STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035268	A. Building B. Wing	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advance Health Care of Scottsdale	9846 North 95th Street Scottsdale, AZ 85258

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews, facility documentation and policy review and the State Agency complaint tracking system, the facility failed to correctly develop and implement their abuse policy following an allegation of sexual abuse for one resident (#11). The deficient practice could result in abuse and neglect to residents.Findings include: Resident #11 was admitted on [DATE] with diagnoses that included traumatic subdural hemorrhage, acute kidney failure, atherosclerotic heart disease, hyperlipidemia, paroxysmal atrial fibrillation, hypothyroidism, iron deficiency anemia, atrial septal defect, hormone replacement therapy, combined rheumatic disorders of mitral, aortic, and tricuspid valves. A Medicare 5-Day Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderate cognitive impairment. The MDS also revealed the resident had not exhibited any behaviors. A late-entry progress note dated September 2, 2025 at 6 p.m. was written on September 5, 2025 at 8:04 a.m. and revealed that the Director of Nursing (DON/Staff#45) spoke with the resident and daughter at bedside concerning care plan and care concerns. The note further revealed that the resident could not answer orientation questions and appeared confused, but the DON would continue to monitor the resident for safety. A grievance filed on September 2, 2025 revealed a grievance regarding a care issue - male Certified Nursing Assistant (CNA) for Resident #11. The grievance further revealed that the issue took place on September 1, 2025 and parties were informed of findings on September 3, 2025 with a resolution to not have male CNA's for personal care. The grievance log also revealed two additional separate care concerns regarding CNA - Female Preference in July of 2025. A care plan focus initiated on September 3, 2025 revealed that the resident had personally experienced and been traumatized by sexual assault with interventions to only have female care givers for all personal cares and to consult trauma informed care portion of the admission observation to identify trauma and stress related issues for the resident. There was no evidence in the clinical record of an allegation of sexual abuse. Review of the State Agency complaint tracking system revealed that the facility submitted a self-report for Resident #11's allegation of staff-to-resident sexual abuse on September 4, 2025 at 12:29 p.m The self-report revealed an allegation of sexual abuse with no evidence that law enforcement or Adult Protective Services (APS) had been contacted or reported to. A call was made by the State Agency (SA) to non-emergency law enforcement on September 17, 2025 at 10:09 a.m. to report the allegation of sexual abuse. Law enforcement notified the SA that they would be contacting APS regarding the sexual abuse allegation. An interview was conducted on September 17, 2025 at 11:12 a.m. with a CNA, Staff#21, who stated that the timeframe for reporting an allegation of abuse was 24 hours, but ideally, as soon as possible. The CNA stated that it was important to report sexual abuse right away to the administrator or DON to get the information going to figure out what happened to the resident and to keep residents safe. An interview was conducted on September 17, 2025 at 11:21 a.m. with a Registered Nurse (RN/Staff#56), who stated that the timeframe for reporting was immediately as the allegation was brought to her, but within one to two hours to the DON or administrator. The RN defined sexual abuse as unwanted physical contact or emotional perturbation, and any sexual abuse allegation would absolutely need to be reported. The RN stated that it was important to report allegations of sexual abuse to manage resident safety and ensure residents are not in harmful situations. An interview was conducted on September 17, 2025 at 11:32 a.m. with an RN, Staff #60, who stated that the timeframe for reporting abuse was immediately or within an hour if there was bodily harm, but within 24 hours if there was no bodily harm. The RN stated that she reported an allegation of sexual abuse a couple weeks ago, and that the allegation was reported to her by the daughter of Resident #11 who told her that a staff member had inappropriately touched her mother. The RN stated that she reported the allegation immediately to the DON and Administrator, and they took the investigation from there. The RN stated that it would be important to report an allegation of abuse to protect the resident, investigate, find who was behind the abuse, call the police, and do right by the patient. The RN further stated that the risk of not reporting allegations of abuse would be continued abuse to that resident and other residents. An interview was conducted on September 17, 2025 at approximately 11:45 a.m. with the DON, Staff #45, who stated that the timeframe for reporting physical abuse with injury was two hours, and any other type of abuse was 24 hours. The DON stated that her expectation of staff was to report abuse immediately to their supervisor and, ultimately, to the Administrator (Admin/Staff #78). The DON stated that it would be important for staff to report within the

