STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035083	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Court Post Acute of Scottsdale	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)
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** 40581 Based on documentation, staff interviews, and the facility policy and procedures, the facility failed to ensure that residents were treated with dignity and respect. The deficient practice could result in residents being psychosocially effected. Findings include: Resident #22 was admitted to the facility on [DATE] with diagnoses that included Fracture of unspecified part of neck of left femur subsequent encounter for closed fracture with routine healing and Hypertension. The brief interview for mental status dated February 5, 2025 included a score of 14 indicating the resident was cognitively intact. The care plan dated February 4, 2025 revealed that the resident has acute/chronic pain related to a ground level fall (GLF) with hip fracture, hypothyroidism, hypertension (HTN), and hypotension. Interventions include to administer analgesia medication as per orders. The order summary included: -February 5, 2025, left hip surgical dressing to stay in place until surgical follow up. -February 5, 2025, Lidocaine External Patch 4% (Lidocaine) apply to affected area one time per day for pain and remove per schedule. -February 6, 2025, patient to transfer to another LTC facility. Review of the medication administration record dated February 2025 revealed that Lidocaine External Patch 4% (Lidocaine) apply to affected area one time per day for pain and remove per schedule was applied by (LPN/staff #1) on February 5, 2025 at 8:00 p.m. A progress note dated February 6, 2025 revealed that the Social Services Manager (#7) followed up with the resident in regard to a reported grievance that occurred overnight. Staff #7 went over the steps of correction the facility was taking, and the resident was both agreeable and at ease with and felt much better. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated February 6, 2025 revealed that the resident requested a transfer to another facility. An interview was conducted on February 25, 2025 at 10:16 a.m. with resident #22, who stated that (LPN/staff #1) wanted to apply the Lidocaine patch, but she had not asked for a patch and it was supposed to be applied as per the order. She stated that (LPN/staff #1) was applying the patch in the upper area and she put her left hand on her lower back, where the glut starts, to show (LPN/staff #1) where the patch is supposed to go. She stated that she didn't remember if there hands touched, but the LPN grabbed her hand, bent her arm back, and twisted it and she told the LPN that she was hurting her. She stated that she told (LPN/staff #1) that she wanted to speak to someone in charge and the LPN told her that she was in charge and there was no one else here. She stated that the LPN got close to her face and said, you don't know how to act like an adult and I am going to teach you how to be an adult. She stated that her roommate didn't say anything and was afraid of (LPN/staff #1) because staff #1 was already mad at her roommate for doing something. She stated that sometime later, it may have been morning, a certified nursing assistant was helping her roommate, and the roommate was telling the CNA what happened. The CNA told them that there have been all kinds of staff and resident complaints about (LPN/staff #1). Then a charge nurse came to talk to her. An interview was conducted on February 25, 2025 at 11:20 a.m. with (LPN/staff #1), who stated that her shift was 6:00 p.m. to 6:00 a.m. and applied the Lidocaine patch as prescribed before 10:00 p.m. She was applying the patch to the left hip. Her voice became elevated and she stated that this was a complete waste of time. The resident asked if she could stand up because it is easier to put the patch on the left buttocks, back area, and partially the left hip. She stated that there was a dressing on the front part of the left leg that was flipped up and she tried to put it back down when the resident grabbed her right wrist and she told the resident not to grab her, she was just trying to help her. The resident let go and said that she wasn't supposed to touch it. Then she put the pain patch on. The resident asked to speak with a charge nurse and she told her that she would have to wait until morning. She stated the resident didn't like the way that she was speaking to her and she stated that her voice is normally high and she spoke to the resident the way she was speaking during the interview, which was agitated and impatient. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on February 25, 2025 at 12:11 p.m. with the Director of Nursing (DON/staff #10), who stated that there is not usually a supervisor available at night, so a resident would have to wait to talk to a supervisor the next morning. She stated that (LPN/staff #1) and resident #22 both claimed that they were grabbed by each other on February 5, 2025. She received a call from a Certified Nursing Assistant (CNA/staff #2) on February 6, 2025 at 5:55 a.m. stating that resident #22 reported that (LPN/staff #1) grabbed her arm and twisted it. She stated that (LPN/staff #1) was still in the facility when she arrived at approximately 6:15 a.m. Staff #10 stated that if the resident told (LPN/staff #1) that she wanted to speak to someone in charge, staff #1 should have contacted the DON or the nurse manager because allegations are to be reported right away. She stated that she interviewed (LPN/staff #1) and was told that she was applying the resident's pain patch and the resident grabbed her wrist. Staff #10 reviewed the MAR dated February 2025 and stated that (LPN/staff #1) did apply the pain patch to the resident at the incorrect time. Then, staff #10 stated that (LPN/staff #1) told her that the bandage covering the surgical wound on the resident's hip was coming off and she was trying to secure the bandage when the resident grabbed her wrist because she didn't want (LPN/staff #1) to touch the bandage. Staff #10 stated that she did not ask staff #1 if she had explained to the resident that she was trying to secure the bandage prior to touching the bandage, but protocol would dictate that the nurse explain what she if going to do, so as not to invade the resident's personal space. Staff #10 stated that (LPN/staff #1) stated that she told the resident not to touch her, she was just trying to help her and the resident told (LPN/staff #1) not to touch the surgical bandage because it was not supposed to come off. (LPN/staff #1) told staff #10 that the resident and her roommate were pushing their call-lights a lot. Staff #10 stated that if there was an allegation of hands being put on each other and/or voices being raised, she should have been called and there are a lot risks if (LPN/staff #1) didn't allow the resident to speak to a charge nurse. Staff #10 stated that the roommate was not interviewed because she had already discharged from the facility. An interview was conducted on February 25, 2025 at 1:52 p.m. with a certified nursing assistant (CNA/staff #2), who stated that resident #22's roommate (resident #33) said that she didn't want (LPN/staff #1) in her room because they were afraid of her. Resident #33 told her that (LPN/staff #1) screamed in her face because she kept putting the call-light on, she needed to go to the bathroom and had wet the bed from urine and water. Staff #2 stated that residents have complained about (LPN/staff #1) and she has reported her to another nurse. She stated that one time, she heard a male resident asking for pain medication and (LPN/staff #1) told him that she would give it to him when she was ready and if he wasn't a drug addict, he wouldn't have a problem. She said to (LPN/staff #1), isn't the medication scheduled? and staff #1 didn't answer her. (CNA/staff #1) stated that she reported the incident to (LPN/staff #24), who told her that she didn't want to get involved. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on February 25, 2025 at 2:14 p.m. with the Social Services Manager (staff/#7), who stated that she was instructed by the (DON/staff #10) to follow up on the incident involving resident #22. She stated that resident #22 made a complaint on February 6, 2025 about (LPN/staff #1) speaking to her with an elevated voice, in an aggressive manner, and was short with her. The resident reported that (LPN/staff #1) twisted her arm when she tried to show her where to apply the pain patch and it hurt, and when she told staff #1 that she wanted to speak with a charge nurse, staff #1 told her that there wasn't a charge nurse. Staff #7 stated that she didn't observe any injuries. Staff #7 also spoke to resident #22's roommate, resident #33, who stated that (LPN/staff #1) was rude, didn't speak in a nice tone, when she asked for toilet paper and that she was not nice to resident #22. Resident #33 heard the altercation between resident #22 and (LPN/staff #1), but did not see anything because the curtain was shut. Staff #7 stated that she did not ask resident #33 what she heard during the altercation and did not document the interview with either resident. An interview was conducted on February 25, 2025 at 4:22 p.m. with (LPN/staff #24), who stated that it is important to treat the residents with dignity and respect, this is their home. She stated that staff should speak in a respectful manner, which includes tone and if she receives a report that staff is being rude or inappropriate, she would pull staff away from the resident and report the incident to the Administrator. She stated that she has heard other staff say that (LPN/staff #1) is mean to the residents: yells at them, doesn't give pain meds, and doesn't answer call-lights. She did remember a (CNA/staff #2) telling her that a male resident asked for pain medication and that (LPN/staff #1) told him to wait until she was ready and she did not report it to anyone. She stated that she thinks that (LPN/staff #1) went on break and staff were looking for her and she would have given the pain medication before she went on break. She stated that she just tries to keep to herself. The facility was unable to provide the resident rights policy, but provided the rights that the residents have to abide by while in the facility.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581 Based on documentation, staff interviews, and the facility policy and procedures, the facility failed to ensure that a thorough investigation was completed for one resident (#22) alleging abuse. The deficient practice could result in residents being physically and psychosocial harmed. Findings include: Resident #22 was admitted to the facility on [DATE] with diagnoses that included Fracture of unspecified part of neck of left femur subsequent encounter for closed fracture with routine healing and Hypertension. The brief interview for mental status dated February 5, 2025 included a score of 14 indicating the resident was cognitively intact. The care plan dated February 4, 2025 revealed that the resident has acute/chronic pain related to a ground level fall (GLF) with hip fracture, hypothyroidism, hypertension (HTN), and hypotension. Interventions include to administer analgesia medication as per orders. The order summary included: -February 5, 2025, left hip surgical dressing to stay in place until surgical follow up. -February 5, 2025, Lidocaine External Patch 4% (Lidocaine) apply to affected area one time per day for pain and remove per schedule. -February 6, 2025, patient to transfer to another LTC facility. Review of the medication administration record dated February 2025 revealed that Lidocaine External Patch 4% (Lidocaine) apply to affected area one time per day for pain and remove per schedule was applied by (LPN/staff #1) on February 5, 2025 at 8:00 p.m. A progress note dated February 6, 2025 revealed that the Social Services Manager (#7) followed up with the resident in regard to a reported grievance that occurred overnight. Staff #7 went over the steps of correction the facility was taking, and the resident was both agreeable and at ease with and felt much better. A progress note dated February 6, 2025 revealed that the resident requested a transfer to another facility. Review of the facilities 5-day investigation revealed that an interview could not be conducted with resident #22's roommate, resident #33, due to discharging on February 6, 2025. It also revealed that five residents were interviewed, but none of the residents' rooms were near resident #22's room. Review of the resident census and the facility map revealed that there residents staying in the rooms near resident #22's room. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on February 25, 2025 at 10:16 a.m. with resident #22, who stated that (LPN/staff #1) wanted to apply the Lidocaine patch, but she had not asked for a patch and it was supposed to be applied as per the order. She stated that (LPN/staff #1) was applying the patch in the upper area and she put her left hand on her lower back, where the glute starts, to show (LPN/staff #1) where the patch is supposed to go. She stated that she didn't remember if there hands touched, but the LPN grabbed her hand, bent her arm back, and twisted it and she told the LPN that she was hurting her. She stated that she told (LPN/staff #1) that she wanted to speak to someone in charge and the LPN told her that she was in charge and there was no one else here. She stated that the LPN got close to her face and said, you don't know how to act like an adult and I am going to teach you how to be an adult. She stated that her roommate didn't say anything and was afraid of (LPN/staff #1) because staff #1 was already mad at her roommate for doing something. She stated that sometime later, it may have been morning, a certified nursing assistant was helping her roommate, and the roommate was telling the CNA what happened. The CNA told them that there have been all kinds of staff and resident complaints about (LPN/staff #1). Then a charge nurse came to talk to her. An interview was conducted on February 25, 2025 at 12:11 p.m. with the Director of Nursing (DON/staff #10), who stated that there is not usually a supervisor available at night, so a resident would have to wait to talk to a supervisor the next morning. She stated that (LPN/staff #1) and resident #22 both claimed that they were grabbed by each other on February 5, 2025. She received a call from a Certified Nursing Assistant (CNA/staff #2) on February 6, 2025 at 5:55 a.m. stating that resident #22 reported that (LPN/staff #1) grabbed her arm and twisted it. She stated that (LPN/staff #1) was still in the facility when she arrived at approximately 6:15 a.m. Staff #10 stated that if the resident told (LPN/staff #1) that she wanted to speak to someone in charge, staff #1 should have contacted the DON or the