

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 04/18/2025
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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and review of facility policy, the facility failed to ensure that one resident (#59) and/or their representative were informed of the risks and benefits of psychotropic medications prior to the administration of the medications. The sample size was 5. The deficient practice could result in residents and/or resident representatives not being aware of the benefits and the potential adverse side effects of psychoactive medications.</p> <p>Findings include:</p> <p>Resident #59 was admitted on [DATE] with diagnoses that include type II diabetes, depression, anxiety, left leg amputation above the knee, thrombosis and embolism of thoracic aorta, insomnia, and chronic pain.</p> <p>Review of the order summary report revealed the following prescriptions for antidepressant medications:</p> <p>-</p> <p>Duloxetine HCl capsule delayed release particles 60 MG (milligrams), prescribed January 24,2025. The order directed to administer 1 capsule by mouth one time a day for depression.</p> <p>-</p> <p>Trazodone HCl tablet 50 MG, prescribed January 24,2025. The order indicated to administer 1 tablet by mouth at bedtime for depression.</p> <p>-</p> <p>Sertraline HCl tablet 50 MG, prescribed January 29,2025. The order indicated to administer 1 tablet by mouth daily for depression.</p> <p>A consent for treatment with psychotropic medications dated 1/24/2025 revealed a signed consent for the use of antidepressant medications duloxetine and trazodone.</p> <p>Review of resident #59 clinical record did not reveal a consent form for the use of Sertraline HCl tablet 50 MG. Furthermore, there was no evidence that the resident and/or the resident's representative had been informed of the risks and benefits of the antidepressant medication, Sertraline.</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 04/18/2025
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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A care plan revised on March 21,2025 revealed that the resident is on psychotropic medications related to depression. Interventions included to educate resident, family/caregivers about the risks, benefits, and the side effects of medication drugs being given.</p> <p>Review of the March and April 2025 MARs (Medication Administration Record), revealed that medications were administered as ordered and monitored as required.</p> <p>The clinical record revealed the resident was discharged from the facility on April 11,2025.</p> <p>An interview with a Licensed Practical Nurse (LPN/staff #3) was conducted on April 16, 2025 at 3:10 p.m. The LPN stated that psychotropic medications are ordered by a provider. According to staff #3 residents who are prescribed psychotropic medications are briefed/ educated by the LPN/RN (registered nurse) regarding the medication's benefits and any possible side effects. Staff #3 stated any consents are filed in the resident's chart as part of the admission packet and are sometimes in a drawer at the nurses' station. The LPN stated that behaviors are documented every shift in the progress note section and/or the MAR/TAR (Medication Administration Record/Treatment Administration Record) in the resident chart. Staff #3 stated that the provider should be notified with any adverse effects from psychotropic medication.</p> <p>Resident #59's clinical record was reviewed with staff #3 (LPN) on April 16, 2025 at approximately 3:10 p.m. Staff #3 verified that there were no consents for the psychotropic antidepressant, Sertraline.</p> <p>An interview was conducted with the Director of Nursing (DON/staff #22) on April 16, 2025 at 3:35 p.m. The DON stated that the facility process for psychotropic medication is that a provider prescribes that medication and a consent is reviewed with the resident/representative and signed prior to the administration. Staff #22 stated that the risk could be, giving wrong medication. Additionally, the resident may not be aware of the side effects. The DON stated that the facility policy is to obtain a consent for the resident prior to administering psychotropic medications.</p> <p>Resident #59's clinical record was reviewed with the DON on April 16,2025 at approximately 3:35 p.m. The DON confirmed that the resident received Sertraline the entire month of February 2025, the entire month of March 2025, and April 1-11 2025. Additionally, staff #22 verified that there were no progress notes that documented that the consent for Sertraline had been obtained.</p> <p>The facility policy titled, Psychoactive Medication, revised May 2024 indicated the facility staff must inform the resident and/or representative regarding the use of the psychoactive medication. The policy also stated that a consent must be obtained from wither the resident or the representative if resident is unable to give consent.</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 04/18/2025
