oriented male on hallway A was conducted on January 4, 2026, at 7:33 a.m. He stated that the facility was usually quiet until that man (referring to Resident #27) was admitted to the facility sometime before December 25, 2025. He said that resident #27 had been yelling out loudly for help often; and that, the yelling had affected his sleep.An interview was conducted with a CNA (Staff #17) on January 4, 2026, at approximately 7:48 a.m. The CNA stated that caring for residents with behaviors was very hard because the facility was so understaffed. The CNA said that Resident #27 screamed all the time, and had gotten up from his chair before in the past; however, the CNA stated that this was the first time Resident #27 had accidentally pulled his foley catheter out.An interview with a random alert and oriented female resident on hallway B was conducted on January 4, 2026 at 8:12 a.m. The female resident stated that she hears the poor man (referring to R

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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 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 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) (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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) (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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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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 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 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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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 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 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 (continued on next page)

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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	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 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 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** -Regarding Resident #82: Resident #82 was admitted on [DATE], with diagnoses that included end stage renal disease and type 2 diabetes mellitus. An admission Evaluation note dated January 2, 2026, revealed Resident #82 admitted from short-term general hospital for intravenous (IV) infusions with contact isolation. A physician order dated January 3, 2026, included contact isolation due to Extended-Spectrum Beta-Lactamases (ESBL) for 5 days or until treatment has been completed on January 6. A care plan focus dated January 4, 2026, revealed the resident had an active infection including ESBL with interventions that included contact/droplet isolation precautions, educate resident and staff regarding preventative measures to contain infection, use as much disposable equipment as possible or use dedicated equipment (i.e. BP cuff, thermometer), non-disposable resident care equipment to be appropriately cleaned and disinfected per facility protocol, provide independent activities or 1:1 activities as tolerated by resident and as able, and administer antibiotic as per physician orders. An Occupational Therapy (OT) Daily Note dated January 5, 2026, revealed the resident was seen in room on isolation precautions. A Nurse Practitioner (NP) progress note dated January 5, 2026, revealed Resident #82 was diagnosed with ESBL E. coli urinary tract infection, and the resident was admitted to the facility for completion of treatment from the hospital, therapy, and rehab. An observation was conducted on January 4, 2026, at 3:46 p.m. of a certified nursing assistant (CNA / Staff #47), who entered Resident #82's room, pushing a vitals cart inside the room. On the right side of the resident's room doorway was a sign that revealed that the resident was on contact isolation precautions. Outside of the resident's room was a clear plastic isolation cart that contained personal protective equipment (PPE). No sanitizing wipes were observed in the room, in the isolation cart, or anywhere in the vicinity of the hallway. As Staff #47 entered Resident #82's room, Staff #47 did not perform hand hygiene with hand washing or hand sanitizer, and did not put on a gown or gloves. Staff #47 stated to Resident #82 that she was going to assess the resident's vital signs, and then proceeded to apply a blood pressure cuff around the resident's ankle as he was lying in bed. The staff then closed the resident's door. The staff then exited the room and did not sanitize the vitals cart, and pushed the vitals cart down the hall to the therapy gym and left the machine in the therapy gym. An interview was conducted on January 4, 2026, at 3:56 p.m. with Staff #47 directly after she left the vitals cart in the therapy gym. Staff #47 stated that if a resident was on isolation precautions, then staff would know because there would be a sign on the resident's door indicating the type of precautions, and what PPE would be worn. For contact precautions, Staff #47 stated staff would be required to wear a gown and gloves when entering the room. Staff #47 stated that when equipment such as a vitals cart is brought in an isolation room for use and brought out of the room to use with other residents, then that equipment is sanitized with sanitizing wipes. Staff #47 stated that she had never heard of disposable equipment such as a disposable or single-use blood pressure cuff or stethoscope for taking vital signs, and that she did not believe the facility had those items. Staff #47 stated that she was not sure if any of the rooms she was assigned to had isolation precautions because she did not receive verbal report at shift change. Staff #47 stated she did not know if the room she was just in for Resident #82 was an isolation room, and Staff #47 stated that she did not wear a gown and gloves when providing care then. Resident #82's room was observed together, and Staff #47 read the sign beside the resident's door and stated that yes, this was a contact isolation room. Staff #47 stated that normally the sign is hung on the center of the door, and this sign was hung to the side of the door, and that was why she missed