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	09/12/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43863 Based on clinical record reviews, staff interviews, and review of policy, the facility failed to ensure one of one sampled resident's (#148) and/or the representative were provided opportunities for participation in the care and treatment planning process. The deficient practice could result in residents not being provided the opportunity to participate in the care planning process. Findings include: Resident #148 was admitted on [DATE] with diagnoses that included subdural hemorrhage, cognitive communication deficit, and atrial fibrillation. Review of a Health Care Power of Attorney, dated March 15, 2006, included the resident's signature and indicated that her son was designated as her agent for all matters relating to her healthcare. Review of the admission information dated March 23, 2023, revealed that Resident #148 was her own responsible party, and her emergency contact was her son. Review of the clinical record revealed no evidence that the baseline care plan was reviewed with the resident or representative within 48 hours of admission. Further review of the clinical record revealed no evidence of a baseline care plan signature sheet indicating that the baseline care plan had been reviewed with the resident/representative by nursing within 48 hours of admission. A care plan initiated on March 24, 2023, revealed a focus on rehospitalization , with interventions that included discuss with resident/family history of hospitalization . A focus regarding discharge plan revealed a goal to develop and follow full discharge plan with comprehensive with interventions that the resident wishes to return home. Review of a nursing Alert note dated March 25, 2023, revealed that the Resident's daughter-in law called requesting information regarding the resident's plan of care, medication list and health in general, and requested a call from a case manager as soon as possible (ASAP). The note further revealed that Resident #148 gave verbal consent agreeing for her son and daughter-in-law to receive information regarding her care/treatment. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of clinical record revealed no evidence that a case manager returned the call to the resident's family per their request. A Health Status Note dated March 25, 2023 at 13:17, revealed that the resident's son called and was upset that no one reached out to him regarding his mother's care plan. The nurse called the resident's son back and left a message that included setting up a care conference with the interdisciplinary team (IDT). Review of the clinical record revealed an IDT late entry note dated March 26, 2023, indicating a team of qualified clinicians met to determine the patient's usual performance during the look-back period. Further review of the clinical record revealed no evidence that the resident or her representative had been included in the IDT meeting, or attended the meeting, per their request. Review of a 5-day Medicare Minimum Data Set (MDS) assessment dated [DATE], revealed no evidence of a Brief Interview for Mental Status (BIMS) assessment. A Cognitive Skills for Daily Decision Making assessment indicated that Resident #148, was independent with decisions regarding daily life, with decisions consistent/reasonable. An interview was conducted on September 10, 2024, with a Licensed Practical Nurse, Case Manager (LPN/staff #52), who stated that the initial discharge planning is conducted by case management with the patient and his/her family, and would be documented in the clinical record on the initial discharge planning form. She also stated that the baseline care plan should be signed by the resident or family when it is reviewed with them by nursing. She further stated that if the resident cannot sign the form, the baseline care plan would be reviewed over the phone with the resident's representative. The LPN stated that the signed baseline care plan signature page should be uploaded into the clinical record. She reviewed the clinical record and stated that there was no evidence of a signed baseline care plan signature page in the clinical record. The LPN stated that IDT care plan meetings include the Director of Nursing (DON), Executive Director (ED), social services, rehabilitation and case management. The LPN also stated that this meeting would also include the resident's family/emergency contact, even if the resident is their own responsible party (unless the patient states otherwise). She stated that the IDT meeting would be documented in a progress note, along with the attendees, along with the care plan signature page with all attendee's signatures, including the resident and/or representative. The LPN reviewed Resident #148's clinical record and stated there was no evidence that the resident's care plan had been reviewed with the resident or her representative, or of a care plan signature page for the March 26, 2023 IDT care plan meeting. The LPN stated the risk of not keeping representatives up dated on patient care/treatment. An interview was conducted on September 10, 2024 at 09:37 AM with the Social Services Director (staff #27), who stated that the baseline care plan is signed by nursing, certified nursing assistants (CNA), physical therapy, case management, social services, dietary, and resident/or resident representative on a signature page, that is kept in the clinical record. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on September 10, 2024 at 09:54 AM, with the Health Information Management (HIM) Director (HIM/staff #63), who stated that she receives the signed/completed baseline care plan signature page and keeps the original in her records, but it is also uploaded into the clinical record. She reviewed the clinical record and stated that there was no evidence of a baseline care plan signature page indicating that it had been reviewed with the resident and/or representative. She also stated that she does not receive the signature page when a IDT Care Conference is conducted, but it should be documented in the clinical record. She further reviewed the clinical record and stated there was no evidence of a signature page from the March 26, 2023 IDT Care Plan meeting with staff and resident/resident signatures indicating attendance. She further stated that there was no evidence of case management progress notes or social service notes or Admission Care Conference notes that the family had been contacted regarding their concerns. She also stated that the risk of not keeping representatives/family updated on resident's care/treatment could result in a determent to the resident's health. Further interview was conducted on September 10, 2024 at 12:35 PM, with the HIM Director (staff #63), who stated that she reviewed her records and stated that there was no evidence that the baseline care plan was reviewed with the resident and/or representative, and there were no signatures on the signature page from the staff or resident/representative. She also stated that the signature page of the baseline care plan is the facility's baseline care plan summary. She further stated that there was no evidence that the resident's representative had been contacted regarding their concerns. An interview was conducted on September 11, 2024 at 10:37 AM with the DON (staff #51), who stated that the baseline care plan should be signed by the resident/representative after it is reviewed with them by social services. She stated that she expected that the resident/representative would sign the signature page on the baseline care plan. She reviewed her records and stated that she did not have the baseline care plan, and that it should be in medical records. She reviewed the clinical record stated that there was no evidence in the clinical record that the resident or her representative were part of the March 26, 2023, IDT care plan meeting and that this did not meet her expectations, stating that it needs to be documented. She stated the risk could result in the family member not being aware of the plan of care for the Resident. Review of the facility policy titled, Baseline Care Plan, revealed that the facility must provide the resident and their representative with a summary of the baseline care plan. Have all care plan attendees sign the last page of the baseline care plan form, provide the resident and/or representative with copies of the baseline care plan. Review of a facility policy titled, Comprehensive Care Plans and Revisions, revealed that each resident and resident representative is involved in developing the care plan and making decisions about his or her care. Review of a facility policy titled, Resident Rights, revealed the resident has the right to be informed of, and participate in, his or her treatment, and to participate in the development and implementation of his or her person-centered plan of care. The resident has the right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility policy titled, Family Involvement and Alternative Means of Communication, revealed family involvement in the resident's life is promoted and maintains the resident's support network. The policy also revealed that the facility should encourage the family to be involved in planning and implementation of the resident's care. The Social Services Director, as a member of the facility interdisciplinary team, designs, supports, and advocates facility systems that promote family involvement by providing information to the family to keep them informed of the resident's status (ie:, progress, changes, etc.).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50553 Based on closed record review, staff interviews, and review of facility policy, the facility failed to ensure care and services were provided to prevent pressure ulcers from developing and worsening for one (#144) of one resident. The deficient practice could result in a decline in a resident's overall health. Findings include: Resident #144 was admitted to the facility on [DATE] with diagnoses including major depressive disorder, paraplegia, and multiple sclerosis. Review of the care plan revealed a focus dated April 18, 2023 that the resident was at risk for breaks in skin integrity. The goal of this area was to maintain intact skin with no skin breaks, and interventions including weekly skin checks. Review of the Admission/Readmission Collection Tool completed on April 18, 2023 revealed that on admission, the resident had an open wound to the left heel and blanchable redness to the coccyx. These were the only skin impairments documented in this tool. Review of physician orders revealed an order dated April 18, 2023 that instructed daily wound care for the resident's left heel wound. There is no mention of wound care for any other wounds, indicating the left heel was the only open wound at this time. Further review of physician orders revealed an order dated April 19, 2023 that instructed to complete a weekly skin assessment every Tuesday night. Review of the Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS also revealed that the resident needed maximal assistance to roll and to move from sitting to lying, indicating the resident was largely reliant on staff for repositioning. Further review of the MDS revealed the resident had one unstageable pressure injury present at admission, and he was at risk at developing pressure ulcers. Treatments in place included pressure reducing device for bed, pressure ulcer care, and application of dressings to feet. Further review of the care plan revealed a focus dated April 24, 2023 that indicated the resident had an impairment to skin integrity on the left heel due to pressure. One of the interventions for this focus included weekly treatment documentation, which included measurement of each area of skin breakdown and any other notable changes. There was no mention in the care plan of any other wounds or pressure ulcers. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the task Turn and Reposition revealed opportunities to chart turning or repositioning a resident every two hours. Review of this task revealed lapses in documentation of turning/repositioning. For example, on April 24, 2023, there was no evidence of the resident being turned or repositioned past 4:00PM, no evidence of turning or repositioning on April 25, 2023, and no evidence of turning or repositioning until 6:00 AM on April 26, 2023. This documentation reflects that the resident was not turned or repositioned from approximately 4:00PM on April 24, 2023 until approximately 6:00AM on April 26,2024. Further review of physician orders revealed an order dated April 29, 2023 that instructed wound care twice a day for a right heel blister. Further review of physician orders revealed an order dated May 1, 2023 to apply barrier cream to the resident's buttocks/coccyx for prevention of skin breakdown every shift and as needed. Additionally, an order was added on May 2, 2023 to apply Triad paste twice a day and as needed to the sacrum. On May 8, 2023, orders were added for daily wound care to the sacrum, including cleansing with normal saline and applying a wound-dressing paste. Review of the Wound Observation Tools dated May 8, 2023 revealed first observations of acquired unstageable pressure ulcers on the sacrum and right heel, in addition to the left heel unstageable pressure ulcer on the left heel. The sacral wound at this time was 8 centimeters in length and 10 centimeters in width. The right heel wound at this time was 1.5 centimeters in length and 3 centimeters in width. Further review of the task Turn and Reposition revealed no evidence of the resident being turned from 6:00AM on May 8, 2023 until 6:00M on May 9, 2023. Additionally, review of tasks revealed no evidence of bed mobility, locomotion, dressing, or transferring on May 8, 2023. Review of the MDS dated [DATE] revealed that the resident had three unstageable pressure ulcers with slough and/or eschar, with only one of these present upon admission to the facility. Review of the discharge summary created May 16, 2023 revealed that the skin condition section was documented as skin intact. Review of the nursing progress note dated May 16, 2023 revealed an entry that was stated to be a correction in documentation. This note revealed that the patient had a pressure ulcer on the sacrum that was 10 centimeters by 4 centimeters, and stage 1 pressure ulcers on both heels at time of discharge. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted on September 10, 2024 at 8:20AM with the resident's son, who stated that at the time of admission, the resident only had a red hotspot on his bottom and the area was not open. He states that on discharge from the facility, the discharge paperwork stated skin intact. The son at this time saw the wounds on his father, and demanded the discharging nurse to assess and change the documentation. The son goes on to state that the facility knew about the extent of the wounds, as the wounds were dressed at the facility. Once discharged to the receiving facility, the son states that the nurse director took photos of the wounds, noting four wounds on the resident's bottom and one on each heel. The son states that the nurse director described the wounds as clearly stageable, with one wound being stage 4. When asked if he felt the facility worked to prevent his father's wounds, the son stated that the facility turned his father but not very often. He describes that his mother would have to often ask the staff to turn the resident, as it was not being done enough. An interview was conducted with the Director of Nursing (DON/Staff #51) on September 10, 2024 at 12:52PM who stated that the expectation of her staff on admission is to complete a head-to-toe skin assessment, documenting any impairments and measurements. From there, weekly skin assessments should be completed, and the wound nurse will come behind nurses for wound assessments Monday through Friday. The DON elaborates that weekly skin checks should be completed for every resident, and skin integrity should be documented, including any new skin issues and pre-existing wounds. The DON goes on to explain that if redness is found on a resident's bottom, it should be reported to the nurse, and then to the doctor and family. The nurse should ensure treatment is ordered. An interview was conducted with a Registered Nurse (RN/Staff #59) on September 12, 2024 at 8:20AM who stated that nurses conduct a full skin assessment on admission and are assessed periodically thereafter. She stated that if new skin breakdown is noticed, it should be reported to the physician and family. A change of condition assessment should be completed at this time, and interventions should be put in place, including new treatments ordered by the doctor. Review of the facility policy titled Skin Integrity & Pressure Ulcer/Injury Prevention and Management indicates that any changes in a resident's skin or any open areas should be reported to the nurse, who will complete further inspection and provide treatment as needed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43863 Based on documentation, staff and resident interviews, and policy and procedures the facility failed to ensure that one of one sampled residents (#145) received adequate supervision to prevent accidents. The deficient practice could result in resident injuries. Resident #145 was admitted on [DATE] with diagnoses that included fracture of left humerus, subluxation of left shoulder, heart failure, type 2 diabetes, atrial fibrillation, and