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews, and facility documentation and policy review, the facility failed to ensure that an allegation of sexual abuse for one resident (#11) was reported to the State Agency (SA), law enforcement, and Adult Protective Services (APS) within the required timeframe. The deficient practice could result in residents not being protected from abuse.Findings include: Resident #11 was admitted on [DATE] with diagnoses that included traumatic subdural hemorrhage, acute kidney failure, atherosclerotic heart disease, hyperlipidemia, paroxysmal atrial fibrillation, hypothyroidism, iron deficiency anemia, atrial septal defect, hormone replacement therapy, combined rheumatic disorders of mitral, aortic, and tricuspid valves. A progress note dated August 26, 2025 at 1:27 p.m. revealed the residents mental status was alert and cooperative. A Medicare 5-Day Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderate cognitive impairment. The MDS also revealed the resident had not exhibited any behaviors. A progress note dated August 30, 2025 at 4:48 p. m. revealed the residents mental status was alert and cooperative. A progress note dated September 1, 2025 at 10:59 p.m. revealed the residents mental status was alert and cooperative. A physician progress note dated September 2, 2025 at 10:02 a.m. revealed that the resident's mental status was drowsy and her cognition indicated she was able to follow simple commands with increased processing time to answer questions. A late-entry progress note dated September 2, 2025 at 6 p.m. was written on September 5, 2025 at 8:04 a.m. and revealed that the Director of Nursing (DON/Staff#45) spoke with the resident and daughter at bedside concerning care plan and care concerns. The note further revealed that the resident could not answer orientation questions and appeared confused, but the DON would continue to monitor the resident for safety. A grievance filed on September 2, 2025 revealed a grievance regarding a care issue - male Certified Nursing Assistant (CNA) for Resident #11. The grievance further revealed that the issue took place on September 1, 2025 and parties were informed of findings on September 3, 2025 with a resolution to not have male CNA's for personal care. The grievance log also revealed two additional separate care concerns for other residents regarding CNA - Female Preference in July of 2025. A progress note dated September 3, 2025 at 4:09 p.m. revealed that the resident was alert but nonverbal and not responding to questions while avoiding eye contact. A care plan focus initiated on September 3, 2025 revealed that the resident had personally experienced and been traumatized by sexual assault with interventions to only have female care givers for all personal cares and to consult trauma informed care portion of the admission observation to identify trauma and stress related issues for the resident. An order was initiated on September 3, 2025 for sertraline tablets; 50 mg amounting to 100 mg once a day for depression as evidenced by social isolation. Review of the State Agency complaint tracking system revealed that the facility submitted a self-report for Resident #11's allegation of staff-to-resident sexual abuse on September 4, 2025 at 12:29 p.m The self-report revealed an allegation of sexual abuse with no evidence that law enforcement or APS had been contacted or reported to. A progress note dated September 4, 2025 at 3:50 p.m. revealed the residents mental status was restless, agitated, and uncooperative. A late-entry progress note dated September 5, 2025 at 12 p.m. was written on September 7, 2025 at 6:58 p.m. and revealed that the patient was confused and paranoid during care and attempted to hit female staff while performing peri care. An order was initiated on September 7, 2025 for lorazepam - schedule IV tablet; 0.5 mg as needed for anxiety as evidenced by restlessness. There was no evidence in the clinical record of an allegation of sexual abuse. A call was made by the State Agency (SA) to non-emergency law enforcement on September 17, 2025 at 10:09 a.m. to report the allegation of sexual abuse. An interview was conducted on September 17, 2025 at 11:12 a.m. with a CNA, Staff#21, who stated that the timeframe for reporting an allegation of abuse was 24 hours, but ideally, as soon as possible. The CNA stated that it was important to report sexual abuse right away to the administrator or DON to get the information going to figure out what happened to the resident and to keep residents safe. An interview was conducted on September 17, 2025 at 11:21 a.m. with a Registered Nurse (RN/Staff#56), who stated that the timeframe for reporting was immediately as the allegation was brought to her, but within one to two hours to the DON or administrator. The RN defined sexual abuse as unwanted physical contact or emotional perturbation, and any sexual abuse allegation would absolutely need to be reported. The RN stated that it was important to report allegations of sexual abuse to manage resident safety and ensure residents are not in harmful situations. An interview was conducted on September 17, 2025 at