it. Regarding sanitizing the vitals cart, Staff #47 stated that she did not know where sanitizing wipes were located, because usually they were located in the isolation cart outside the resident's door, and that currently there were none there. Staff #47 stated that she believed there were some sanitizing wipes in the wound nurse's cart, but that was locked and the wound nurse was not in the facility, so she was not sure where the sanitizing wipes (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	could be found. Another observation was conducted on January 4, 2026, directly after the interview with Staff #47 ended, and Staff #47 was observed asking another staff member where sanitizing wipes were, and at 4:06 p.m., Staff #47 obtained sanitizing wipes and cleaned the vitals machine in the therapy gym. An interview was conducted on January 6, 2026, at 9:39 a.m. with a registered nurse / unit manager (RN / Staff #7) who stated that if a resident was on contact precautions, then there would be a sign on the door indicating the type of precautions, and that a gown and gloves were required to be worn when entering the resident's room to provide care. Staff #7 stated that when exiting the resident's room, the PPE would be taken off before leaving the room, and any equipment would be sanitized prior to leaving the room with sanitizing wipes. Staff #7 stated that additionally, hand washing was required before leaving a room on contact precautions. Staff #7 stated that if a staff did not put on PPE or wash hands or clean equipment when required to do so, then the risk could be spread of infection. An interview was conducted on January 6, 2026, with a licensed practical nurse (LPN /Staff #9) at 11:36 a.m. who stated that if a resident was on contact isolation precautions that there would be a sign by the resident's door that would indicate what PPE was required for staff to wear when providing care to the resident. Staff #9 stated that equipment that was used for a resident on isolation precautions either remains in the room with the resident while on isolation precautions, or the equipment was sanitized when leaving the room, with sanitizing wipes. Staff #9 stated that staff are required to wash hands or perform hand hygiene before and after providing resident care. Staff #9 also stated that if staff did not wear PPE or wash hands or sanitize equipment when indicated, then the risk could be spread of infection to other residents or staff. An interview was conducted on January 6, 2026, at 3:10 p.m. with the Director of Nursing (DON / Staff #19) who stated she expected staff who were caring for a resident on contact isolation precautions to observe the sign on the resident's door and put on the required PPE prior to entering the resident's room, wash their hands before leaving the room, and to sanitize any equipment leaving the room with sanitizing wipes that should be located in the isolation carts outside the resident's room. Staff #19 stated that there would be a risk of spread of infection if staff did not follow the infection control practices. Review of the facility policy titled Managing Infections: Isolation - Categories of Transmission-Based Precautions, dated January 1, 2024, revealed transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents. Standard precautions are used when caring for residents at all times regardless of their suspected or confirmed infection status. Transmission-based precautions are additional measures that protect staff, visitors and other residents from becoming infected. These measures are determined by the specific pathogen and how it is spread from person to person. The three types of transmission-based precautions are contact, droplet and airborne. Transmission-based precautions are used only when the spread of infection cannot be reasonably prevented by less restrictive measures. When a resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance door and on the front of the chart so that personnel and visitors are aware of the need for and the type of precaution. The signage informs the staff of the type of CDC precaution(s), instructions for use of PPE, and/or instructions to see a nurse before entering the room. When transmission-based precautions are in effect, non-critical resident-care equipment items such as a stethoscope, sphygmomanometer, or digital thermometer will be dedicated to a single resident (or cohort of residents) when possible. If re-use of items is necessary, then the items will be cleaned and disinfected according to current guidelines before use with another resident. Contact precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. The decision on whether contact precautions are necessary are evaluated on a case by case basis. Staff and visitors wear gloves (clean, non-sterile) when entering the room. While caring for a resident, staff will change (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	gloves after having contact with infective material (for example, fecal material and wound drainage). Gloves are removed and hand hygiene performed before leaving the room. Staff avoid touching potentially contaminated environmental surfaces or items in the resident's room after gloves are removed. Staff and visitors wear a disposable gown upon entering the room and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after gown is removed. Review of the facility policy titled Managing Infections: Isolation - Initiating Transmission - Based Precautions, dated January 1, 2024, revealed transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents. Transmission-based precautions may include contact precautions, droplet precautions, or airborne precautions. When transmission-based precautions are implemented, the infection preventionist (or designee): ensures that protective equipment (i.e., gloves, gowns, masks, etc.) is maintained outside the resident's room so that anyone entering the room can apply the appropriate equipment, ensures that protective equipment and supplies needed to maintain precautions during care are in the resident's room; and ensures that an appropriate linen barrel/hamper and waste container, with appropriate liner, are placed in or near the resident's room.

