

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/05/2026
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)		
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on clinical record review, staff interviews, and facility policy, the facility failed to protect the rights of two out of the four sampled residents (Resident #18 and Resident #21) to be free from Physical abuse by another resident (Resident #11 and Resident #51). The deficient practice could result in the other residents being abused. Findings Include: -Regarding Resident #18 and Resident #11: Resident #18 was admitted to the facility on [DATE], with diagnosis of T Acute and Subacute Infective Endocarditis, Schizoaffective disorder, anxiety disorder, chronic viral hepatitis C, and other psychoactive substance abuse. Orders dated May 24, 2024, revealed orders for monitoring behavior every shift for anti-anxiety episodes, monitoring for side effects of antianxiety/anxiolytics, and monitoring side effects of pain medication. Orders dated May 28, 2024, revealed an order for Hydroxyzine HCL 10mg 2 tablets by mouth every 8 hours as needed for anxiety AEB restlessness for 10 days, and May 28, 2026 orders revealed an order for Suboxone sublingual film 4-1mg twice a day for substance abuse. An admission MDS (Minimum Data Set) assessment dated [DATE], revealed Resident #18 had a BIMs (Brief Interview for Mental Status) score of 15, which indicates no cognitive impairment. Resident #18 was assessed on the MDS to show no behaviors indicative of refusing care or resistant to staff directives. Orders dated June 2, 2026, revealed an order for change of condition for psychosocial well being. A Progress Note, dated June 2, 2024, revealed a change of condition for Resident #18 and stated the resident will be assessed for psychosocial wellbeing every shift for 3 days. Resident #18 was assessed June 2, 2024 at 20:50 to be resting quietly in bed, with no complaints. A care plan revised June 2, 2024 revealed a focus on psychosocial well-being related to a physical and a potential for a behavior problem related to physical altercation. -Resident #11 was admitted to the facility May 13, 2024, with a diagnosis of Acute Osteomyelitis of the right ankle and foot, Schizophrenia, and psychoactive substance abuse. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Orders dated May 14, 2026 revealed Oxycodone HCL 10mg tablet every 4 hours as needed for pain 7-10. Orders dated May 17, 2024, revealed monitoring for behavior every shift for psychotic episodes, monitor side effects of anti-psychotics, monitor side effects of pain medication and Olanzapine 5mg tablet at bedtime for schizophrenia AEB auditory hallucinations. An admission MDS assessment dated [DATE], revealed Resident #11 had a BIMs score fo 13, which indicates that Resident #11 was not cognitively impaired. Resident #11 was assessed to have a mood severity score of 12, indicating moderate depression or clinically significant mood distress. Resident #11 was not assessed to have no behaviors indicative of refusing care or resistant to staff directives. Orders dated June 2, 2024, revealed change of condition for psychosocial well-being monitoring for 3 days. A Progress note dated June 2, 2024, revealed a change of condition for psychosocial well-being to be monitored for 3 days, no issues noted at assessment date June 2, 2024 at 15:35. A care plan revised June 2, 2024, revealed Resident #11 had a potential for a psychosocial well-being problem related to a physical altercation. Resident #11 was assigned 1:1 sitter and increased supervision. An interview was attempted with Resident #18 on June 2, 2026, although the phone number listed on Resident's chart was inactive. Resident #18 was discharged [DATE]. An interview was attempted with Resident #11 on June 2, 2026, upon calling Resident #11 a family member answered the phone and it was revealed that Resident #11 is currently residing in Arizona State Prison and unable to be interviewed. An interview was conducted June 3, 2026 at 9:06 AM with Staff #91, licensed practical nurse (LPN). Staff #91 stated that a lot of things could be described as abuse, such as verbal, physical and sexual. He stated that if he notices any signs of abuse or if a resident voices concerns regarding abuse, he goes directly to the Abuse Coordinator of the facility. Staff #91 stated that if he notices residents becoming more agitated or loud in the way they communicate with each other he usually separates the residents from each other, ensuring they remain safe, and contacts the Abuse Coordinator. Staff #91 currently works on the Skilled Unit hallway and cannot recall the names of Residents #18 or #11, as most residents stay on average 6-8 weeks or less. Staff #91 stated that the facility does a good job at making sure that residents who may be easier to agitate or are more sensitive are closely monitored and if needed room changes can be accommodated. Another interview was conducted on June 3, 2026 at 9:38 AM with Staff #92, certified nursing assistant (CNA). Staff #92 stated the process when witnessing a resident-to-resident altercation or if a resident were to voice concern about a resident-to-resident altercation she would report immediately to the Abuse Coordinator of the facility, the Nurse or Director of Nursing (DON). She stated that CNAs do not document anywhere in a Resident's chart, but that if needed to provide any documentation of what they witnessed the Abuse Coordinator would inform them. If she witnessed a resident-to-resident altercation, Staff #92 stated that she would separate the residents, call the assigned Nurse immediately. She did not recall any recent resident-to-resident altercations, nor did she recall Resident #18 or Resident #11. (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the previous administrator for the facility, Staff #109, was conducted June 3, 2026 at 1:30 PM. Staff #109 stated that during his time as an administrator he could not recall any allegations that were substantiated, although he has not been the administrator since 2024. Staff #109 stated that if an abuse allegation was made the facility would have conducted an internal investigation immediately. If the facility was investigating a resident-to-resident altercation, the facility would have separated the residents to ensure they were safe and conduct an investigation. He stated, again, that he does not recall the names of Residents #18 or #11. An interview was conducted with Staff #28, Director of Nursing (DON) was conducted June 5, 2026 at 1:24 PM. Staff #28 stated that forms of abuse are physically hitting, verbal, exploitation, misappropriation, and isolation. Staff #28 stated that if a resident-to-resident altercation occurs, her expectations are that staff would separate the residents and ensure their safety and inform her immediately. Staff #28 stated that an assessment would be conducted on both residents, skin checks, neuro, physical assessment and a psychology evaluation. Staff #28 stated that the investigation of the resident-to-resident altercation would include interviews with each resident to find the root cause of the altercation, interviews with staff, and an Interdisciplinary meeting with staff to evaluate future care plans for each resident. Staff #28 was asked regarding the resident-to-resident altercation between Resident #18 and Resident #11. Staff #28 stated that she does not recall the exact event but does remember having the two residents in the facility. Staff #28 recalled that this incident was considered to be an unanticipated and isolated event, and that she cannot recall any other occurrences of the same behavior from Resident #11 after the care plan 1:1 sitter. Staff #28 was asked what the risks are for resident-to-resident altercations, and she stated that the aggressor could act in a similar manner affecting other residents and that the victim could be attacked again or fear that they will be. Staff #28 stated that the risk of not investigating and care planning appropriately to the allegation could cause fear and harm to other residents. Review of the facility's five day interval investigation of the incident revealed resident #18 and resident #11 were both involved in a physical altercation. The report stated that resident #11 was observed by staff to have his hands on resident #18's neck. Staff #91 and staff #28 both interviewed resident #11, where it was revealed that resident #11 did grab resident #18's neck and shirt after claims resident #18 was making fun of resident #11. Skin assessments were completed on resident #18, 1:1 was put in place for resident #11, and psychological evaluations were ordered for each resident. The local police were notified and an investigation initiated immediately. The facility interviewed five residents regarding their safety and concerns with residents #11 and #18; there were no concerns reported. The facility interviewed five staff members regarding residents #11 and #18 and who they would contact regarding a resident-to-resident abuse, all interviewed staff stated no concerns with either resident and that they would report any abuse to the Abuse Coordinator. The facility verified this an isolated and unanticipated incident. - Regarding Resident # 21 and Resident # 51: Resident # 21 was re-admitted on [DATE], with diagnoses of Depression, Anxiety Disorder, and Hyperlipidemia. Orders dated August 31, 2023, revealed an order for a change of condition for Psychosocial well-being for every shift for 3 days. A quarterly MDS (Minimum Data Set) assessment dated [DATE], revealed resident #21 had a BIMS (Brief Interview for Mental Status) score of 15, which indicated cognitive intactness. (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Progress note dated August 31, 2023, at 23:32 pm revealed that Resident # 21 had a change of condition for psychological well-being. Resident # 51 was admitted to the facility on [DATE], with diagnoses of Anxiety, Bipolar Disorder, and Schizophrenia. A Quarterly MDS dated [DATE], revealed that the assessment for Mental Status in Section C Resident #51's cognitive skills for daily decision making were severely impaired. A Progress Note dated August 31, 2026, 23:27 revealed that Resident # 51 had a change of condition for psychological well-being. A facility investigation dated August 31, 2023, revealed that Resident #21 stated that he was retrieving his hat from the closet when Resident #51 scratched him on the face. Resident #21 then reported pushing Resident #51's hand away and returning to his closet, and then Resident #51 had grabbed and scratched his arm. Resident #21 stated that he was only pushing Resident # 51 away. The investigation then revealed that an attempt was made to interview Resident #21, but due to Resident #21's cognitive status, an interview was unable to be completed. The investigation also revealed that the facility had verified that this was an unanticipated incident. A Care plan dated on September 15, 2023, revealed Resident #51 had a focus plan for potential psychological well-being problems related to a resident-to-resident altercation. An attempt was made on June 3, 2026,10:18 AM to contact Resident #51was no longer residing at that facility. An interview was conducted via phone on June 04, 2026, at 10:14 am with Certified Nursing Assistant (CNA/Staff #40), who stated that to the best of his knowledge, something did happen between Resident #51 and Resident #21. He then stated that he can not recall who the aggressor was, but he did report to the Executive Director (ED) at the time. However, A review of the facility follow-up investigation completed on August 31, 2023, revealed that (CNA/Staff #40) stated that he had witnessed Resident #21 hit Resident #51 in the back of the head. The facility follow-up investigation revealed that Staff #40 had separated the residents and alerted the Director of Nursing at the time. An interview was conducted on June 04, 2026, at 1:35 pm with CNA(staff #23), who stated that when there is a resident-to-resident altercation, staff will: separate the resident, notify the nurse, and inform social services. Staff #23 then stated that social services will place the residents in different rooms to prevent further altercations. The CNA then stated that the different types of abuse are: mental, physical, and neglect. He also stated that hitting or striking is a form of abuse. He further stated that when abuse is not addressed, it can cause a mental health disorder. An interview was conducted on June 05, 2026, at 10:55 AM with a Licensed Practical Nurse (LPN/staff #54), who stated the DON does the onsite/in-person training, and they have online training as well. She then stated that the different types of abuse are: physical, mental, and verbal. She further stated that physical abuse is unwanted touching, grabbing someone too hard, or jerking someone's arm. She stated that verbal abuse would be profanity or anything that makes someone fearful or intimidated. She also stated that when there is a resident-to-resident physical abuse, they will separate the resident, make sure that the victim is safe, conduct a head-to-toe, and report it to the DON. She then stated that DON will report to local law enforcement and would let them know the (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	next steps for them to take. She stated that if abuse is ongoing, the potential risk is that it could cause mental and physical harm to the alleged victim. An interview was conducted on June 05, 2026, at 1:26 p.m. with the Director of Nursing, who stated that staff receive monthly education on physical, emotional, and verbal abuse. Staff #28 stated that physical abuse includes hitting or resident-to-resident altercations, while verbal abuse includes speaking negatively or rudely to a resident. Staff #28 stated that when a resident altercation occurs, staff are expected to separate the residents, ensure resident safety, complete a skin and neurological assessment, and notify the administrator. She further stated that an investigation would include interviews with staff and residents to determine the root cause, and notifications would be made to the provider, Medical Director, local law enforcement, and state agencies. Upon Review of the 5-day follow-up the DON stated that the incident dated August 31, 2023, Resident #51 was retrieving his hat from the closet and Resident #51 had hit him in the back of the head. She then stated that the facility had verified the incident and that it was an isolated, unanticipated event and that it constituted abuse. She then stated that the potential risks would be that the resident would not feel safe. A policy Revised/Reviewed in November 2017 titled Freedom From Abuse, Neglect, Exploitation revealed that the resident has the right to be free from abuse.		