STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035217	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehab at Scottsdale Village Square	2620 North 68th Street Scottsdale, AZ 85257

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to ensure advanced directives were accurately completed and maintained for two residentsNumber of residents sampled: 2Number of residents cited: 2Based on clinical record review, staff interview, and facility policy and procedure, the facility failed to ensure that the advance directives were consistent throughout for two of 103 sampled resident's (#66 & 86) clinical record. The deficient practice could result in residents receiving services that are not in accordance with their wishes.Findings include:Resident #66 was admitted to the facility on [DATE] with diagnoses that included Hypertension, hyperlipidemia, epilepsy, schizoaffective disorder, intracranial injury with loss of consciousness, disorders of brain and major depressive disorder.A physician's order dated [DATE] revealed that the resident was full code status.Review of the Pre-hospital medical care directive, signed by the resident on [DATE] revealed that the resident did not want CPR (cardiopulmonary resuscitation), and that the resident was a DNR (Do Not Resuscitate).The review of Face sheet dated [DATE] for the resident revealed the resident's advance directive was FULL CODE.Review of the care plan initiated on [DATE] revealed the resident was a full code status. The goal was that the resident's wishes for end of life will be honored. Resident #86 was admitted to the facility on [DATE] and readmitted on December28,2023 with diagnoses that included kyphosis, hypertension, Type 2 Diabetes Mellitus with diabetic neuropathy, spinal stenosis, atherosclerotic heart disease, vascular dementia, mood disturbance, GERD, hyperlipidemia, anxiety disorder, chronic obstructive pulmonary disease, dysphagia, major depressive disorder.Review of VA Advance Directive, signed by the resident on [DATE] revealed that the resident was a DNR.Review of the Pre-hospital medical care directive, signed by the resident on February 14,2025 revealed that the resident did not want CPR (cardiopulmonary resuscitation), and that the resident was a DNR (Do Not Resuscitate). The review of Face sheet dated [DATE] for the resident revealed the resident's advance directive was FULL CODE.Review of the care plan initiated on [DATE] revealed the resident was a full code status. The goal was that the resident's wishes for end of life will be honored. Review of progress notes dated [DATE] revealed that the resident was a full code status.A physician's order dated [DATE] revealed that the resident was full code status.An interview was conducted with the MDS Coordinator (Staff # 172) on [DATE] at 11:45 AM, he stated that advance directives are signed upon admission and can be changed during quarterly care plan meetings. They confirmed that a specific form (Exhibit 3 - Advance Directive) is required to document any changes and that the electronic health record should be updated by medical records staff.An interview was conducted with the LPN (Staff # 188) on [DATE] at 12:32 PM, Stated that to check a resident's code status, she would look at the physical chart and then cross-reference it with the face sheet in the PointClickCare application. She acknowledged that not following the correct procedure could lead to care that is not in line with a resident's wishes.An interview was conducted with the Director of Nursing (DON/ Staff # 163) on (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] at 02:06 PM Confirmed that advance directives are initiated upon admission and reviewed quarterly. The DON also stated that staff should check both the physical and computer charts for a resident's code status. The DON acknowledged that if a discrepancy exists, staff should contact management for guidance. After reviewing the charts for both residents, the DON confirmed that a discrepancy existed and that the potential harm is that a resident's end-of-life wishes would not be honored.The facility's policy Advance Directives (revised [DATE]) revealed that the resident or representative is provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. The advance directives are honored in accordance with state law and facility policy. These are reviewed annually with the resident by the interdisciplinary team during the annual assessment process to ensure they are still the resident's wishes. The nurse supervisor is required to inform emergency medical personnel of a residents advance directive or POLST when a resident is transferred from the facility via ambulance or other means.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Facility failed to store medications according to professional standards. Number of residents sampled:Number of residents cited: Based on observations, staff interviews, and a review of facility policies, the facility failed to ensure that expired medications were properly discarded and not available for use. Additionally, the facility failed to ensure medications for one resident (#17) were not left at the bedside. These deficient practices could result in residents receiving expired medications, and could result in resident injury, medication over-dose or contradictions. The facility census was 103. Findings include: An observation was conducted of the Central medication room on 07/31/2025 at 09:55 AM with the Director of Nursing (DON/staff #163). The following expired medications were identified: Two boxes of unopened Alfrin Allergy Sinus nasal spray, with an expiration date of January 2025. Two boxes of unopened Bisacodyl stimulant laxative, with an expiration date of June 2025. One box of unopened Vitamin E 180mg (400 IU), with an expiration date of April 2025. An observation was conducted of the Vistas South medication room on 07/31/2025 at 10:09 AM with the Director of Nursing (DON/staff #163). During this review, twenty boxes of Flucelvax Trival 2024-2925 SYR were found in the medication refrigerator. All of these items had an expiration date of 06/17/2025. Following this observation, an interview was conducted with the DON (Staff # 163). The DON stated that the facility's policy prohibits the storage of any medications in either the medication rooms or on the medication carts. To maintain compliance, medication carts and all storage areas are audited twice weekly using a pharmacy-provided form, which specifically checks for expired medications and properly dated insulin etc. Discontinued and expired medications are destroyed using a specialized Rx buster, a process that requires the oversight of two nurses. For controlled substances, the process is even more stringent, the night supervisor (Staff #29), being primarily responsible. The DON(Staff#163) additionally stated that the destruction of these medications must be documented on a Controlled Drug Record, which requires two nurse signatures and details the method, quantity, and date. The DON(Staff#163) stated that this procedure is followed for medications that are discontinued, when a resident is discharged , and during the bi-weekly cart check. To prevent the accumulation of expired medications, nurses are instructed to check expiration dates before placing any medication on the cart. Additionally, the DON(Staff#163) stated that the central supply area is checked monthly by the Director of Environmental Services (Staff #18). The DON(Staff#163) stated that there are currently no formal tracking logs, a new in-service on expired medication protocols is being planned to address staff training needs, as there is no current system to remind staff of expiration dates. The facility recognizes that the administration of expired medications can compromise their efficacy, potentially preventing residents from receiving the full therapeutic benefit. Therefore, any such incident is treated as a medication error. If a discrepancy is found, residents and their families are promptly notified. - Regarding Resident #17: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #17 was admitted to the facility on [DATE], with a diagnosis of alcohol dependence, major depressive disorder, anxiety disorder, gastro-esophageal reflux disease, chronic obstructive pulmonary disease, type 2 diabetes, and hyperlipidemia. An observation was conducted on July 29, 2025, at 10:10 AM revealed Resident #17 was sleeping and next to him, on the bedside table was a small cup with the medications, aripiprazole, hydroxyzine, and cholecalciferol. Review of the Minimum Data Set (MDS) dated [DATE], reveals Resident #17 had a Brief Interview for Mental Status (BIMS) score of 12, indicating the resident was moderately cognitively impaired. Review of the medical record revealed a PAC-Physician's progress note dated July 10, 2025, that Resident #17 was alert and oriented times 2. Review of the clinical record revealed no evidence that the resident was assessed and determined to be able to self-administer medications. An interview was conducted on July 29, 2025, at 10:11 AM with Licensed Practical Nurse (LPN), staff #138. She stated she was the nurse who administered the medications to Resident #17 that morning. She thought he took them but stated he must have pocketed them in his mouth and spit them out after I left. Staff #138 immediately went to Resident #17's room and ensured that he took the medication. The facility's policy titled Medication Labeling and Storage included the following: The facility's policy requires that all expired, discontinued, or deteriorated medications be promptly removed from storage and handled in accordance with pharmacy instructions. Review of the facility's policy on Administering Medications dated April 2019, states Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely.