STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035076	A. Building B. Wing	07/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Osborn Health and Rehabilitation	3333 North Civic Center Plaza Scottsdale, AZ 85251

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 47341 Based on resident and staff interviews, clinical record review, and facility policy, the facility failed to ensure services/treatment are provided per plan of care and physician orders for one resident (#2). Findings include: Resident #2 admitted to the facility on [DATE] and discharged on [DATE] with diagnoses that included hypertensive heart disease with heart failure, asthma, paroxysmal atrial fibrillation, hypo-osmolality and hyponatremia, and traumatic brain injury. The Care plan initiated on 06/24/2024 included for hypertension with interventions that included to give anti-hypertensive medications as ordered, obtain blood pressure readings, and provide a calm, quiet environment. To manage his hypertension, the resident had a physician's order for hydralazine 25 mg (milligram) tablet in the morning that was discontinued on 6/26/2024. This was replaced by an order dated 06/26/24 for one Hydralazine 25mg tablet three times a day. The physician progress note dated 06/26/2024 included that the resident #2 had an elevated blood pressure and they would monitor it. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 for resident #2 which indicated he was cognitively intact. The MDS also indicated he was hypertensive. According to the complaint filed to SA (State Agency) on 6/29/2024, resident #2 had reported that at around 3pm of 6/29/2024, his blood pressure was 167/116 and 3 hours later he had not received any blood pressure (BP) medication or help of any kind. Review of resident's vitals revealed that on 6/29/2024 at 3:47 pm, resident #2 blood pressure read 164/116 mmHg. The BP was taken by staff #15. Review of the records revealed that the next BP was taken by a RN (Registered Nurse/ staff #23/ charge nurse) on 6/29/2024 at 9:41 pm and the BP read 128/89. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035076	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Osborn Health and Rehabilitation	3333 North Civic Center Plaza Scottsdale, AZ 85251

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The electronic health record (EHR) included a nursing progress note dated 6/29/2024 at 9:42 pm, that included a blood pressure warning, value that showed 164.0/116.0 and vital date of 6/29/2024 at 3:47 pm. The note further included that a systolic high of 160 exceeded and diastolic high of 95 exceeded. The note also included that a medication was given, BP was rechecked and was within the limit. The resident's EHR did not indicate which medication was given and at what time. Further review revealed no record in the EHR of any blood pressure monitoring or additional interventions during the interval of almost 6 hours from 3:47pm till 9:41 pm on 6/29/2024. Further review of resident #2 orders included a physician's order for a PRN (as needed) hydralazine 25 mg table that was ordered on 06/30/2024. There were no documentations of administration of a PRN hydralazine prior to 06/30/2024. In an interview with Staff #23, on 7/15/2024 at 4:17 pm, she stated that she believed she gave Resident #2 hydralazine for his blood pressure reading outside of normal limits, but she cannot be sure. She stated that his blood pressure was taken before she came on. When she took it and noticed it was high, she gave him the assumed hydralazine. She stated the physician was probably notified on the day shift, but she personally did not notify them. At shift change, the day nurse let her know about the high blood pressure; she asked if anything had been given and was told no. After administering medication, she rechecked his vitals at a half hour and hour interval and his blood pressure had come down. She stated that the day nurse had been licensed practical nurse (LPN), Staff #45, and they would have been the one to notify the physician. In an interview with the certified nursing assistant (CNA), Staff #15, on 7/15/2024 at 4:39 pm, she stated that when she takes vitals, anything over 140 is considered high and is reported to the nurse. When asked about Resident #2's vital of 164.0/116.0 mmHg, she stated she reported it to the nurse (Staff #23) and she probably retook it. She stated that after reporting to the nurse, it was out of her hands as she does not do any follow up. In an interview with Staff #9 (Registered Nurse/ RN) on 7/15/2024 at 4:56 pm, he stated he provided care for Resident #2, and that he has high blood pressure, but he does take a blood pressure maintenance medication. He stated if he got a blood pressure reading that exceeded 165/95, but that patients blood pressure was expected to be high, he would give the scheduled maintenance medication. He would then check back in an hour or two. If it was still high, he would give the PRN (as needed) medication. If it is still high, he would contact the provider. In an interview with Staff #45 on 7/15/2024 around 5:03 pm, he stated while he recalled the patient, he could not clearly recall the situation. After refreshing his memory of the blood pressure exceeding 160/95mmHg, he said that he believed the doctor was called and they got a script for a blood pressure medication. He stated that this communication with the doctor is not something he would document in a progress note. He stated they usually communicate via text message. He stated he did not recall the medication. When asked about vitals being taken at 3:47 PM, and medication not being given until 9:42 PM, he said vitals would have been rechecked in the interim. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Osborn Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 3333 North Civic Center Plaza, Scottsdale, AZ 85251	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON/ staff #77) on 7/15/2024 at 5:22 pm, the DON stated that if a patient has blood pressure outside normal limits (exceeded 160/95), the CNA will have to report to the nurse. The DON stated the system also will trigger a vitals alert once the blood pressure values were entered. Her expectation is for the nurse to recheck it to see if it is still high or even accurate. The DON stated staff will then check for a PRN medication and communicate with the provider when there is no PRN. The DON stated that she would expect the nurse to document on the medication administration record (MAR) when they give the PRN medication. In a facility policy entitled Routine Procedures- Vital Signs, Weight and Height) last revised in 05/2024, it states The facility shall identify and utilize established thresholds as determined by the medical director and/or attending providers .these threshold will be used to determine need for notifications to the provider and use of medications . Any vital sign taken on a resident that is outside the established thresholds will be reported to the attending provider and documented on in the medical record.