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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 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 (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 (continued on next page)

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Haven of Scottsdale	3293 North Drinkwater Boulevard Scottsdale, AZ 85251

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 called out loudly call my family repeatedly, and also called out for help repeatedly. No staff attended to the resident. -7:16 a.m.: The resident called out loudly and repeatedly for help and call my family over 35 times. -7:22 a.m.: The resident stated loudly I'm going to start breaking things. No staff were observed near the resident. The resident attempted to stand up from the gerichair and a voice called out to the resident to sit down. The nurse then approached the resident and stated to the resident that it was too early to call his family. -7:24 a.m. the nurse walked away from the resident, and the resident stated he was going to throw things, and then the resident tried to stand up again. Two nurses were observed at the nurses' station facing away from the resident. One nurse turned to face the resident who was partially standing up from the chair. As the resident attempted to stand up, the wheels of the gerichair were not securely locked and the chair rolled backward until the back of the gerichair contacted the wall that was behind the resident, and the resident landed sitting back in the chair. The nurse quickly approached the resident. The foley catheter bag had landed on the floor, and the nurse picked the foley bag up off the floor and hung it on the gerichair frame. The nurse stated to the resident that we need you to stay here. -7:27 a.m.: The nurse stated she will go get the resident's family's phone number and then they will call, and the nurse would be right back. The nurse then left the area. -7:32 a.m.: Resident #27 yelled for help loudly and repeatedly. No staff attended to the resident. The resident yelled out for help over 35 times. -7:37 a.m.: a therapist staff stopped to talk to the resident and stated that his family would be coming later and that she would come back later and help with his breakfast, and walked away. -7:40 a.m.: The resident yelled out loudly and repeatedly for help and for the police. Since 6:00 a.m., no staff had assisted the resident with using the bathroom or changing him, and no staff had assisted the resident with calling his family. -7:41 a.m.: a staff approached the resident who was yelling out loudly for help. The staff stated that it was early in the morning and that the resident's family lived far from the facility. The staff then walked away from the resident while the resident was still talking to her. No staff was nearby the resident. The resident called out loudly I'm going to start messing things up and then Lady, I'm going to start breaking things.-7:42 a.m.: The resident then stood up from the gerichair and yelled out loudly Lady, (continued on next page)

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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 near 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 resident in the bathroom to get him cleaned up, and then Staff #9 would re-insert the catheter. Staff #17 positioned the gerichair directly in front of Resident #27 and said in a rude tone of voice, sit down here. Resident #27 then asked Staff #17 what is this. The CNA did not explain further, and stated again in a rude tone of voice sit in here. Resident #27 asked Staff #17 again the question of what is this, and Staff #17 stated again firmly and rudely sit in there. The resident sat in the gerichair and was wheeled away from the area.An interview was conducted with an LPN (Staff #9) on January 4, 2026, at 10:34 a.m. Staff #9 stated that sometimes staff would sit with the resident on a 1 to 1 basis to help manage his behaviors. Regarding the incident where Resident #27 accidentally pulled out his foley catheter earlier that day, Staff #9 stated she observed the CNA (Staff #17) attempting to guide the resident to the chair, and that both of Staff #17's hands were on Resident #27's one arm, and that she might have pulled him while trying to turn the resident. Staff #9 stated she had told Staff #17 not to pull on the resident. Staff #9 stated she believed Staff #17's tone of voice when speaking to the resident was anxious.An interview was conducted on January 5, 2026, at 11:53 a.m. with a CNA (Staff #30), who stated that if a resident had impaired cognition and had behaviors of yelling out, that she would try to put herself in the resident's shoes and remember that the resident was a human looking for comfort, and that she would try to calm the resident down. Staff #30 stated if a resident had dementia and kept trying to get up from the bed or wheelchair and the resident was unsteady or unsafe to do so unassisted, then Staff #30 would help the resident to sit in a chair by the nurses' station so that the resident was in eyesight of multiple staff members for increased supervision, or try to find an activity that would help calm the resident down. Staff #30 stated that it was not difficult to help calm a resident, just time consuming. Staff #30 stated she was familiar with Resident #27, and the resident yelled out for his family sometimes all night and all day. Staff #30 stated that one night, she had to sit with the resident and hold his hand nearly all night so that he would not continue yelling out.An interview was conducted with a registered nurse (RN / Staff #32) on January 5, 2026, at approximately 12:00 p.m. Staff #32 stated that if a resident had impaired cognition and behaviors of yelling out repetitively or if the resident was trying to get up from a chair or bed and walk unsteadily without assistance, that she would try to console the resident, ask what is wrong, and try to meet the resident's needs. Staff #32 stated she was familiar with Resident #27, and that he had behaviors of yelling out consistently almost all day long.An interview was conducted on January 5, 2026, at 2:10 p.m. with a CNA (Staff #14) who stated that if a resident had impaired cognition with behaviors of yelling out, then Staff #14 would sit and talk to the resident and help calm the resident down. If a resident with impaired cognition was unsafe to mobilize independently, and continued to try to get up from a chair or bed to walk, Staff #14 stated that she would make sure that resident was not in their room alone, that she would place the resident in front of the nurse's station for staff to supervise the resident. Staff #14 also stated she would try to convince management to allow a 1-to-1 staff member to be with the (continued on next page)