nurse manager because allegations are to be reported right away. Staff #10 stated that the roommate was not interviewed because she had already discharged from the facility. An interview was conducted on February 25, 2025 at 1:52 p.m. with a certified nursing assistant (CNA/staff #2), who stated that resident #22's roommate, (resident #33), said that she didn't want (LPN/staff #1) in her room because they were afraid of her. Resident #33 told her that (LPN/staff #1) screamed in her face because she kept putting the call-light on, she needed to go to the bathroom and had wet the bed from urine and water. Staff #2 stated that residents have complained about (LPN/staff #1) and she has reported her to another nurse. She stated that one time, she heard a male resident asking for pain medication and (LPN/staff #1) told him that she would give it to him when she was ready and if he wasn't a drug addict, he wouldn't have a problem. She said to (LPN/staff #1), isn't the medication scheduled? and staff #1 didn't answer her. (CNA/staff #1) stated that she reported the incident to (LPN/staff #24), who told her that she didn't want to get involved. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on February 25, 2025 at 2:14 p.m. with the Social Services Manager (staff/#7), who stated that she was instructed by the (DON/staff #10) to follow up on the incident involving resident #22. She stated that resident #22 made a complaint on February 6, 2025 about (LPN/staff #1) speaking to her with an elevated voice, in an aggressive manner, and was short with her. The resident reported that (LPN/staff #1) twisted her arm when she tried to show her where to apply the pain patch and it hurt, and when she told staff #1 that she wanted to speak with a charge nurse, staff #1 told her that there wasn't a charge nurse. Staff #7 stated that she didn't observe any injuries. Staff #7 also spoke to resident #22's roommate, resident #33, who stated that (LPN/staff #1) was rude, didn't speak in a nice tone, when she asked for toilet paper and that she was not nice to resident #22. Resident #33 heard the altercation between resident #22 and (LPN/staff #1), but did not see anything because the curtain was shut. Staff #7 stated that she did not ask resident #33 what she heard during the altercation and did not document the interview with either resident. An interview was conducted on February 25, 2025 at 4:22 p.m. with (LPN/staff #24), who stated that it is important to treat the residents with dignity and respect, this is their home. She stated that staff should speak in a respectful manner, which includes tone and if she receives a report that staff is being rude or inappropriate, she would pull staff away from the resident and report the incident to the Administrator. She stated that she has heard other staff say that (LPN/staff #1) is mean to the residents: yells at them, doesn't give pain medications, and doesn't answer call-lights. She did remember a (CNA/staff #2) telling her that a male resident asked for pain medication and that (LPN/staff #1) told him to wait until she was ready and she did not report it to anyone. She stated that she thinks that (LPN/staff #1) went on break and staff were looking for her and she would have given the pain medication before she went on break. She stated that she just tries to keep to herself. The facility policy, Freedom from Abuse, Neglect, and Exploitation states that all identified events are reported to the Administrator immediately. An investigation will include the following: an interview with the person(s) reporting the incident; an interview with the residents; interviews with any witnesses to the incident, including the alleged perpetrator, as appropriate; an interview with all staff members (on all shifts) who may have information regarding the alleged incident; interviews with other residents to whom the accused employee provides care or services or who may have information regarding the alleged incident.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581 Based on documentation, staff interviews, and the facility policy and procedures, the facility failed to ensure that one resident (#44) was administered medication as prescribed. The deficient practice could result in adverse effects of medications administered. Findings include: Resident #44 was admitted to the facility on [DATE] with diagnoses the included vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 2 indicating the resident was severely impaired. It also included that the resident did not exhibit any physical or verbal behaviors during the look-back period. A care plan dated January 18, 2025 revealed that the resident was at risk for impaired cognitive function/dementia or impaired thought processes related to new environment. Interventions included to administer medications as ordered. The order summary included: -January 18, 2025, Seroquel oral tablet 50 mg (Quetiapine Fumate) give one tablet by mouth one time a day for major depressive