

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035083	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/31/2024
NAME OF PROVIDER OR SUPPLIER Heritage Court Post Acute of Scottsdale		STREET ADDRESS, CITY, STATE, ZIP CODE 3339 North Drinkwater Boulevard 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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49399</p> <p>Based on clinical record review, staff interviews, and review of facility policies and procedures, the facility failed to ensure adequate supervision was provided to one resident (#1) to prevent elopement. The deficient practice could result in injury or harm to the resident.</p> <p>Findings included:</p> <p>Resident #1 was admitted to the facility on [DATE] with diagnosis of encephalopathy, dementia, and alzheimer's Disease.</p> <p>A review of record titled LN-Elopement/Wandering Evaluation-V2 dated December 11, 2024 revealed a score of 10.0 indicating resident is high risk.</p> <p>A review of care plan initiated on December 11, 2024 revealed resident at risk for impaired cognitive function/dementia or impaired thought processes related to new environment. The interventions with a revision date of December 30, 2024 included to administer medication as ordered, identify self at each interaction, face when speaking and make eye contact, reduce any distractions- turn off TV, radio, close door etc., use simple, directive sentences, provide with necessary cues- stop and return if agitated, and keep routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion</p> <p>A review of care plan initiated on December 12, 2024 revealed Elopement risk/wanderer related to dementia. The goal included that safety will be maintained through the review date. The interventions with a revised date of December 16, 2024 included 1:1 supervision, document wandering behavior and attempted diversional interventions, identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate and provide structured activities: toileting, walking inside and outside, provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes.</p> <p>A review of record titled POC Response History Task: Behavior Symptoms dated December 15, 2024 at 15:12 revealed a check mark for wandering.</p> <p>(continued on next page)</p>

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: 035083	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/31/2024
NAME OF PROVIDER OR SUPPLIER Heritage Court Post Acute of Scottsdale		STREET ADDRESS, CITY, STATE, ZIP CODE 3339 North Drinkwater Boulevard 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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of record dated December 15, 2024 revealed At approximately 1915 it was noted that patient was no longer in her room. Staff conducted a room to room search and searched area around the building. Police were notified at approximately 1930 and a search was initiated. Police found the patient on the corner of [NAME] and [NAME] street and returned her to facility. A head to toe assessment was performed and no injuries were noted. Staff notified the provider and family member, care plan updated and one on one supervision was initiated.</p> <p>Review of MDS (Minimum Data Set) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 3.0 indicating severely impaired cognition, resident has inattention and disorganized thinking behavior continuously present, does not fluctuate, has wandering behavior occurred 1 to 3 days, and has an active diagnosis of Anemia, Hypertension, Alzheimer's Disease, and Non-Alzheimer's Dementia.</p> <p>Review of facility document, Sign In Sheet, for December 16, 2024 revealed a sitter/Staff #14 was assigned as sitter.</p> <p>An interview was conducted on December 31, 2024 at 2:27 pm with certified nursing assitant (CNA)/staff #9. Staff #9 stated that they work in the skilled unit part of the facility which is from rooms 401 through 416.</p> <p>An interview was conducted on December 31, 2024 at 2:31 pm with a licensed practical nurse (LPN)/staff #8. Staff #8 stated that she takes care of residents in their skilled unit who requires occupational and physical therapy services, who are on intravenous antibiotics, and who needs wound care. Their resident to nurse ratio is 20 to 23 residents per nurse and they have three CNAs today. Staff #8 stated that most of her residents in the skilled unit require assistance with ambulation, are aware and oriented.</p> <p>An interview was conducted on December 31, 2024 at 3:02 pm with hospitality aid/Staff #14. Staff #14 stated that she was assigned as a sitter for a resident on December 16 and does not remember the resident's name. Staff #14 stated that they watch the resident so resident does not leave. Staff #14 stated that while she was the resident's sitter, the resident had conversation with her regarding wanting to go back to their apartment and going somewhere.</p> <p>An interview was conducted on December 31, 2024 at 3:17 pm with a LPN/Staff #10. Staff #10 stated that she does not remember any resident who wandered outside their facility or disappeared, but stated that they had a resident with a sitter and the sitter who was assigned was from their human resource (HR)/Staff #16. Staff #10 stated that they use a sitter sometimes when resident had a fall, when a resident is abusive to others or a resident who wanders. Staff #10 stated that when a resident wanders, they have a code to use for missing resident which they announced to all their staff using their walky talky device to help search for the missing resident, and if the resident is not found by staff, they call 911 and their director of nursing (DON).</p> <p>An interview was conducted on December 31, 2024 at 3:29 pm with HR staff/Staff #16. Staff #16 stated that she was a sitter/one on one for a resident who eloped from the facility on December 15 and the resident returned on the same day accompanied by their activities director/Staff #19. Staff #16 stated that the resident needed constant surveillance/one on one. Staff #16 stated that she was not aware on how the elopement happened.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035083	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/31/2024
NAME OF PROVIDER OR SUPPLIER Heritage Court Post Acute of Scottsdale		STREET ADDRESS, CITY, STATE, ZIP CODE 3339 North Drinkwater Boulevard 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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A phone interview was conducted on December 31, 2024 with LPN/Staff #13. Staff #13 stated that she was working on December 15, 2024 which was a Sunday. Staff #13 stated that she was the nurse for resident #1. Staff #13 stated that she was in the middle of passing medication and resident #1 was wandering around. Staff #13 stated that she saw resident by the exit area around sevenish and then one CNA informed her that their resident is missing. They searched for resident #1. Staff #13 stated that a resident stated that they saw a lady who went out of the front door. Staff #13 stated that they notified resident's family, then a staff member found resident in the street, they called the police, and then resident was returned back in the facility. Furthermore, Staff #13 stated that a staff nurse let the resident out when resident push the button to unlock the door to open. Staff #13 stated that resident may have been gone for a whole hour. Furthermore, staff #13 stated that after the elopement incident, they no longer use the tablet to open and close the door. Staff #13 explained that before the elopement incident, they were using a camera with a ring tablet to see who is it such as a delivery or an ambulance. And now, staff #13 stated that they will physically open the door for each person who enters the facility after 6:00 pm.</p> <p>An interview was conducted on December 31, 2024 at 4:13 pm with the DON/Staff #11. The DON stated that for a resident with dementia, if they do not wander, they treat them as normal resident, but with resident at higher risk and active, they put more eyes on them. The DON stated that resident #1 did not trigger elopement so they did not place them on a one on one until after the elopement occurred. The DON stated that they were made aware of the elopement incident with resident #1 when she received a call from the nurse, their staff looked around their surroundings to search for the resident, and one of their nurse stayed in the facility and called the police. The DON stated that the police found the resident, and their activity director went out to verify that the person with the police is their resident and then they brought resident #1 back to their facility. The DON stated that resident left their building when one of their nurses thought the resident was a family member because the resident was dressed in normal clothes. The staff did not know that the person they opened the door for was one of their residents until the staff was told by the CNA looking for the resident that she might have let a resident out. The DON stated that the incident was brought up during their QA (quality assurance) meeting. The DON stated they did not have any elopement incident in the past except this incident and that there is no camera or video to view regarding the elopement incident.</p> <p>Review of facility's policy titled Elopement last revised on May 2024 revealed that it is the policy of this facility to ensure that the facility provides a safe and secure atmosphere for all residents in the facility. To ensure that residents at risk for elopement are properly monitored (1) Residents identified to be high risk for elopement will have an appropriate plan of care developed to address the risk.</p>		