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Resident #16 stated that he believed Resident #27 just wanted someone to talk to, and if staff found the right activity for Resident #27, that it would probably calm the resident down.An interview was conducted on January 6, 2026, at 9:02 a.m. with a CNA (Staff #37) who stated that if a resident was confused, had dementia, or appeared to be restless or agitated, that she would approach the resident calmly and try to redirect the resident, give the resident an activity to do, turn on a tv show the resident enjoyed, or try to talk to the resident to see what the resident needed. Staff #37 stated that if a resident was confused and restless, that she would redirect the resident, even if it required 100 times, then she would do that, or she would stay with the resident for a while to help the resident calm down. Staff #37 stated that she would not leave a confused and restless or agitated resident alone or unattended in the hallway if the resident was in that state. Regarding Resident #27, Staff #37 stated that she was familiar with the resident, and he was confused, had memory problems, would forget things after a few minutes, and had behaviors of screaming out a lot.An interview was conducted with a licensed practical nurse (LPN / Staff #9) on January 6, 2026, at 11:36 a.m. who stated that if a resident had dementia or impaired cognition and appeared to be restless or agitated, that she would approach the resident very calmly, at eye level, with no hurried movements, and with a calm, low pitch voice to try to calm the resident. Regarding Resident #27, Staff #9 stated that he had behaviors of near constant yelling and that it had been ongoing the whole time the resident was at the facility. Staff #9 stated that she would try to talk to the providers about his behaviors, and try to talk to the resident to determine why he was yelling, and to re-assure him.An interview was conducted on January 6, 2026, at 1:02 p.m. with the Administrator (Staff #55) after reviewing the facility's video camera footage together. Staff #55 stated that Resident #27 had a lot of behaviors and that the staff were doing the best they could considering that they were also caring for other residents. Regarding Staff #17 pulling on Resident #27, Staff #55 stated he believed she was doing the best she could given the circumstance. Staff #55 stated that it was his expectation for staff to assess resident's needs and assist the residents as needed, and regarding Resident #27's requests to go to the bathroom, Staff #55 stated that he believed the staff could have done a better job of that.A follow up interview was conducted with the Administrator (Staff #55) on January 6, 2026, at 2:58 p.m. Staff #55 stated that he believed having a staff member sit with Resident #27 benefitted him, however when staff walked away, the resident would start yelling again. Staff #55 stated that at the time of Resident #27's incident, there was no staff with the resident, however the staff were within earshot.An interview was conducted with the Director of Nursing (DON / Staff #19) on January 6, 2026, at 3:10 p.m., who stated that if a resident had impaired cognition or dementia, and was agitated or restless, she would expect the staff to approach the resident calmly, to make sure the resident could see the staff, to make eye contact, and to be friendly. If that resident had behaviors of yelling out, then Staff #19 stated that she would expect staff to offer redirection or provide anything that would get the resident to stop yelling, offer a change of scenery, provide a blanket, offer fluids, and for the nurse to determine if there were any medications available to address the agitation. If the resident were to be left with ongoing behaviors of yelling, Staff #19 stated she did not know what effect that would have on the resident who was yelling, but that it would be disruptive to other residents in the facility. Regarding Resident #27, Staff #19 stated that she was aware the resident had yelling behaviors and impulsivity since his admission, and that she had heard from other residents that Resident #27's yelling was disruptive.Review of the facility policy titled Resident Rights / Dignity: Resident Rights, dated January 1, 2024, revealed employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to:a. a dignified existence;b. be treated with (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	respect, kindness, and dignity;c. be free from abuse, neglect, misappropriation of property, and exploitation;d. be free from corporal punishment or involuntary seclusion, and physical or chemical restraints not required to treat the resident's symptoms;e. self-determination;f. communication with and access to people and services, both inside and outside thefacility

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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) 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 (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical record, interview, and review of facility policy and procedure, the facility failed to ensure a resident (#27) was administered narcotic medication according to physician order. The deficient practice could lead to physical harm of a resident from overdose of narcotic medication.-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 initiated December 5, 2025, revealed Resident #27 had or was at risk for pain, with interventions that included to administer analgesia medication as per orders, to anticipate the resident's need for pain relief and respond as soon as possible to any complaint of pain, to monitor / record / report to the nurse any signs and symptoms of non-verbal pain including yelling out, and for non-medication intervention for pain to be given prior to administration of as needed medication.A Physician Progress Note dated December 9, 2025, revealed the resident had advanced dementia with behaviors.An eMar (Electronic Medication Administration Record) Note dated December 11, 2025, revealed the resident was yelling and screaming throughout the night, and that as needed (PRN) anxiety medication was not effective.A psychiatry provider encounter note dated December 11, 2025, revealed Resident #27 was seen near the nursing station, resting in wheelchair. The note revealed the resident had been yelling and screaming throughout the night, and had been given as needed anti-anxiety medication with no effect, and that nursing stated that the resident did not sleep.