disorder (MDD) as evidenced by severe mood swings. -January 18, 2025, (AD) monitor behavior every shift for depression episodes as evidenced by verbalized sadness every shift for depression. Verbalized sadness refer to NPI. -January 18, 2025, (AD)-monitor for sided effects of anti-depressants: common side effects sedation, drowsiness, headache, decreased appetite. Less common side effects: dry mouth, blurred vision, urinary retention. Rare side effects: extra pyramidal side effects. Notify provider if present every shift. -January 20, 2025, (AP) monitor behavior every shift for psychotic episodes as evidenced by target behavior: severe mood swings every shift. -January 20, 2025, (AP)- monitor for side effects of antipsychotics - common side effects: drowsiness, dry mouth, blurred vision, constipation, translent nausea, weight gain, increase salna, sweating. Less common side effects: edema, postural hypotension, urinary retention, stiff or tight muscles, shakiness, serious blood disorders. Rare side effects: extra pyramidal, [NAME] dyskinesia, jaundice, allergic reaction, increased photosensitivity, allergic dermatitis. Notify provider if present every shift. -January 21, 2025, per provider discontinue Seroquel oral tablet 50 mg (Quetiapine Fumate) give one tablet by mouth one time a day for major depressive disorder (MDD) as evidenced by severe mood swings. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-January 23, 2025, change of condition for: (D/C Seroquel) provider notified, resident/responsible party aware and agreeable to point of care, responsible party notified. Every shift for 3 days post follow-up for discontinued Seroquel. A care plan initiated January 19, 2025 and resolved January 23, 2025 revealed the use of psychotropic medications use related to major depressive disorder (MDD) as evidenced by severe mood swings. Interventions included to monitor medications as ordered. Monitor/document for side effects and effectiveness and to monitor/record occurrence of for target behavior symptoms severe mood swings and document. Review of the medication administration record dated January 2025 revealed that Seroquel oral tablet 50 mg (Quetiapine Fumate) give one tablet by mouth one time a day for major depressive disorder (MDD) as evidenced by severe mood swings was administered on the 19, 20, and 21, 2025. An interview was conducted on February 26 2025 at 11:55 a.m. with the Director of Nursing (DON/staff #10), who stated that the facility received a discharge summary from the hospital when the resident was admitted , which included medication orders. She stated that the orders didn't include Seroquel, which is an Antipsychotic prescribed for schizophrenia and bipolar disorder. She reviewed the clinical record and stated that the resident did not have a diagnoses for schizophrenia or bipolar disorder and had a diagnosis for dementia and was administered Seroquel on January 19, 20, and 21, 2025. She stated that the Assistant Director of Nursing (ADON/staff #43) reconciled the medications and entered an order for Seroquel by mistake. Staff #43 created the order for the physician's verification. She stated that the psych provider saw the resident on January 21, 2025 and mentioned to the resident's caregiver that the resident was taking Seroquel. The caregiver told the psych provider that the resident is not supposed to be on Seroquel and the family reported the concern to her and the Seroquel was discontinued on January 21, 2025. She stated that this was a medication error and the physician was notified; the physician ordered for the resident to be monitored for side effects for 72 hours. The personal caregiver and the family had reported that the resident appeared over-sedated and it was not the resident's normal baseline. She stated that one of the risks of Seroquel is over-sedation and an altered mental status and the resident did experience over-sedation, which is documented in the progress notes dated January 21, 2025. An interview was conducted on January 21, 2025 at 12:22 p.m. with the Assistant Director of Nursing (ADON/staff #43), who stated that the hospital summary included the orders. The nurse reviews the orders and then looks for a diagnosis to go with each order. Then the nurse contacts the physician to relay the orders and the physician reviews the orders to make everything is correct. She stated once there is an orders, she puts the orders in the electronic record and the nurses start administering the medications. She acknowledged that she requested an order for Seroquel instead of Sertraline and stated that there is a risk to administering antipsychotics when not needed because it increases changes in the brain, increases the neurological activity, and a resident may not be able to sleep. The facility policy, Physician Orders states that admission orders are reviewed with the physician upon admission based on the discharge instructions from the discharging facility and are transcribed accordingly.