STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035143	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Scottsdale	9494 East Becker Lane Scottsdale, AZ 85260

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 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** Based on staff interviews, facility documentation, and review of facility's policy, the facility failed to ensure that 1 out of 4 sampled residents (Resident # 52), received only medications that were ordered for them by a physician. The deficient practice could result in adverse drug interactions.Findings include:Resident # 52 was admitted to the facility on [DATE] with diagnosis that included hypo-osmolality and hyponatremia, acute skin changes due to ultraviolet radiation, dysphagia, difficulty walking, and unspecified malignant neoplasm of skin of left lower limb, including hip. Review of the order summary report revealed no orders for Duloxetine 30 milligrams (mg) nor Omeprazole 20 mg. Review of the medical diagnosis revealed no diagnosis of depression or gastroesophageal reflux disease (GERD). Review of the Minimum Data Set (MDS) dated [DATE] revealed no indication of depression or anxiety. The MDS also revealed no active diagnoses of any psychiatric or mood disorders. A Case Management note dated September 5, 2025 revealed that Registered Nurse (RN/Staff # 4) took over administering medications from an agency nurse who had informed Staff # 4 those medications were administered to Resident # 52. Further review by Staff # 4 revealed that Resident # 52 had not received her medications. Staff # 4 administered morning medications to Resident # 52. Staff # 4 realized that the medications administered were not that of Resident # 52 and stopped the Resident from taking all the medications. Resident # 52 had taken two of the medications administered including Omeprazole 20 mg and Duloxetine 30 mg. An interview with Staff # 4 on February 12, 2026 at 1:59 p.m., revealed that when she had started the shift, they had an agency nurse administering medications on the floor but the facility had decided to send the nurse home and replace the agency nurse with Staff # 4. Staff # 4 revealed that the agency nurse was in the middle of the med pass and gave Staff # 4 a report that the agency nurse had only a couple medications to administer. Staff # 4 revealed that agency nurse was upset being sent home and did not give her a full report and Staff # 4 had to figure out where the agency nurse left off. Staff # 4 was informed that Resident # 52 had not received her medications so she administered Resident # 52's medications. Staff # 4 revealed that after she gave the medications to Resident # 52, she went back and to the electronic medical administration record (EMAR) without observing Resident # 52 taking the medications. Staff # 4 revealed that when she looked at the EMAR she realized she was looking at the wrong resident EMAR and yelled to the resident to stop taking the medication. Resident # 52 had stopped taking the medication but it was revealed that she took the Omeprazole and Duloxetine. Resident # 52's family was present when the medication error occurred and had asked Staff # 4 to be removed from care of the Resident. Staff # 4 revealed that she notified the Assistant Director of Nursing and Director of Nursing of the medication error. The physician was also notified, and he ordered the resident be monitored. Staff # 4 was then reassigned to a different area of the facility. An interview with Licensed Practical Nurse (LPN/Staff # 22) on February 12, 2026 at 2:41 p.m., revealed that when he administers medications, he makes sure he has the correct resident by looking at the (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
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	name and verifying with picture on the medical administration record and that he has the correct medication and the correct dosage based on the orders. An interview with the Director of Nursing (DON/Staff # 2) on February 12, 2026 at 2:55 p.m. revealed that she was the Assistant Director of Nursing at the time of the incident and was notified by the DON that the wrong medication was given to Resident # 52. The DON revealed that they were to monitor the resident and they reassigned Staff # 4 to different residents. The DON revealed that her expectation is the nurses make sure that medications are administered to the right resident with the right medication and dosage. The DON also revealed the concern if the nurses do not verify the correct resident is residents can receive the incorrect medications which could cause adverse reactions to the residents. A policy and procedure titled Administration of Medications, revised February 13, 2023, revealed that the facility will ensure medications are administered safely and appropriately per physician order to address residents' diagnoses and signs and symptoms. The policy also revealed that staff who are responsible for medication administration will adhere to the 10 rights of medication administration. The policy identified that a resident is to be identified by verbal confirmation as well as visual (name and photo). The policy further revealed that If there is no photo the use of an armband cand be used to verify or the nurse can validate the resident's identity with a second associate who is familiar with the resident and compare the resident's name to the MAR.