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** Based on clinical record review, facility documentation, staff interviews and policy review, the facility failed to ensure that one of one sampled resident's (#427) environment was free of accident hazards regarding medicated cream left at the bedside. This deficient practice could result in an adverse event for the resident.</p> <p>Findings include:</p> <p>Resident #427 was admitted to the facility on [DATE] with diagnoses that included urinary tract infection, acute pyelonephritis, type 2 diabetes mellitus, hypertension, acquired absence of right leg below knee and acute kidney failure.</p> <p>A care plan initiated on April 10, 2025 revealed that the resident was at risk for impaired cognitive function/dementia or impaired thought processes. Interventions included to administer medications as ordered.</p> <p>Review of a care plan revised on April 11, 2025 revealed that the resident had a fungal rash on his bilateral (both sides) buttocks. Interventions included to administer treatments as ordered and monitor for effectiveness.</p> <p>An initial observation of resident #427 was conducted on April 15, 2025 at 10:00 AM. The resident was observed lying in his bed. During the observation, four medicine cups containing a pink cream, were observed on a nightstand next to the resident's bed.</p> <p>A subsequent observation was conducted on April 15, 2025 at 10:20 AM. The four medicine cups containing the pink cream remained on the resident's nightstand.</p> <p>Review of the order summary revealed an order dated April 11, 2025. The order prescribed anti-fungal cream for a fungal rash, to be administered on the resident's bilateral buttocks every shift.</p> <p>An interview with a Registered Nurse (RN/staff #105) was conducted on April 15, 2025 at 10:22 AM. The RN stated that the cups contained a medicated cream and should not be at the bedside. Staff #105 was observed to go into resident #427's room, remove the cups from the table, and threw them in the trash can.</p> <p>An additional interview was conducted with an RN (staff #7) on April 15, 2025 at 10:25 AM. The RN stated that medicated creams should never be left at the bedside.</p> <p>During an interview with a Licensed Practical Nurse (LPN/staff #44) conducted on April 17, 2025 at 11:00 AM, the LPN stated that the cream was an anti-fungal cream which contained 2% miconazole nitrate.</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 04/18/2025
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>An interview with the Director of Nursing (DON/staff #22) was conducted on April 16, 20215 at 12:20 PM. The DON stated medications should not be left at the bedside. She stated that the facility did not have a self-medication administration evaluation and that none of the residents should be self-administering their medications. The DON noted that the anti-fungal cream should not have been at the bedside.</p> <p>The DON indicated that the risk of having medications at the bedside could include inappropriate resident use, overuse of medications, and/or improper use of medications.</p> <p>A policy request for medication administered at the bedside was requested on April 17, 2025. The facility stated that they did not have a specific policy for medications administered at the bedside and to refer to the Medication Administration policy.</p> <p>A policy titled, Medication Administration, stated the nurse preparing the medication administers it and must remain with the resident until all of the medication is used.</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 04/18/2025
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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility documentation, staff and resident interviews and policy review, the facility failed to ensure two of three sampled residents (#426 and #427) with an indwelling catheter received a physician order for the catheter and catheter care. This deficient practice could lead to residents not receiving proper catheter care and the development of an infection.</p> <p>Findings include:</p> <p>Regarding Resident #426:</p> <p>-Resident #426 was admitted to the facility on [DATE], with diagnoses that included multiple fractures of ribs, left side, malignant neoplasm of left breast, anemia and chronic obstructive pulmonary disease.</p> <p>Review of an admission Brief Interview for Mental Status (BIMS) assessment, dated April 12, 2025, revealed a BIMS score of 15, indicating that the resident was cognitively intact.</p> <p>During initial observations on April 15, 2025 at 10:00 AM, resident #426 was observed to have an indwelling catheter in place.</p> <p>A Hospital Visit Summary, dated April 10, 2025, indicated that the resident had a Foley catheter in place upon discharge from the hospital.</p> <p>A care plan, revised April 10, 2025, revealed that the resident had an indwelling catheter. Interventions indicated to provide catheter care every shift as needed, monitor/document, and report to physician signs and symptoms of UTI (urinary tract infection), urine frequency/output and change in behavior.</p> <p>Review of the Order Summary Report retrieved April 15, 2025, revealed no orders for an indwelling catheter or for indwelling catheter care.</p> <p>The April 2025 Treatment Administration Record (TAR) indicated no evidence of scheduled or completed catheter care.</p> <p>A provider order was written on April 16, 2025, to remove the indwelling catheter.</p> <p>An interview with resident #426 was conducted on April 15, 2025 at 9:58 AM. Resident #426 stated that she had the catheter in the hospital and was admitted to the facility with the catheter in place.</p> <p>An interview with a Registered Nurse (RN/staff #182) was conducted on April 16, 2025 at 10:00 AM. The RN stated that resident #426's catheter was ordered to be removed for a voiding trial.</p> <p>Resident #426's record was reviewed with the RN (staff #182) on April 16, 2025 at approximately 10:00 AM. The RN verified that there were no orders regarding the resident's indwelling catheter prior to the order to remove the catheter on April 16, 2025.</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 04/18/2025
