

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 07/11/2025
NAME OF PROVIDER OR SUPPLIER Osborn Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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. (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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to ensure that drug records are in order and that an account of all controlled drugs are maintained for 1 out of 22 residents (Resident # 50).Based on clinical record review, interviews, and facility policy, the facility failed to ensure drug records were in order and that an account of all controlled drugs was maintained for 1 out of 22 sampled residents (# 50). The deficient practice could result in the potential for the resident not to be properly medicated. Findings include: Resident # 50 was admitted on [DATE], with diagnoses that included aftercare for joint replacement surgery, left hip joint replacement, and Alzheimer's disease with dementia.Review of the Resident's care plan revealed that Resident # 50 is currently prescribed an opioid for pain, effective June 27, 2023, with an intervention task that included administering opioid medication as prescribed. Review of the Resident's orders revealed an order dated June 27, 2023, to administer 1 tablet of Hydrocodone-Acetaminophen oral tablet 5-325 milligrams (MG) by mouth every 6 hours as needed (PRN) for pain levels 4-10. The start date for the order was June 27, 2023, and there is no end date indicated for the order. Review of June 2023 Medical Administration Record (MAR) indicated administration of one tablet of Hydrocodone-Acetaminophen on June 28, 2025, at 8:22 a.m. for a pain level of 7, and another tablet was administered at 5:23 p.m. for a pain level of 7. There were no other administrations of the Hydrocodone-Acetaminophen in the June 2023 MAR. Review of the Controlled Drug Receipt/Record/Disposition Form revealed that 2 tablets of Hydrocodone-Acetaminophen 5-325 MG were pulled from the cart on June 28, 2023. On June 29, 2023, 1 tablet of Hydrocodone-Acetaminophen 5-325 MG was pulled from the cart at 11:24 a.m., even though there was no record of administration of this tablet in the June 2023 MAR. There was no indication that any of the tablets that were pulled were wasted. Review of the Facility Investigation Report with no date, revealed an interview of Licensed Practical Nurse (LPN/Staff #452) who reported that on June 29, 2023, at approximately 11:20 a.m. she administered 1 tablet of Hydrocodone-Acetaminophen 5-325MG upon the request of the family. An interview was conducted on July 10, 2025, at 1:04 pm with Licensed Practical Nurse (LPN/Staff # 65), who stated that if a narcotic needed to be administered, once the medication is pulled from the cart, she would document the date, time, and the amount of the narcotic on the narcotic count sheets. Once it is recorded, we then administer the narcotic to the resident, and then we document the administration into the MAR. If the resident refuses or the narcotic gets dropped, we then waste the medication and document on the narcotic sheet that the medication was wasted. An interview with the Director of Nursing (DON/Staff # 402) was conducted on July 10, 2025, at 2:13 p.m. The DON acknowledged that LPN # 452 did not document the administration of the Hydrocodone-Acetaminophen 3-325 MG tablet in the MAR on June 29, 2023. The DON revealed that her expectation is that once a narcotic is pulled from the cart that Resident's #50 narcotic is documented in the narcotic count sheets, and if the narcotic is administered, then it is documented in the MAR. The DON revealed that if not appropriately documented, the staff are unable to know what was administered to the residents and what was not. Review of the facility policy titled Medication Administration, reviewed August of 2024 revealed that it is the policy of the facility to accurately prepare, administer and document oral medications. The policy also revealed that all medications are documented once administered.</p>		