long term use of insulin. Resident #147's comprehensive care plan initiated on April 25, 2024 and revised on August 09, 2024, included the following: -Resident requires ADL assistance with interventions including to assist with mobility. -Activity of Daily Living (ADL) self-care performance deficit related to limited mobility and pain, with interventions to encourage resident to use bell to call for assistance. -At risk for falls, deconditioning, gait/balance problems, vision/hearing problems with interventions that included to anticipate the resident's needs, educate family/resident about safety reminders and what to do if a fall occurs. -On anticoagulant therapy with interventions that included to monitor for side effects and effectiveness, observe and report PRN adverse reactions including bruising. -Break in skin integrity with interventions that included weekly skin checks. -Has skin tears/potential for skin tear incident of unknown origin initiated on May 17, 2024, revised August 09, 2024 with interventions that included to use caution during transfers/bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. Review of a 5-day Medicare Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 14 which indicated intact cognition. The assessment included the resident required substantial/maximal assistance sit to stand, supervision or touching assistance, and toilet transfer supervision/touching assistance. Review of an x-ray report dated May 14, 2024 of the left humerus revealed no evidence of acute fracture or dislocation. Review of a skilled progress note dated May 27, 2024 revealed that the resident was alert, oriented and able to make her needs known. The note also included that the resident required assistance for mobility and activities of daily living (ADL) care. Review of an Event Note dated May 30, 2024 revealed that the resident had a lump with bruising on her right lower back above the hip, and that the resident had complained of right thigh pain. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Health Status Note dated May 30, 2024, revealed that a cold compress was applied with good relief, bruising was purple in color. A late entry communication note dated May 30, 2024 by a Registered Nurse (RN), revealed communication with provider, related to Resident with swelling/bruising to right lower back. The note included that the resident did not know how this occurred. The LPN also included that the bruising was across the lower back and the swelling was on the lower right side, and an x-ray was ordered. The facility investigation for Injury of Unknown Cause report dated May 30, 2024, was completed by a Registered Nurse (RN) Supervisor (RN/staff #33) and that Resident #145 was observed with swelling and bruising on her right lower back, above the hip. The report included the resident's statements that she did not fall or bump into anything, and that she did not know how she ended up with this. The report included that the resident was ambulatory with assistance, and was oriented to person, situation, place and time. The report also included that there were no predisposing environmental factors. The investigation report also included the following statements: -A Social Services Director (staff #27) wrote that he contacted Adult Protective Services (APS) and the Scottsdale Police Department. He also wrote that after contacting the police department and officer came to the facility and interviewed the resident. Staff #27 also wrote that the officer stated that she had no concerns and drove away. -A RN Supervisor (staff #33) wrote that Resident #145 was educated on the safety of using the call bell when she needs to use the toilet, and that the resident repeatedly takes herself to the toilet without using the call bell for assistance. The RN wrote that the resident would use the call bell after she had taken herself to the toilet to have her briefs pulled up. She further included that the bruise was on the patient's back at the same level as the bar in the bathroom. -A statement was provided by staff (unknown signature) who wrote that he/she did not know about a bruise on the resident. -A statement was provided by staff (unknown signature) who wrote that he/she saw a bruise on the resident's hip when he/she was helping the resident out of the restroom, and informed the Director of Nursing (DON). The statement included that the resident was not complaining of pain. Review of the staff schedule dated May 29, 2024 revealed: -CNA (Staff #53) was assigned to provide care to Resident #145 on 6 AM-6 PM shift. -CNA (staff #5) was assigned to provide care to Resident #145 on the 6PM-6AM shift. Review of the staffing schedule dated May 30, 2024 revealed: -CNA (staff #30) was assigned to provide care to Resident #145 on the 6 AM-6PM shift. -CNA (staff #5) was assigned to provide care to Resident #145 on the 6PM-6AM shift. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of provider orders revealed the following orders: -Cold compress to lower right back above hip for swelling, dated May 30, 2024. - STAT x-ray of sacrum/coccyx related to fall with small hematoma lower back, dated May 31, 2024. -CT scan to the right flank area nodule with pain dated June 7, 2024. Review of a radiology interpretation dated May 31, 2023 for nontraumatic hematoma of soft tissue, revealed lumbar spine 2-3 views: osteoporosis without fracture, and disc space narrowing at all lumbar levels. Sacrum-Coccyx min 2 - views: revealed posterior soft tissues that suggest sacral decubitus ulcers. Further review of the radiology report revealed no x-rays were taken of the lower right back and hip associated with the hematoma. Review of skin assessments dated May 2, 2024 through June 9, 2024, revealed no evidence regarding new bruising or hematoma that was observed on May 30, 2024. Review of a progress note completed by the Medical