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 to administer medications as ordered, and monitor / document for side effects and effectivenessAn eMar Note dated December 12, 2025, revealed the resident woke up off and on and yelled out for his wife, and was redirected as needed.eMar Notes dated December 13, 2025, revealed the resident continued to yell out every now and then, and later, that the resident was constantly yelling out even after needs had been met, and the resident was confused, redirected as needed, and continued to yell out.Another eMar Note dated December 16, 2025, at 9:15 p.m., revealed the resident was yelling and agitated.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 included to administer medications as ordered.A psychiatry provider encounter note dated December 22, 2025, revealed Resident #27 was noted yelling out when needing assistance and often requires frequent reorientation, and that the resident became restless and yelled out at times.A Daily Skilled Evaluation note dated December 24, 2025, revealed the resident had a foley catheter in place, and had verbal behavior directed at others requiring frequent redirection, and frequently yelled out.A Physician Progress Note dated December 28, 2025, revealed the resident constantly yelled I need help repeatedly.An OT daily Note dated December 29, 2025, revealed the resident was easily confused, upset, and not easily redirected, and that the resident continued to perseverate on going home, and was unable to participate in therapy session.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 was sitting on the edge of the bed, and remained confused, alert and oriented to (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	self only, and was yelling out for his wife.A hospice face sheet for Resident #27 revealed hospice start of care was December 31, 2025.A care plan 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 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 physician order dated January 2, 2026, included Morphine Sulfate (Concentrate) Oral Solution 20 mg/ml, to give 0.25 ml every 4 hours as needed for pain / shortness of breath.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. The documentation revealed that as needed (PRN) doses of lorazepam (anti-anxiety medication) and morphine (narcotic medication) were administered into the resident's cheek pocket, pending effectiveness.An Individual Control Drug Record for Resident #27's medication revealed for morphine 5 mg, pre-filled syringe (0.25 ml / 5 mg), that two doses were administered on January 2, 2026, with one dose administered at 10:00 a.m. and one dose administered 2 hours and 10 minutes later at 12:10 p.m.Despite the individual control drug record including that two doses of morphine were administered to Resident #27 on January 2, 2026, review of the progress notes revealed morphine was administered, but did not specify how many doses, or when the administration occurred.Additionally, the Medication Administration Record (MAR) for January 2026, revealed no evidence that any doses of morphine sulfate oral solution 20 mg/ml were administered.An interview was conducted with a registered nurse (RN / Staff #32) on January 5, 2026, at approximately 12:00 p.m. Staff #32 stated that if a resident had impaired cognition and behaviors of yelling out repetitively or if the resident was trying to get up from a chair or bed and walk unsteadily without assistance, that she would try to console the resident, ask what is wrong, try to meet the resident's needs, and if those methods did not work, then Staff #32 would see what medications the resident had available to help with the behaviors. Regarding medication administration, Staff #32 stated that once a physician order was received, the order appeared on the MAR in the electronic medical record (EMR). Staff #32 stated once the medication was administered, it would be documented in the MAR to show that the medication was administered. Staff #32 also stated that controlled substances such as narcotic medications, would also be documented on the narcotic reconciliation sheets (Individual Control Drug Record). Staff #32 stated that nurses document the administration of medication on the MAR because the risk of not doing so would be not knowing exactly when the medication was administered, and that overdose could occur from administering a second dose too soon.An interview was conducted with a licensed practical nurse (LPN / Staff #9) on January 6, 2026, at 11:36 a.m. who stated that if a resident had impaired cognition and had behaviors of yelling out, that it was not good for the resident to medicate the behaviors away, so she would attempt to determine what the resident needed. If a resident had impaired cognition and kept trying to get up from a wheelchair or bed, and was unsafe or unsteady, then Staff #9 stated that she would try to keep the resident where staff could keep eyes on (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident. Staff #9 stated that Resident #27 had behaviors of near constant yelling and that it had been ongoing the whole time the resident was at the facility. Staff #9 stated that she would try to talk to the providers about his behaviors, and try to talk to the resident to determine why he was yelling, and to re-assure him. Regarding medication administration, Staff #9 stated that when a resident is administered a medication, the physician order appears on the MAR, and then the nurse records when the dose is administered. Staff #9 stated that the importance of recording the medication administration in the clinical record would be to verify that the resident received the medication, and prevent an accidental administration of another dose outside of time parameters. Staff #9 stated that the narcotic reconciliation sheet is completed at the beginning and end of each shift.An interview was conducted with the Director of Nursing (DON / Staff #19) on January 