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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #426's clinical record was reviewed with the Director of Nursing (DON/staff #22) on April 16, 2025 at approximately 12:25 PM. The DON confirmed that there were no orders for catheter care from the time of the resident's admission to the facility on April 10, 2025 through April 16, 2025.</p> <p>Further, the DON (staff #22) stated that the risk of not having orders for the catheter and for catheter care is that the resident could develop an infection.</p> <p>Regarding Resident #427:</p> <p>-Resident #427 admitted to the facility on [DATE] with diagnoses that included urinary tract infection, acute pyelonephritis, type 2 diabetes mellitus, hypertension, acquired absence of right leg below knee and acute kidney failure.</p> <p>A care plan pertaining to resident #427's risk for infection related to indwelling catheter was revised on April 15, 2025. Interventions included to monitor for signs and symptoms of acute infection and to notify the physician.</p> <p>A care plan revised April 16, 2025, revealed that the resident had an indwelling catheter related to BPH (benign prostatic hyperplasia) with obstructive uropathy. Interventions included to change the catheter bag and tubing as ordered, and to provide catheter care every shift as needed.</p> <p>Review of an Order Summary Report retrieved April 15, 2025, revealed no orders for and indwelling catheter or for indwelling catheter care.</p> <p>Additionally, review of the April 2025 TAR revealed no evidence of catheter care.</p> <p>However, review of the Order Summary Report retrieved April 17, 2025 revealed physician's orders dated April 16, 2025, for the catheter care to be performed every shift.</p> <p>An interview with RN (staff #182) was conducted on April 16, 2025 at 10:00 AM. The RN stated that the medical record did not contain provider orders for resident #427 to have catheter care performed prior to April 16, 2025.</p> <p>The resident's clinical record was reviewed with the DON (staff #22) on April 16, 2025 at approximately 12:25 PM. Staff #22 confirmed that there were no orders for catheter care form the time of the resident's admission to the facility on April 10, 2025 through April 16, 2025.</p> <p>During an interview with the DON (staff #22) conducted on April 16, 2025 at 12:25, she stated that if a resident had an indwelling catheter, orders for catheter care should be prescribed. The DON stated that the risk of not having orders for the catheter or for catheter care is that the resident could develop an infection.</p> <p>A policy titled, Catheter Care Indwelling, stated it is the facility's policy that each resident with an indwelling catheter will receive catheter care daily and as needed for soiling.</p> <p>A policy titled, Physician Orders, stated that the facility is to accurately implement orders from providers and that treatments or related procedure orders are to be transcribed into the eTAR (electronic treatment administration record).</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 04/18/2025
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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility documentation, staff and resident interviews and policy review, the facility failed to ensure that two of two sampled residents (#426 and #427) received appropriate respiratory care per physician orders. This deficient practice could lead to respiratory issues.</p> <p>Findings include:</p> <p>Regarding Resident #426:</p> <p>-Resident #426 was admitted to the facility on [DATE], with diagnoses that included multiple fractures of ribs, left side, malignant neoplasm of left breast, anemia and chronic obstructive pulmonary disease.</p> <p>Review of an admission assessment for Brief Interview for Mental Status (BIMS), dated April 12, 2025, revealed the resident had a BIMS score of 15, indicating the resident was cognitively intact.</p> <p>A care plan that was initiated April 10, 2025, revealed that the resident has COPD (Chronic Obstructive Pulmonary Disease). Interventions included to give oxygen therapy as ordered by the provider.</p> <p>A provider order dated April 10, 2025, prescribed oxygen at 2 LPM (liters per minute) via nc (nasal cannula) continuous. May titrate to 5 LPM to keep O2 (oxygen) sats (saturation) above 90%.</p> <p>The April 2025 Medication Administration Record (MAR) indicated nursing staff were to document every shift that the resident was receiving oxygen continuously and record how many liters of oxygen the resident was receiving, as well as the oxygen saturation level.</p> <p>Review of the Weights and Vitals log, for April 10, 2025 through April 17, 2025 revealed that the resident's oxygen saturations were between 91% and 99%. However, the values for April 11, 14, 15, 16 and 17, 2025 indicated the resident was on room air during the readings.</p> <p>A care plan initiated on April 15, 2025 indicated that the resident had oxygen therapy related to ineffective gas exchange. Interventions included to administer oxygen per physician's orders.