Director dated May 31, 2024, included that the resident had sustained bruising on the sacral area with a small hematoma on her lower back. He wrote that the resident denied any falls and tenderness. The Medical Director wrote that they will get a lumbosacral and coccygeal area x-ray. Further review of Medical Director progress notes: - Dated June 3, 2024, revealed the hematoma was stable. - Dated June 4, 2024, revealed the hematoma and bruising had improved, no pain on palpation, and that it felt more like soft tissue. - Dated June 6, 2024, revealed the small lump on the resident's back is slightly decreased in size, bruises resolving. Review of the clinical record revealed CT scan results dated June 26, 2024 related to contusion of lower back/pelvis. The report impression revealed likely hematoma with surrounding edema. An interview was conducted on September 11, 2024 at 09:03 AM with a Certified Nursing Assistant (CNA/staff #24), who stated that he was familiar with Resident #145's care, and that she was cares in pairs. The CNA also stated that he remembered hearing that she had a hematoma on her side, but he was not scheduled to work at that time. The CNA stated that Resident #145 would walk herself to bathroom, but would need assistance with pulling up her briefs, and she would get into a wheelchair without assistance. The CNA stated that he did see the bruise/discoloration on the resident's right side, and the resident stated that she could not remember how it happened. The CNA stated that the Scottsdale police were at the facility and received a report regarding Resident #145's injury. The CNA also stated that he was not interviewed regarding the incident, but the resident was not assigned to him that day. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on September 11, 2024 at 09:21 AM with a CNA (CNA/staff #30) who stated that he was not aware that the Resident had been injured. The CNA further stated that when a resident tells him that they have an injury, or he observed an injury, he would report it to the nurse. An interview was conducted on September 11, 2024 at 10:37 AM with the Director of Nursing (DON/staff #51), who stated that weekly skin evaluations are completed weekly and address any issues that are observed at that time, notify family and the MD for orders. The DON also stated that if an area has already been addressed on a previous skin evaluation, it did not need to be documented on the following skin assessments. The DON further she stated that that if an issue was found during the week after the skin assessment, it should be documented on the following skin assessment. She stated that she did find a copy of the investigation, and that they did complete staff interviews. She stated that she reviewed the clinical record and that there was no documentation on the 6/2/2024 regarding the hematoma. In interview was conducted on September 11, 2024 at 11:42 AM with a Certified Occupational Therapist Assistant (COTA/staff #66), who stated that she vaguely remembered Resident #145. The COTA reviewed the therapy records dated May 20, 2024 through May 30, 2024 and stated that the resident required stand-by assist, and that therapy would let nursing know the resident's functional level. The COTA stated that the resident should not have been ambulating in her room unattended. The definition of avoidable accident means that an accident occurred because the facility failed to implement interventions, including adequate supervision consistent with a resident's needs, goals, care plan and current professional standards of practice. An interview was conducted on September 11, 2024 at 12:12 PM with a Nurse Aide (staff #5), who stated that Resident #154, ambulated herself to the restroom, and required constant room checks because she would get out of bed unassisted. The CNA stated that she advised Resident #154 to call for assistance using the call light, but she did not, so they had to constantly go in room. The CNA stated on May 29, 2024, she found the resident had taken herself to the restroom and was sitting on the toilet. The CNA stated at that time the resident stated that she sat down too fast and her back hit the toilet. The CNA stated that the resident stated that she was fine, good and the patient declined assistance from the CNA. The CNA stated that she waited outside the restroom for the patient, and that she did not assess the patient for an injury. The CAN further stated that she did not inform the nurse that the resident reported hitting her back on the toilet, but she may have mentioned that they needed to keep an eye on the resident. The CNA further stated that she was not interviewed on May 30, 2024 regarding the resident's bruising by administration. (continued on next page)

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	09/12/2024

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further interview was conducted with CNA (staff #30) on September 11, 2024 at 12:17 PM, who stated that he now remembered the patient. He stated that Resident #145 ambulated by herself and that she would get up and go into the bathroom by herself, then request help to put on her briefs. The CNA further stated that the resident was able to go into the bathroom by herself, and most of the time the resident required assistance once she was in the bathroom. The CNA then stated that Resident #145 was able to ambulate and would not call for assistance to go into the bathroom. The CNA also stated that physical therapy would notify him regarding the patients that can walk on their own, or require assistance. The CNA also stated that when he received report he was told that Resident #145 could go to the bathroom, so he did not educate her on calling for assistance when she wanted to go to the bathroom. The CNA stated that he did not document that he educated the patient not to go to the