6, 2026, at 3:10 p.m., who stated if a resident with impaired cognition or dementia had behaviors of yelling out, then Staff #19 stated that she would expect staff to offer redirection or provide anything that would get the resident to stop yelling, offer a change of scenery, provide a blanket, offer fluids, and for the nurse to determine if there were any medications available to address the agitation. Regarding medication administration, Staff #19 stated that nurses should document medication administered on the MAR. If a nurse did not document a medication administered on the MAR, then Staff #19 stated that the risk could be missing communication that the medication was administered or not, and that the medication could accidentally be administered again. The clinical record was reviewed for Resident #27, and Staff #19 stated that the MAR for January 2026 revealed that no doses of morphine were administered. The physician order for morphine was reviewed, and Staff #19 stated that the morphine was ordered to be given every 4 hours as needed. The narcotic reconciliation sheet for Resident #27's morphine was reviewed and Staff #19 stated that Resident #27 was administered a morphine dose at 10:00 a.m. and again at 12:10 p.m. on January 2, 2026, and that it would not meet her expectation as far as following the physician order. Review of the facility policy titled Medication: Administering Medications, dated January 1, 2024, revealed medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders, including any required time frame. Medication errors are documented, reported, and reviewed by the QAPI committee to inform process changes and or the need for additional staff training. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones, or documents in the electronic medical administration record. As required or indicated for a medication, the individual administering the medication records in the resident's medical record:a. the date and time the medication was administered;b. the dosage;c. the route of administration;d. the injection site (if applicable);e. any complaints or symptoms for which the drug was administered;f. any results achieved and when those results were observed; andg. the signature and title of the person administering the drug.Review of the facility policy titled Medications: Controlled Substances, dated January 1, 2024, revealed 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). Controlled substances are counted upon delivery. The nurse receiving the medication, along with the person delivering the medication, must count the controlled substances together. Both individuals sign the designated controlled substance record. If the count is correct, an individual resident controlled substance record is made for each resident who will be receiving a controlled substance. Do not enter more than one (1) prescription per page. This record contains:a. name of the resident;b. name and strength of the medication;c. quantity received;d. number on hand;e. name of the prescriber;f. prescription number;g. name of issuing pharmacy;h. date and time received;i. time of administration;j. method of administration;k. signature of person receiving medication; andl. signature of nurse administering medication.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 (continued on next page)

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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 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 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, 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 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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	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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews and review of policies and procedures, the facility failed to ensure that food was labeled and stored in accordance with professional standards. The deficient practices could result in food-borne illnesses.Findings include:-Regarding food labeling, dating and storageA kitchen observation was conducted on January 4, 2026 at 7:21 a.m. with the morning cook (staff #6) and revealed the following:-A [NAME] [NAME] style cooking wine in walk-in dry storage was found with use by date of August 25, 2025--Within the large, three-door freezer, peas and sliced carrot were discovered wrapped in a blue plastic bag and lacked any date labeling.Initial observation of the nourishment refrigerator located close to nurse station was conducted on January 4, 2026, at approximately 8:20 a.m., revealed that the multiple edible items which were almost full capacity in an unorganized fashion and the following items were not labelled and dated:-A transparent plastic container with a red lid containing diced fruit and liquid which was unlabeled and undated- An array of individual snacks, 2 triangle shaped pieces of bread were unlabeled and undated-A transparent rectangular container with a lid which contained 2 round yellow substance on a visible white substance with dark color speckles on top of a yellowish substance. This container was unlabeled and undated-A black plastic container with clear lid containing what appeared to be 3 pancakes and several slices of bacon which was unlabeled and undated- A white styrofoam cup with a lid contained what appeared to be translucent vegetable soup with ice formation on top which was unlabeled and undated-A transparent plastic container containing approximately a 12 oz ounce fruit cup containing purple grapes, green grapes, watermelon and cantaloupe slices with a sell through date of December 16, 2025, were unlabeled-A light blue plastic container with a lid containing what appeared to be meatballs and pasta which was unlabeled and the date on the container was August 26-A black plastic container with a transparent lid containing what appeared to be red raspberries covered with light brownish fuzzymix with what appeared to be blue berries was unlabeled and undatedAn interview was conducted on January 4, 2026, at approximately 8:25 a.m., with a cook (staff #6) who stated that the [NAME] style cooking wine in the walk-in dry storage was not good anymore because it expired last month and needs to be thrown away. The cook then explained that the peas and sliced carrots in blue plastic bag in the freezer were received yesterday in a cardboard box, and due to a lack of