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	10/10/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51006 Based on clinical record reviews, facility documentation, staff interviews, and policy review, the facility failed to ensure that two residents (resident #272 & #273) were free from resident to resident verbal abuse, and that one resident (resident #369) are not physically abused by visitors. The deficient practice could result in further resident to resident verbal abuse, and visitor to resident abuse. In regards to resident #272, findings include: Resident #272 was initially admitted on [DATE] with diagnosis of Hypertension, Diabetes Mellitus, Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke, Hemiplegia or Hemiparesis, Schizophrenia. Resident #272 was discharged on [DATE]. A review of a quarterly Medicare Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated intact cognition. A review of a progress note created on June 27, 2024 @ 2PM revealed Resident #272's involvement in the incident, indicating that the incident occurred. A review of the intake information for AZ00198684 revealed that the Facility Reported Incident (FRI) was submitted on June 27, 2024 at 3:36PM. This review revealed that Resident # 272 and Resident #273 exchanged verbal profanities to each other, indicating resident #272's involvement in the incident. A review of a progress note titled 'Change of Condition' created on June 28, 2023 at 1:04PM revealed that Resident #272 underwent daily monitoring for the next 30 days, following the verbal altercation, indicating that the incident occurred. (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 10/10/2024

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	An interview was conducted on October 9, 2024 at 1:21PM with the Director of Nursing (DON/Staff # 66), who stated the expectations and their understanding of the facilities abuse policy. Staff #66 identified abuse as, any form of physical, emotional, verbal, sexual, misappropriation, seclusion and neglect. Staff #66 then stated that the process of reporting and investigating allegations is to report to the Department of Health Services within 2 hours of notification, then they have 5 days to provide the investigation results back to the Department of Health Services, Staff #66 also reported that additional parties of notification include Adult Protective Services, law enforcement, the provider, and any families/Power of Attorney's. Staff #66 stated that the impact of abuse on the residents could include, the overall psychosocial wellbeing of the resident. Staff #66 then stated that in regards to the incident that took place on July 27, 2023 between Resident #272 and Resident #273, that she could not re-call the incident and would need to review the full investigation notes provided by their predecessor. Staff #66 reported their conclusion of the full investigation notes, and stated that their immediate response was to separate the two residents, to put into effect 'Change of Condition' monitoring, and, to complete medication assessments and psychiatric evaluations for both Resident # 272 and Resident #273. Staff #66 reported that Resident # 272 and Resident #259 refused a room change, which would be another step in the separation of all involved parties. A review of a policy titled, Abuse: Prevention of and Prohibition Against revealed the guidelines that the facility utilized in regards to interventions to prevent abuse, neglect, exploitation and misappropriation. The policy provided definitions on what the facility defined as 'Abuse'. The policy stated that abuse includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. In regards to resident #273, findings include: Resident #273 was admitted on [DATE] with the diagnoses of Coronary Artery Disease (CAD), Heart Failure, Hypertension, Renal Insufficiency, Renal Failure, or End-Stage Renal Disease (ESRD), Anxiety Disorder, Resident #273 was discharged on [DATE]. Review of a quarterly Medicare Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated intact cognition. A review of a progress note created on June 27, 2024 @ 2PM revealed Resident #272's involvement in the incident, indicating that the incident occurred. A review of the intake information for AZ00198684 revealed that the Facility Reported Incident (FRI) was submitted on June 27, 2024 at 3:36PM. This review revealed that Resident # 272 and Resident #273 exchanged verbal profanities to each other, indicating resident #273's involvement in the incident. A review of a progress note titled 'Change of Condition' created on June 28, 2023 at 1:18PM revealed that Resident #273 underwent daily monitoring for the next 30 days, following the verbal altercation, indicating that the incident occurred. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	An interview was conducted on October 9, 2024 at 1:21PM with the Director of Nursing (DON/Staff # 66), who stated the expectations and their understanding of the facilities abuse policy. Staff #66 identified abuse as, any form of physical, emotional, verbal, sexual, misappropriation, seclusion and neglect. Staff #66 then stated that the process of reporting and investigating allegations is to report to the Department of Health Services within 2 hours of notification, then they have 5 days to provide the investigation results back to the Department of Health Services, Staff #66 also reported that additional parties of notification include Adult Protective Services, law enforcement, the provider, and any families/Power of Attorney's. Staff #66 stated that the impact of abuse on the residents could include, the overall psychosocial wellbeing of the resident. Staff #66 then stated that in regards to the incident that took place on July 27, 2023 between Resident #272 and Resident #273, that she could not re-call the incident and would need to review the full investigation notes provided by their predecessor. Staff #66 reported their conclusion of the full investigation notes, and stated that their immediate response was to separate the two residents, to put into effect 'Change of Condition' monitoring, and, to complete medication assessments and psychiatric evaluations for both Resident # 272 and Resident #273. Staff #66 reported that Resident # 272 and Resident #259 refused a room change, which would be another step in the separation of all involved parties. A review of a policy titled, Abuse: Prevention of and Prohibition Against revealed the guidelines that the facility utilized in regards to interventions to prevent abuse, neglect, exploitation and misappropriation. The policy provided definitions on what the facility defined as 'Abuse'. The policy stated that abuse includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. 51158 -Regarding Resident #369: The resident was admitted on [DATE] with diagnoses including Alzheimer ' s disease and Non-Alzheimer ' s Dementia. Review of nursing notes revealed no evidence of concerns regarding interactions between the resident and her daughter from March 29, 2024 to April 8, 2024. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) assessment score of 5, which indicated severe cognitive impairment. Review of the comprehensive care plan initiated on April 1,2024 identified a focus of alteration in neurological status due to the disease process of dementia. The care planned interventions included discussing with the resident/family about any concerns, fears, or issues; as well as, having therapy to evaluate and treat as ordered. Further review of the comprehensive care plan initiated on April 2, 2024, identified a focus due to displayed behavioral issues. Resident #369 would yell out, not directed at others, rather for her daughter. The care planned interventions included receiving medications as ordered, and monitoring the behaviors and episodes. Review of the clinical record revealed no evidence of nursing notes regarding the alleged abuse on April 8, 2024. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of the clinical record revealed no evidence of orders regarding 1:1 visitation after the alleged abuse that occurred on April 8, 2024. A nursing note dated April 8, 2024 at 3:57 PM, revealed that the physician was notified of increased agitation with care and the resident complained of sensitivity in lower extremities. There were no new orders at the time, and the facility continued to monitor. Further review revealed no evidence of physician notification regarding the incident. Review of a facility abuse investigation dated April 8, 2024, regarding a report of abuse between Resident #369 and her daughter. The report revealed two interviews with nursing staff, and 2 interviews with the victim and perpetrator. The conclusion of the investigation was that the allegation of abuse was unsubstantiated. The findings did identify that the incident, physical interaction, did occur; which led to supervised visits throughout the course of the investigation. An interdisciplinary team (IDT) progress note dated April 10, 2024 at 3:40 PM, revealed there were no resident concerns with 1:1 visits, and that supervised visits would be continued. Another IDT note dated April 12, 2024 at 2:50 PM, revealed that the supervised visits were discontinued as the patient was safe in the facility. The physician was made aware and there were no noted psychosocial effects, the daughter was made aware and social services would be following up. A comprehensive care plan initiated April 12, 2024, was developed for the resident ' s behaviors revealed in a change of condition (COC) note that the daughter was on supervised visits. An interview was conducted on October 9, 2024 at 11:42 AM with a Physical Therapy Assistant (PTA/Staff #284). The PTA (Staff#284) was familiar with the resident and was able to recall the incident that occurred with the victim and her daughter. The PTA stated that he walked into the resident ' s room to bring the resident to physical therapy; the resident was in her room and her daughter was in a chair off to the side of the room. The PTA let the resident know who he was and that he wanted to take her to therapy to which Resident #369 stated she was in too much pain and did not want to go; the perpetrator interjected and stated that the resident needed to get up. The PTA stated he could sense there was agitation in the interaction. The PTA (Staff #284) stated that the resident ' s daughter threatened Resident #369 saying if you don ' t get up I ' m going to rip your head off while simultaneously grabbing her ankle and squeezing it as if the daughter knew this would hurt the victim. The PTA then physically demonstrated the grasp around the ankle; showing how the palm was at the top of his ankle with the four fingers towards one side and thumb towards the other side. The PTA stated that he believes this was intentional and that the Resident ' s daughter did it on purpose and that it felt like abuse to him and he needed to let a nurse know. The PTA stated it was his first time working with Resident #369 and he was not sure if this was normal but due to how the resident and her daughter were screaming at one another and using foul language he verbally reported it to the nurse, who went to the administrator and filled out an incident report. An interview was conducted on October 9, 2024 at 1:02 PM with the Director of Nursing (DON/Staff #66) and Administrator (Staff #181). The DON (Staff #66) stated that she was made aware of the situation and immediately removed the Resident ' s daughter from Resident #369 ' s room. The DON stated she then notified the physician, Scottsdale police department, and adult protective services (APS). The DON stated that a skin integrity assessment was conducted and there was no evidence of physical injury. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	An interview was conducted on October 9, 2024 at 2:38 PM with the Resident ' s daughter. She stated that the resident passed away in September. She then stated that she would never hurt her mom and cared for her, she simply wanted her to participate in physical therapy and get better. She went on to say that the facility did have supervised visits for 6 days and there was a staff member present at all times, and the conclusion of the investigation visitation went back to normal and the resident was discharged home not long after. Review of facility policy titled, Abuse: Prevention of and Prohibition Against, revealed that the facility is to ensure the health and safety of each resident with regard to visitors, such as family members or resident representatives, friends, or other individuals subject to the resident ' s right to deny or withdraw consent at any time and to reasonable clinical and safety restrictions.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51124 Based on observations, interviews, facility documentation, and review of facility policy, the facility failed to ensure appropriate treatment and services for activities of daily living were provided, according to residents' preferences and to meet residents' needs, for Residents #320 and #322. The deficient practice could lead to a resident's needs not being met, or a decline in a resident's physical function or psychosocial status. -Regarding Resident #320: Resident #320 was admitted into the facility on [DATE], with diagnoses that included pigmentary retinal dystrophy, sepsis, urinary tract infection, pneumonia, and adult failure to thrive. Review of Resident #320's care plan dated October 01, 2024 revealed that the resident had a focus for an activities of daily living (ADL) self-care performance deficit, with an intervention in place for 1:1 assistance with meals: Resident is blind. A review of the resident's physician's orders revealed an order in place dated October 01, 2024, for 1:1 Assistance with meals; Resident is blind. Review of the Speech Therapy Evaluation and Plan of Treatment dated October 02, 2024 revealed that the resident is legally blind and that the resident requires supervision/ assistance 50-75% of the time at meal time due to swallowing safety. A review of the Brief Interview for Mental Status (BIMS) assessment that was completed on October 02, 2024, revealed Resident #320 had a score of 14, indicating intact cognition. Upon review of the progress notes, a Social Services Summary note dated October 04, 2024, revealed that Resident #320 eats meals with 1:1 staff assist in her room. A Weekly Clinical Interdisciplinary Team (IDT) Review note dated October 08, 2024, revealed nursing to provide assist with meals. A follow-up review of the resident's care plan revealed that the care plan had been adjusted. Under the focus of ADLs, the resident still had the intervention in place for 1:1 assistance with meals: Resident is blind. However, under the focus of 4.2% significant weight loss x 5 days, the resident had a new intervention dated October 09, 2024, that Patient & family would like to encourage resident to eat independently prior to assist. Review of the resident's clinical record revealed there was no evidence of documentation in the progress notes prior to October 10, 2024, regarding updates to Resident #320's status of 1:1 assistance during mealtimes. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Therapy progress note dated October 10, 2024, revealed that Patient status changed from 1:1 assist to set up for meal times. Patient is able to independently manage meals after set up. Husband prefers to feed wife when he is present mainly at lunch time as this is his daily routine in the home. Patient manages her daily routine with verbal cues. An observation was conducted on October 08, 2024 at 7:56 AM, of Resident #320 in her room. There was no signage outside the room or inside the room indicating that the resident was blind. An interview was conducted at this same time with the resident, who stated that I don't have central vision, I'm not able to read and I can't see anything on my plate. I have to touch my food to see what it is. An additional observation was conducted the same morning at 8:12 AM, in the resident's hallway just outside of her doorway. The meal cart was on the hall, and staff passed out meal trays. A staff member delivered a meal tray to Resident #320, who was lying in bed in her room. The staff provided no assistance other than placing the tray on the bedside table, and the staff left the room. At 8:24 AM, the resident was still lying in bed, and the meal tray was still observed to be untouched on the bedside table beside the resident. At 8:36 AM, Resident #320 was observed lying in bed with her meal tray in front of her attempting to eat her food, with no staff assisting her. The resident was using her fingers to eat the scrambled eggs and bacon, and her silverware lay untouched on the tray