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review, the facility failed to ensure that an allegation involving sexual abuse was documented completely and accurately in the clinical record for one resident (#11). The deficient practice could result in incomplete or inaccurate documentation in resident medical records and violation of resident rights to be free from abuse.Findings include: Resident #11 was admitted on [DATE] with diagnoses that included traumatic subdural hemorrhage, acute kidney failure, atherosclerotic heart disease, hyperlipidemia, paroxysmal atrial fibrillation, hypothyroidism, iron deficiency anemia, atrial septal defect, hormone replacement therapy, combined rheumatic disorders of mitral, aortic, and tricuspid valves. A Medicare 5-Day Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderate cognitive impairment. The MDS also revealed the resident had not exhibited any behaviors. A late-entry progress note dated September 2, 2025 at 6 p.m. was written on September 5, 2025 at 8:04 a.m. and revealed that the Director of Nursing (DON/Staff#45) spoke with the resident and daughter at bedside concerning care plan and care concerns. The note further revealed that the resident could not answer orientation questions and appeared confused, but the DON would continue to monitor the resident for safety. A grievance filed on September 2, 2025 revealed a grievance regarding a care issue - male Certified Nursing Assistant (CNA) for Resident #11. The grievance further revealed that the issue took place on September 1, 2025 and parties were informed of findings on September 3, 2025 with a resolution to not have male CNA's for personal care. The grievance log also revealed two additional separate care concerns regarding CNA - Female Preference in July of 2025. A care plan focus initiated on September 3, 2025 revealed that the resident had personally experienced and been traumatized by sexual assault with interventions to only have female care givers for all personal cares and to consult trauma informed care portion of the admission observation to identify trauma and stress related issues for the resident. There was no evidence in the clinical record of an allegation of sexual abuse. An interview was conducted on September 17, 2025 at 11:21 a.m. with a Registered Nurse (RN/Staff#56), who stated that she would be required to document an allegation of abuse in the clinical record as per the facility policy. The RN further stated that she would use a progress note to document how she protected the patient, that she checked their vitals and potential injuries, the nature of the allegation, and whether or not the resident felt safe. The RN stated that the potential risk if an allegation of abuse wasn't documented in the clinical record could be that staff would be unaware that an incident occurred, something could get missed in the investigation, and they might fail to follow the correct protocols for the safety of the patient. An interview was conducted on September 17, 2025 at 11:32 a.m. with an RN, Staff #60, who stated that she would be required to document an allegation of abuse in the clinical record in the progress notes as per the facility policy. The RN further stated that the progress note would detail what the allegation was, what they did about it, how they ensured the patient was safe, who was notified, and the basic important details. The RN stated that the potential risk if an allegation of abuse wasn't documented in the clinical record could be that staff wouldn't be able to be aware of the situation to protect and care for the patient appropriately, and they would know to look for certain behavior changes or risks. The RN stated that the allegation of sexual abuse from Resident #11 was reported to her and that she did not complete any documentation of the incident in the clinical record and she was just doing what they told her to do. An interview was conducted on September 17, 2025 at approximately 11:45 a.m. with the DON, Staff #45, who stated that it was her expectation of nursing staff to document allegations of abuse, including sexual abuse, in the clinical record so they can have a trail of what they did around the situation and to establish what occurred so they can prevent future situations. The DON further stated that nursing staff needed to document allegations of abuse in the clinical record under progress notes for the safety of the patient, and the note would need to include the direct quote from the patient and a summary of what the patient reported. The DON also stated that if an allegation of abuse was not documented in the clinical record there would be potential risk that they would not be able to monitor the situation closely enough. The DON stated that there was no documentation in the clinical record of Resident #11 regarding the allegation of sexual abuse. Review of a policy titled, Charting Requirements, was updated in June of 2024 and revealed that any incident would be charted on and addressed in the medical record every shift for 72 hours after onset and then daily until resolved. Review of a policy titled, Change in Patient Condition, was updated in July of 2023 and revealed that the nurse supervisor or charge