space in freezer, Staff #6 removed the blue plastic bag containing sliced vegetables from the box and stored the bag in the refrigerator. Staff #6 then stated that she used the sliced carrot and peas from blue bag yesterday night January 3, 2026, to make turkey pot pie and puree. Staff #6 stated that CNAs' (Certified Nursing Assistant) are responsible for cleaning and throwing out expired food from the nourishment refrigerator.An interview was conducted on dated January 4, 2026, at 4:04 p.m. with a Kitchen Dietary Director (staff #59) who stated that kitchen staff #10, #24, and #3 were responsible for cleaning all nourishment refrigerators every Monday, Tuesday, and Wednesday. Staff #59 then stated that there was lot of food preparation happening in the kitchen due to the holiday party so food got cluttered in the refrigerator. Staff #59 then stated that food should be dated, labelled, and stored no more than 72 hrs. (hours) in the refrigerator due to a risk of food getting cross contamination with other food. Staff #59 then stated that he would not let that happen again. Staff #59 also stated that he provided in-service training regarding labelling, storing, and cleaning of refrigerators to staff #10, #24, and #3 so the staff understand the food policy and all kitchen staff are on the same page. Staff #59 then stated that he emptied all food items from the nourishment refrigerator, and cleaned and disinfected the nourishment refrigerators to start fresh.An interview was conducted on January 6, 2026, at 9:31 a.m., with a Dietary Aide (staff #3) who stated that staff #59 and she were responsible for cleaning all kitchen and nourishment refrigerators. Staff #3 then stated that she mostly cleans all refrigerators every Monday and Wednesday as she does not work on Friday (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and the weekend. This aide then stated that when resident's families bring in the food it needed to be dated, labelled, and used within 5 to 7 days. Then the aide stated that if food was not dated, labelled, and expired, there would be a risk of a resident getting food poisoning, and may cough and get sick due to bad odor of food.An interview was conducted on January 6, 2026, at 9:55 a.m., with a CNA (staff #37). This CNA stated that if food is brought by family for a resident then the CNA would ensure that the resident was not allergic to the food and then either family or staff would label the food with resident name and date and store in the nourishment refrigerator. Staff #37 stated that maintenance staff are responsible for cleaning nourishment refrigerators every Sunday. Staff #37 also stated that if food brought by family members was not labeled and dated then there would be a health hazard risk and residents could also get sick due to food contamination.A follow-up interview was conducted on January 6, 2026, at 10:14 a.m., with Kitchen Dietary Director (staff #59) who stated that food got cluttered in nourishment refrigerators due to the holiday season last month and that the facility has multiple parties for staff and residents. Staff #59 then stated that nourishment refrigerator had only a temperature log and no cleaning log currently. Staff #59 further stated that he cleaned both nourishment refrigerator this Sunday January 4, 2026, and then created a new cleaning log for nourishment refrigerators and also delegated the cleaning task to staff #3 from Monday through Thursday, and then to staff #24 from Thursday to Sunday. Staff #59 then stated that his expectation from kitchen staff, who do the temperature log daily for refrigerators, is that they should have noticed unlabeled and undated food in refrigeratorsReview of the facility policy titled, Food Brought in from Outside Sources and Personal Food Storage, dated 2021, revealed that foods and beverages brought in from outside sources that require refrigeration or freezing should be labeled with the patient/resident's name and date and stored in the refrigerator/freezer apart from facility food.Review of the facility policy titled, Food Storage and Date marking, dated 2021, revealed that all refrigerated food should be covered, labeled, and dated and routinely monitored to assure that foods (including leftovers) will be consumed by their safe use by dates, or frozen (where applicable), or discarded.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical record, interviews, and review of facility policy and procedure, the facility failed to ensure the medical record was complete and accurate for one resident (#27). The deficient practice could lead to care team members not being fully aware of a resident's status.-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 initiated December 5, 2025, revealed Resident #27 had or was at risk for pain, with interventions that included to administer analgesia medication as per orders, to anticipate the resident's need for pain relief and respond as soon as possible to any complaint of pain, to monitor / record / report to the nurse any signs and symptoms of non-verbal pain including yelling out, and for non-medication intervention for pain to be given prior to administration of as needed medication.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 to administer medications as ordered, and monitor / document for side effects and effectivenessA physician order dated January 2, 2026, included Morphine Sulfate (Concentrate) Oral Solution 20 mg/ml, to give 0.25 ml every 4 hours as needed for pain / shortness of breath.A physician order dated January 2, 2026, included Lorazepam Intensol oral concentrate 2 mg/ml, to give 1 ml by mouth every 2 hours as needed for anxiety as evidenced by restlessness / agitation, related to anxiety disorder.