beside her plate. An interview was conducted with the resident at that time. The resident was asked if anyone had helped her set up her meal tray and help her eat, to which the resident replied that she did it herself. The observation continued, and at 8:53 AM, a staff member entered the resident's room and asked if she was done with breakfast. Resident #320 stated No, I am not, and the staff member then left the room. It was observed that the resident still had plastic wrap covering the juice cup on her tray. Additionally, multiple pieces of scrambled egg were on the front of the resident's clothing as she lay in bed. A follow-up interview was conducted with the resident at 9:05 AM. The resident stated that she was not able to see anything on her meal tray and that I have to feel my way around. When asked if she knew she had a bowl of oatmeal in the corner of her tray, the resident stated No. An observation was conducted on October 08, 2024 at 11:45 AM on the resident's hallway. The meal cart was on the hall for lunch, and a staff member dropped off the tray to Resident #320 in her room. The resident's husband was present in the room, and no staff stayed to assist the resident during the mealtime. Staff did not provide orientation or identification of items on the meal tray. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation was conducted on October 09, 2024 at 7:22 AM. Resident #320 had been moved to another room on a different hallway. From the hallway just outside the resident's room, the resident was observed to be in lying in bed, and a certified nursing assistant (CNA/ Staff #280) delivered the meal tray to the resident. The CNA set up the breakfast tray on the bedside table and cut up the pancakes for the resident. As the CNA was leaving the room, the resident asked if her food was in front of her, to which the staff responded yes and that she didn't want the food too close to the resident. The CNA then left the room. The cover was still on the oatmeal bowl, and the drinks still had plastic wrap on the tops of the cups. The observation continued from just outside the resident's doorway, and at 7:25 AM, the resident took a bite of bacon and stated What is this crap? Nobody was in the room when she said this. The resident continued to feel around her plate with her fingers. The resident stated that she needed her chin wiped. Again, nobody was in the room when she said this. The resident then touched the small covered bowl on her tray and asked out loud, Is this oatmeal over here? and then Can somebody put sugar in my oatmeal? Again, nobody was in the room when the resident said this. Finally, the resident stated Can somebody help me eat my oatmeal? An Assistant Director of Nursing (ADON/ Staff #205) then entered the room at 7:34 AM, and closed the door. In a follow-up interview conducted on October 09, 2024 at 7:45 AM, the ADON (Staff #205) stated that she was in the room assisting the resident with one to one assistance for the meal. When asked specifically what she was assisting with, the ADON stated that she was cutting food and giving verbal cues due to vision loss. The ADON stated that she is aware of which residents require this type of assistance because it is in the resident's chart, in the orders, on the special instructions banner in the medical record, and in the care plan. The ADON was notified that a CNA was observed to enter Resident #320's room, cut up the food, and then leave. The ADON stated that this was inappropriate. An interview was conducted with the CNA (Staff #280) on October 09, 2024 at 8:15 AM. The CNA stated that staff receives information on individualized care needs through verbal report and that the nurses put it in the computer. The CNA stated that it is the facility's expectation for staff to follow care plans and physician's orders. The CNA further stated that for a resident who requires one to one assistance for meals, that it requires the CNAs to go sit with the resident, to offer assistance, and to use wipes and sanitizers to clean the resident's hands before and after the meal. When asked if she was aware of Resident #320's orders for one to one assistance for meals, the CNA stated, I was aware. Additionally, the CNA stated that she had called on the radio for a staff member to come help Resident #320 after she had put the tray in the resident's room. An interview was conducted on October 09, 2024, at 12:15 PM, with Resident #320's husband who was present with the resident in her room. He stated, I came in today, she was eating lunch by herself. I'm assuming that they're (facility staff) too busy to sit down with the resident to assist. He also stated, I have never noticed staff helping with meals. I've noticed her eating by herself, sometimes she asks me what's on her plate. I always told her what's on the plate and where it is. Resident #320's husband further stated, I never had any conversation with any staff giving instructions on how to serve her meals. When they bring it in, they just bring it in and drop it and leave. I usually have to tell her what she's got. I think they got more patients than they can handle. At that time, Resident #320 joined the interview and stated I need help identifying what's on the plate. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On October 10, 2024 at 9:33 AM, an interview was conducted with the Director of Nursing (DON/ Staff #66). The DON stated that it was her expectation for staff to follow care plans and to follow physician orders. Further, the DON stated that if a staff member was concerned that a care plan or an order may be inappropriate for a resident, or if it may need to be adjusted, that it would be communicated to the provider and discussed with the resident, with family as needed, and with the interdisciplinary team. The DON stated that she was not aware of any staff coming to her with recommendations or concerns about Resident #320's care plan. The DON stated that sometimes the resident's husband comes in and provides assistance during meals for the resident, and that the facility encourages the resident to do as much as she can. In a follow-up interview at 10:09 AM, the DON (Staff #66) brought a copy of an updated care plan dated October 09, 2024. The DON stated that the ADON (Staff #205) and Resident #320 had a conversation during breakfast on October 09, 2024 where the resident stated that she wants encouragement to eat independently prior to assistance being provided, and that the order and care plan were changed to reflect that. On October 10, 2024 at 10:29 AM, an interview was conducted with Resident #320. The resident stated that she did not recall ever telling staff that she wanted her assistance level with meals changed yesterday. The resident stated that she did ask to have a private room, and that she got a private room. She further stated that she did not recall discussing with staff that she no longer needed assistance with meals. She stated, I do think I need someone helping me with meals. I like having someone help me with that, that way I know what I am eating. On October 10, 2024 at 10:32 AM, an additional interview was conducted with Resident #320, this time an ADON (Staff #356) was also present in the resident's room. The resident stated I like to have someone here to tell me what is on the tray, that helps. The resident further specified that she did not feel she needed someone to sit with her the whole meal, however, she did request help to set up the tray and to identify and orient her to items on her meal tray. Review of the facility's policy titled ADL, Services to Carry Out, revised July 2015, revealed that if a resident is unable to carry out the activities of daily living, the necessary services to maintain good nutrition, grooming, and personal oral hygiene will be provided by qualified staff. Further, residents will be involved in decision making and given choices related to ADL activities as much as possible. -Regarding Resident #322: Resident #322 was admitted into the facility on [DATE], with diagnoses that included chronic respiratory failure, chronic pulmonary edema, morbid obesity, and depression. Review of Resident #322's care plan dated October 02, 2024, revealed that the resident had a focus for an activities of daily living (ADL) self-care performance deficit, with a goal in place for the resident to maintain current level of function in bed mobility and transfers. A review of the resident's physician's orders revealed an order dated October 02, 2024, which prescribed activity as tolerated for Resident #322. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the resident's Physical Therapy Evaluation and Plan of Treatment dated October 03, 2024, revealed that Resident #322 had no contraindications to treatment. It was documented by a Physical Therapist (PT/ Staff #475) that the resident's prior living situation was other long-term care facility, and that she used a manual wheelchair, and her prior level of function was totally dependent on staff for transferring from the bed to a wheelchair. The PT evaluation also revealed that the resident's current level of function was dependent on staff for transfers. A review of the Brief Interview for Mental Status (BIMS) assessment that was completed on October 04, 2024, revealed Resident #322 had a score of 13, indicating intact cognition. Upon review of the progress notes, it was revealed in a Social Service Summary dated October 07, 2024, that Resident #322 plans to remain in the facility for long term care, that she is alert and able to make her needs known, and that she requires maximum assistance for bed mobility and dependent on staff for transfers. In an observation conducted October 07, 2024 at 10:37 AM, Resident #322 was observed to be lying in her bed in her room. In an interview conducted at the same time, Resident #322 stated that she had been here since last Wednesday, and that she had been waiting to get up into a wheelchair since then. Resident #322 stated that she asked the certified nursing assistants (CNAs) to get out of bed last Thursday morning, and other days as well. She stated that the CNAs said that they could not get her up because physical therapy hadn't signed off on it yet. The resident stated that she has already been seen by therapy. Resident #322 appeared very frustrated and stated I'm used to spending 6-9 hours a day in a wheelchair and I'm growing roots in this bed. In an observation conducted October 07, 2024 at 11:55 AM, Resident #322 was observed to be lying in her bed in her room. Another observation was conducted October 08, 2024 at 7:42 AM. Resident #322 was again observed to be lying in her bed in her room. A follow-up interview was conducted with the resident at this time. Resident #322 stated that no staff helped her to get out of bed again yesterday. She stated that a short, male therapist visited her in the room and stated that they will try to get her out of bed tomorrow. Resident #322 repeated that she has been asking to get out of bed for several days and that nursing staff keeps telling her that it has not been approved. In an observation conducted October 08, 2024 at 1:54 PM, Resident #322 was observed to be still lying in her bed in her room. (continued on next page)

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 10/10/2024

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Another follow-up interview was conducted with the resident at this time. Resident #322 stated that she has been asking the CNAs on the floor to get up out of bed today. When clarifying who exactly she had asked to get up, the resident went on to state the first name of a CNA (Staff #280) who was working on the hallway that date, and used descriptors that portrayed that CNA. Resident #322 continued to state I asked her to check with the PT department to get up in the wheelchair today. A therapist in the PT department visited and he said 'I got you a chair' and put a wheelchair outside the room. Sounds like he was expecting CNA staff to get me up, but nobody's got me up. Resident #322 continued to state that when the CNAs came in, they said they didn't have a hoyer sling, because they weren't sure they were supposed to get her up. Resident #322 stated that she felt that nobody in this facility talks to each other. Resident #322 stated that before she came to this facility, she was getting up in the wheelchair every day and sitting up for multiple hours. She stated she liked to be sitting up in a wheelchair in her room normally. Upon exiting the resident's room after the interview, it was noted that two wheelchairs were folded and placed against the hallway rail, right outside the resident's door. In an observation conducted on October 09, 2024 at 7:57 AM, Resident #322 was observed to be lying in her bed in her room. In a follow-up interview at that time, Resident #322 stated that the staff did not help her get out of bed again yesterday. In an observation conducted October 09, 2024 at 9:45 AM, Resident #322 was observed to be lying in her bed in her room. In an interview conducted at this time with Resident #322, the resident stated she's ready to attempt getting out of bed and will ask the staff via the call light in a few minutes. In an observation conducted October 09, 2024 at 9:57 AM, from the hallway, it was observed that Resident #322's call light was put on. The observation continued and at 10:02 AM, a Hospitality Aid (HA/ Staff #170) answered the call light. Resident #322 was observed and overheard to state that she wanted to get up in the wheelchair. In an observation conducted October 09, 2024 at 10:40 AM, Resident #322 was still lying in bed. In a follow-up observation conducted October 09, 2024 at 1:40 PM, Resident #322 was, again, still lying in bed. In an observation conducted October 09, 2024 at 1:59 PM, Resident #322 was observed to be still in bed. In a follow up interview at the same time, Resident #322 stated When I asked to get up out of bed, the hospitality aid stated I'll let the CNA know. The resident also stated, I've just about given up. I've been here since last Wednesday night and I have been in this bed ever since. A final observation was conducted on October 10, 2024 at 8:57 AM. Resident #322 was being assisted by staff with a hoyer lift to transfer her to a wheelchair. The PT (Staff #475) was assisting with the transfer. (continued on next page)

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	035076	A. Building B. Wing	10/10/2024

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on October 09, 2024, at 11:53 AM, with the Director of Nursing (DON/ Staff #66). The DON stated that information regarding a newly admitted resident's mobility is gained from report taken from where the resident is coming from. The DON further stated that we promote the highest level of function while providing care. In an interview conducted October 09, 2024 at 1:19 PM, a Registered Nurse (RN/ Staff #160) stated that if a resident is admitted to the facility, staff would know the resident's mobility status and how that resident would safely transfer because there is an exchange of report between the two facilities. The RN also stated that the facility's admissions team also provides that information to floor staff. Additionally, the RN stated that in this facility, CNAs, nurses, and some management are all trained to help a resident transfer from bed to a wheelchair. If a resident were to request to get up into a wheelchair, the RN stated that she would first check to see what kind of assistance was required and if multiple people were needed for safety. Then she would assist the resident in getting out of bed. Lastly, the RN stated that the importance of residents getting out of bed was to prevent skin breakdown, and to promote mental health and circulation in the body. An interview as conducted on October 09, 2024 at 1:09 PM with an Occupational Therapist (OT/ Staff #246) who stated that she was not a full-time employee of the facility, but was from another sister facility and was helping this facility for approximately the 6th time. The OT stated that CNAs, nursing, and therapy are all trained to safely assist a resident out of bed into a wheelchair. An additional interview was conducted on October 08, 2024 at 1:25 PM, with the Director of Rehab (DOR/ Staff #138). The DOR stated that if a resident admits to the facility from the hospital or from another long-term care setting, that the admissions team uploads documents into the electronic health record regarding the resident's mobility status. The DOR also stated that every CNA, nurse, and therapist in this facility is trained to assist a resident with transferring into a wheelchair. In addition, the DOR stated that if staff was not sure how to safely transfer a resident, that they