bathroom on her own. The CNA further stated that he told the resident that if she needs to call for help to use the call light. The CNA stated that the resident knew how to use her call light, and that she should have been educated by staff. The CNA further stated that if the care plan stated the resident required assistance while ambulating then that should be provided. He further stated that as far as he knows the care plan was not being followed when the resident ambulated into the restroom without assistance. The CNA also stated that he did not notice any bruising when he cared for Resident #145 on May 30, 2024, and that the resident did not say anything regarding an injury. An interview was conducted on September 11, 2024 at 12:33 PM with a CNA (Staff #53), who stated that the she could not remember Resident #145. She stated that if the care plan interventions include to assist with mobility, then she would assist the resident into the bathroom with a gait belt and a walker. She also stated that she would educate the resident to use the call light if she observed the resident walking to the bathroom unassisted, and notify nursing. An interview was conducted on September 11, 2024 at 12:45 PM with a Registered Nurse (RN/staff #45), who stated that Resident #145 would use her call light, but would sometimes not use it to go to the bathroom. The RN also stated that the resident required stand by assist. The RN further stated that no CNA had informed her that the resident hit her back on the toilet when she worked on May 29, 2024 and May 30, 2024. The RN further stated that when a patient tells a CNA that they hurt themselves, the CNA would notify the nurse, the nurse would notify the MD, and the resident's family. The CNA also stated that even if the patient told the CNA that he/she was ok she would expect that the nurse would be notified. Further interview was conducted with the DON (staff #51), on September 11, 2024 at 1:41 PM, who stated that she would expect staff to follow care planned interventions. The DON also stated that therapy documents on a white board the residents that require stand by assistance, and communicate this during grand rounds and from nurse to CNA. The DON further stated that If they are not sure how a patient transfers, the nurse would complete an transfer assessment upon admission. The DON further stated that there is also CNA to CNA reports that communicate the residents needs/requirements. The DON stated that when a resident informs staff of an injury she would expect the staff member to report to the nurse, and the nurse would report to DON, MD, family if appropriate. She also stated that then the nurse would start the risk assessment/incident report, that patient re-education would be conducted and would be documented in the incident report, and progress note. The DON stated that before an incident occurred she would expect that if staff were aware that a patient was ambulating without out assist, she would expect that it would be documented in progress notes. (continued on next page)

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Life Care Center of Scottsdale	9494 East Becker Lane Scottsdale, AZ 85260

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled, Resident Rights, revealed that the resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. A facility policy titled, Incident/Reportable Event Management, revealed that the facility must ensure that the resident receives adequate supervision and assistance devices to prevent accidents.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51239 Based on observation, staff interviews, and facility policy, the facility failed to ensure that refrigerated food was not expired. The deficient practice could result in potential affect to all residents in facility. During the initial tour of the kitchen on [DATE] at 8:39AM, conducted with the Dietary Manager (Staff #9), during an observation of the refrigerator, one container of Horseradish was labeled with a received date of [DATE] and opened on [DATE]. Further observed revealed that the best used by date from the manufacture was [DATE]. The Dietary Manager stated that they can use the Horseradish condiment after the used by the date for up to a year. The Dietary Manager immediately throw the horseradish condiment into a trashcan. An interview was conducted on [DATE] at 09:12 AM with the Dietary Manager (Staff #9) and Consultant Dietitian (Staff #185). The Consultant Dietitian stated that the facility process for the expired food is that it should be discarded and thrown away. She further stated that the food can be used after the best if used by/before. The Consultant Dietitian also stated that the horseradish could be used after the used by date depending on quality and flavor. She further stated that she has not taste tested the flavor or the quality of the horseradish condiment. The Dietary Manager further stated that she does not know when the horseradish condiment was last used. An interview was conducted on [DATE] at 11:33 AM with the Administrator (Staff #102) . who stated that the facility process for expired food is to throw way after the expiration date. She also stated that she expects the Dietary Manager to follow the policy item on how long they should keep the food after the used by date. She further stated that she does not see horseradish condiment on the list and it should not have been used. She Stated that Horseradish condiment should been thrown away. Review of the facility policy titled, Food Storage, revealed that Best if Used By/before-gives the recommended shelf life for best flavor or quality. The food can be used safely past this date. It has also revealed that Date of pack or Manufacture Date refers to when the food was packed or processed for sale, these are not use by date, however horseradish was not one of the items listed.