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. The documentation revealed that as needed (PRN) doses of lorazepam (anti-anxiety medication) and morphine (narcotic medication) were administered into the resident's cheek pocket, pending effectiveness.An Individual Control Drug Record for Resident #27's morphine 5 mg, pre-filled syringe (0.25 ml / 5 mg), revealed that two doses were administered on January 2, 2026, with one dose administered at 10:00 a.m. and one dose administered 2 hours and 10 minutes later at 12:10 p.m.An Individual Control Drug Record for Resident #27's lorazepam 2mg/ml, revealed that two doses were administered on January 2, 2026, with one dose at 10:00 a.m. and another dose 2 hours and 10 minutes later at 12:10 p.m.Despite the individual control drug records including that two doses of morphine and two doses of lorazepam were administered to Resident #27 on January 2, 2026, review of the progress notes revealed the morphine and lorazepam were administered, but did not specify the number of doses, or when the administration occurred.Review of the Medication Administration Record (MAR) for January 2026, revealed no evidence that any doses of morphine sulfate oral solution were administered. Additionally, the record revealed no evidence that the 2mg/ml doses of lorazepam were administered to the resident in January 2026. Also, under target symptoms / behavior tracking, no episodes of anxiety as evidenced by restlessness were recorded on the MAR for any shifts in January 2026.An interview was conducted with a registered nurse (RN / Staff #32) on January 5, 2026, at approximately 12:00 p.m. Staff #32 stated that if a resident had impaired cognition and behaviors of yelling out repetitively or if the resident was trying to get up from a chair or bed and walk unsteadily without assistance, that she would try to console the resident, ask what is wrong, try to meet the resident's needs, and if those methods did not work, then Staff #32 would see what medications the resident had available to help with the behaviors. Regarding medication administration, Staff #32 stated that once a physician order was received, the order appeared on the MAR in the electronic medical record (EMR). Staff #32 stated once the medication was administered, it would be documented in the MAR to show that the (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication was administered. Staff #32 also stated that controlled substances such as narcotic medications, would also be documented on the narcotic reconciliation sheets (Individual Control Drug Record). Staff #32 stated that nurses document the administration of medication on the MAR because the risk of not doing so would be not knowing exactly when the medication was administered, and that overdose could occur from administering a second dose too soon.An interview was conducted with a licensed practical nurse (LPN / Staff #9) on January 6, 2026, at 11:36 a.m. who stated that if a resident had impaired cognition and had behaviors of yelling out, Staff #9 stated that it was not good for the resident to medicate the behaviors away, so she would attempt to determine what the resident needed. Staff #9 stated that Resident #27 had behaviors of near constant yelling and that it had been ongoing the whole time the resident was at the facility. Staff #9 stated that she would try to talk to the providers about his behaviors, and try to talk to the resident to determine why he was yelling, and to re-assure him. Regarding medication administration, Staff #9 stated that when a resident is administered a medication, the physician order appears on the MAR, and then the nurse records when the dose is administered. Staff #9 stated that the importance of recording the medication administration in the clinical record would be to verify that the resident received the medication, and prevent an accidental administration of another dose outside of time parameters. Staff #9 stated that the narcotic reconciliation sheet is completed at the beginning and end of each shift.An interview was conducted with the Director of Nursing (DON / Staff #19) on January 6, 2026, at 3:10 p.m., who stated if a resident with impaired cognition or dementia had behaviors of yelling out, then Staff #19 stated that she would expect staff to offer redirection or provide anything that would get the resident to stop yelling, offer a change of scenery, provide a blanket, offer fluids, and for the nurse to determine if there were any medications available to address the agitation. Regarding medication administration, Staff #19 stated that nurses should document medication administered on the MAR. If a nurse did not document a medication administered on the MAR, then Staff #19 stated that the risk could be missing communication that the medication was administered or not, and that the medication could accidentally be administered again. The clinical record was reviewed for Resident #27, and Staff #19 stated that the MAR for January 2026 revealed that no doses of morphine were administered and no doses of the 2 mg/ml lorazepam were administered. The narcotic reconciliation sheets for Resident #27's morphine and 2 mg/ml lorazepam were reviewed and Staff #19 stated that Resident #27 was administered both morphine and 2 mg/ml lorazepam doses at 10:00 a.m. and again at 12:10 p.m. on January 2, 2026, and that it would not meet her expectation as far as documentation in the clinical record.Review of the facility policy titled Documentation: Charting and Documentation, dated January 1, 2024, revealed all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Documentation of procedures and treatments will include care-specific details, including: the date and time the procedure/treatment was provided, the name and title of the individual(s) who provided the care, the assessment data and/or any unusual findings obtained during the procedure/treatment, how the resident tolerated the procedure/treatment, whether the resident refused the procedure/treatment, notification of family, physician or other staff, if indicated; and the signature and title of the individual documenting.Review of the facility policy titled Medication: Administering Medications, dated January 1, 2024, revealed medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders, including any required time frame. Medication errors are documented, reported, and reviewed by the QAPI committee to inform process changes and or the need for additional staff training. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones, or documents in the electronic medical administration record. As required or indicated for a medication, the individual administering the medication records in the resident's (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medical record:a. the date and time the medication was administered;b. the dosage;c. the route of administration;d. the injection site (if applicable);e. any complaints or symptoms for which the drug was administered;f. any results achieved and when those results were observed; andg. the signature and title of the person administering the drug.