</p> <p>However, during an observation conducted on April 15, 2025 at 11:05 AM, resident #426, was observed without a nasal cannula in place and was not administered oxygen as ordered.</p> <p>An additional observation was conducted on April 16, 2025 at 9:56 AM. Resident #426 was observed with the nasal cannula on. The oxygen concentrator indicated she was receiving 5 LPM of oxygen.</p> <p>An interview was conducted on April 16, 2025 at 10:05 AM, with a Registered Nurse (RN/staff #182). The RN stated that resident #426 had an order for continuous oxygen at 2 LPM that could be increased to 5 LPM if oxygen saturations were less than 90%. The RN stated that the resident's oxygen saturations were 92% that morning and she would expect the resident to be receiving 2 LPM of oxygen.</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 04/18/2025
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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An observation of Resident #426's oxygen concentrator was conducted with the RN (staff #182) on April 16, 2025 at 10:17 AM. The RN stated the concentrator was set to 5 LPM. She assessed the resident's oxygen saturation which was 93%. The RN stated she did not know why the concentrator was set to 5 LPM and she adjusted it to 2 LPM.</p> <p>During an interview with the Director of Nursing (DON/staff #22), conducted on April 16, 2025 at 12:25 PM, she stated that the resident's oxygen order meant that the resident should always be on at least 2 LPM of oxygen. The DON said that if the resident's oxygen saturation was less than 90%, the nurse could increase the liters per minute until the oxygen saturations reached 90%. The DON further stated that if the resident's oxygen saturations were 92%, the resident should be on 2 LPM of oxygen. The DON stated that if the resident was on 5 LPM of oxygen, it might have been because her oxygen saturations dropped at some point during the night and would need to be reassessed.</p> <p>The DON further stated that the risk of resident #426 not receiving oxygen per provider order could be shortness of breath and/or hypoxia (low levels of oxygen in the blood).</p> <p>A follow-up observation was conducted on April 17, 2025 at 8:33 AM. Resident #426 was observed without a nasal cannula in place and was not administered oxygen as ordered.</p> <p>Regarding Resident #427:</p> <p>- Resident #427 admitted to the facility on [DATE] with diagnoses that included urinary tract infection, acute pyelonephritis, type 2 diabetes mellitus, hypertension, acquired absence of right leg below knee and acute kidney failure.</p> <p>A provider order dated April 10, 2025 prescribed oxygen at 2 LPM via nc continuously. The order indicated the oxygen may be titrated to 5 LPM to keep O2 sats above 90%.</p> <p>The April 2025 Medication Administration Record (MAR) indicated nursing staff were to document every shift that the resident was receiving oxygen continuously and record how many liters of oxygen the resident was receiving, as well as the oxygen saturation level.</p> <p>A care plan initiated on April 15, 2025 revealed that the resident was on oxygen therapy for ineffective gas exchange. Interventions included to administer oxygen per physician's orders.</p> <p>However, an observation conducted on April 15, 2025 at 11:31 AM revealed resident #427 did not have a nasal cannula in place and was not administered oxygen.</p> <p>A follow-up observation was conducted on April 16, 2025 at 9:54 AM. Resident #427, was observed without a nasal cannula in place and was not administered oxygen as ordered.</p> <p>An interview with resident #427 was conducted on April 16, 2025 at 9:54 AM. The resident stated he usually only used his oxygen at night due to sleep apnea.</p> <p>During an interview with RN (staff #182) conducted on April 16, 2025 at 10:15 AM, she stated that resident #427 had orders for continuous oxygen at 2 LPM. The RN stated that the resident's oxygen could be increased to 5 LPM if oxygen saturations were less than 90%. Staff #182 confirmed that the resident was not receiving oxygen at the time of the interview.</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 04/18/2025
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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview with the DON (staff #22) was conducted on April 16, 2025 at 12:20 PM. She stated that resident #427 should have his oxygen on at all times, per provider's order. The DON further stated that despite the resident's oxygen saturations being above 90%, he should still have his oxygen at all times.</p> <p>The DON indicated that the risk of not following provider orders for oxygen for resident #427 could be shortness of breath and/or hypoxia.</p> <p>A policy titled, Oxygen Administration, stated oxygen therapy is administered by a licensed nurse as ordered by the physician. Furthermore, the policy noted that the purpose of oxygen therapy was to provide sufficient oxygen to the blood stream and tissues.</p> <p>A policy titled, Physician Orders, stated the facility is to accurately implement orders from providers and that medications/treatments are to be transcribed into the MAR/TAR. It further stated that biological orders much be recorded in the resident's medical record under orders. The policy indicated that the facility would accurately implement orders upon the orders of a person licensed and authorized to do so in accordance with the resident's plan of care.</p>		