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	09/09/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035083	A. Building B. Wing	09/09/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, facility documentation, and policy review, the facility failed to report allegations of abuse for one resident (#1). The deficient practice could result in allegations of abuse not being reported, not investigated, and residents not being protected from further abuse.Resident #1 was admitted on [DATE] with diagnosis included fracture of left femur, difficulty in walking, anxiety disorder, depression, anemia, and cerebral infarction.The Admissions Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating that resident is cognitively intact.Nursing note dated August 15, 2025 at 09:30AM revealed the patient informed, thinks she was gang raped by night staff. However, the incident was not reported to state agency.A physician's progress Nursing note dated August 15, 2025 at 06:57PM revealed that the resident was having delusions patient informed, thinks she was gang raped by night staff. However, the incident was not reported to state agency.On September 09, 2025 at 8:10AM, a request was made at entrance to provide a document from the facility including list of all self-reports and investigation in the last 90 days. However, the DON was unable to produce documents because there were no self-reports in the last 90 days. On September 09, 2025 at 9:20AM, a second request was made for any abuse allegation in last 3 month. Director of Nursing signed on September 09, 2025 at 9:39AM she stated that there are no self-reports in last 3 months.Later on, September 09, 2025 at 2:50PM the DON provided internal investigation for resident #1. However, there was no evidence they reported to state agency.An interview was conducted on September 09, 2025 at 11:25AM with the Certified Nursing Assistant (CNA/staff#95), who stated that that abuse can be multiple things such as mental, physical, verbal and emotional. She stated the facility process for abuse is to notify supervisor and there is number in the break room where they can report the abuse. Staff #95 also stated that abuse should reported immediately to the supervisor.An interview was conducted on September 09, 2025 at 11:38AM with the Certified Nursing Assistant (CNA/staff#27), who stated abuse is defined as hitting, sexual, verbal, and financial. She stated that the facility process for abuse is to make resident safe, reported to ADON or DON. Staff#27 stated that resident #1 told her that she had been tried to rape but she fought them off on August 15, 2025 when she did morning vitals for her. Staff #27 stated that she reported to ED right away. She also stated Administrator got the ADON talked to her about resident #1 allegations. The CAN confirmed that any abuse allegation should be reported right away. An interview was conducted on September 09, 2025 at 12:50PM with the Registered Nurse (RN/staff #84), who defined abuse as any harm such as injury to resident which can caused by anyone such as staff or family members. He stated that the facility process for abuse to notify admin or DON immediately. He also stated he has not heard or witness any abuse within the last month.An interview was conducted on September 09, 2025 at 12:58PM with a Licensed Practical Nurse (LPN/Staff #69), who defined abuse as something that is wrong, out of character, empathic and sympathetic for the patient. He stated there are multiple types abuse such as mental, physical, seclusion, verbal, neglect, financial, and sexual. Further he stated that the facility process for abuse is not to leave the resident alone to ensure their safety, stop the abuse immediately if witnessed, let the management know immediately. He stated that he has not heard or witness any within the last month.An interview was conducted on September 09, 2025 at 1:07PM with Assistance Director of Nursing (ADON/Staff #56), who stated that she was aware of resident #1's allegation and notified Administrator. She stated that she conducted investigation on resident #1, however did not document anything down. She further stated that it depends on the situation if the Department of Health Services (DHS) needs to know about abuse allegation and if there is sexual abuse the police are notified. Then she stated resident #1 abuse allegation should be reported to DHS for either good or bad outcome. Staff #56 stated that risk of not reporting abuse to DHS would be the facility getting tagged, facility being closed down, abuse goes on with resident #1 and she can get hurt. An interview was conducted on September 09, 2025 at 2:31PM with Director of Nursing (ADON/Staff #19), who stated that as part of the abuse coordination, her role when they receive abuse allegation she is to investigate, report to the state, police, aps, ombudsman, provider, and family. She stated we would report the abuse allegation within two hours. Then she stated that she was aware of the potential sexual allegation that was from August 15, 2025. She stated that based on their internal investigation, resident #1 did not said anything about sexual assault or allegation so they did not report to DHS. Further she stated that it truly depends on the when they are supposed notify the DHS, if she had said it to the staff