could ask a nurse or a therapist for clarification. Finally, the DOR stated that unless there is a doctor's restriction, there should never be a situation where a resident asks to get up out of bed into a wheelchair and does not get up. An interview was conducted with the Hospitality Aid (HA/ Staff #170) on October 09, 2024 at 2:02 PM. At this time, the HA was notified that he had been observed responding to Resident #322's call light earlier that date in the morning, and that he was overheard to say that he would let the CNA know of the resident's request to get out of bed. The HA then stated Yes, I'm pretty sure I called over the radio to have a CNA come to the room, and then further stated that he had not followed up with anyone to see if a CNA actually came to the room to assist the resident with her specific request. The HA then asked if the resident was still in bed, and was then notified that the resident had not been assisted to get in the wheelchair. The HA stated that his next course of action would be to go to the floor to see who is still here, if the CNA can't get her up due to it being close to shift change, then he would let the next shift know of the resident's request to get up. (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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On October 10, 2024 at 9:02 AM, an interview was conducted with the PT (Staff #475), who confirmed that he had done the initial PT Evaluation for Resident #322. The PT stated that the resident had said she really wanted to work on transfers, and that there was no medical hold that would keep her from performing those tasks. The PT stated that the resident had expressed her desire to get out of bed that day, and during his session, he had been focused on helping her to get to the edge of the bed. The PT further stated that all CNAs are capable of assisting that resident to transfer to a wheelchair, and that Resident #322 would require a hoyer lift to transfer to the wheelchair. The PT stated that the impact on a resident of not getting out of bed could be that it affects the resident's emotional state, that it can cause depression, and isolation of residents who are bound to their rooms. The PT stated that it would not meet his expectations if a resident requested to get out of bed and was not assisted by staff to do so, and that it should be accomplished within an hour or a reasonable timeframe. A follow-up interview was conducted with the DON (Staff #66) on October 10, 2024 at 9:55 AM, where the DON was notified of Resident #322 not being assisted with transferring out of bed into a wheelchair when she had requested to do so yesterday morning. The DON stated that she was notified of the resident's concern yesterday afternoon, and the facility filed a grievance with the resident about not getting up to the wheelchair. The DON further stated that last night, staff helped the resident get up in the wheelchair, that the resident went to a pumpkin activity, and could only tolerate 15 minutes in the wheelchair. The DON stated that She changes her mind a lot. An interview was conducted with Social Services Director (SSD/ Staff #91) on October 10, 2024 at 10:23 AM. The SSD stated that she was notified of the resident's concern about not getting up in the wheelchair at approximately 2:30 PM yesterday afternoon (October 09, 2024). The SSD stated that she filed a grievance with the resident, and after that, the resident was assisted up into a wheelchair and then went to a pumpkin painting activity. The SSD stated that the resident was satisfied. Review of the facility's policy titled ADL, Services to Carry Out, revised July 2015, revealed that it is the policy of this facility that residents are given the appropriate treatment and services to attain or maintain the highest practicable well-being of each resident. In addition, residents will be involved in decision making and given choices related to ADL activities as much as possible. Further, the policy revealed that ADL care, including transfers, will be provided according to the resident's assessed needs and level of support, and documented in the medical record accordingly.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 51006 Based on observation, staff interviews, review of the manufacturer instructions and policy review, the facility failed to ensure that one medication in a medication cart was labeled, with an open date. The deficient practice could result in further medication lacking an open date for proper usage. Findings include: An observation of the medication administration was conducted with a Registered Nurse (RN/Staff #147) on October 9, 2024 at 4:23PM. Staff #147 was observed administering a Tuberculin PPD Step 2, which was not marked with an open date. An interview was conducted on October 9, 2024 at 4:30PM with staff #147, who stated that the Tuberculin PDD should have been dated when it was opened, and that this particular medication will have an expiration date of 28 days from opening. A review of the Center of Disease Control guidelines pertaining to 'Mantoux tuberculin skin test,' revealed the expectations to review vial labels to make sure that the vial contains the tuberculin that you wish to choose, and that the label should indicate the expiration date. Revealing that if a vial has been open more than 30 days, or the if the expiration date has passed, then the vial should be thrown away and a new vial should be used. With the expectation that the new vial is expected to reflect the open date and as well as the initials of the individual who opened the vial.