STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035286	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sante of North Scottsdale	17490 North 93rd Street Scottsdale, AZ 85255

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581 Based on documentation, staff and resident interviews, and the facility policy and procedures, the facility failed to ensure that resident (#22) was given a safe place to store valuable personal belongings and personal/medical information for safe keeping in her room to prevent personal property from being misappropriated. The deficient practice could result in residents' property being misappropriated. Findings include: Resident #22 was admitted to the facility on [DATE] with diagnoses that included periprosthetic fracture around internal prosthetic left hip joint, fall on the same level, Parkinson's Disease, and dementia. The inventory of personal effects dated November 23, 2024 revealed: one black purse, one brown wallet, one credit card, two forms of identification (ID), #53.00, and a medical card. The form was signed by a certified nursing assistant (CNA/staff #15). The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 15 indicating the resident was cognitively intact. The care plan dated December 24, 2024 revealed the resident has a impaired cognitive function/dementia or impaired thought process. Interventions included for staff to use approaches that maximize involvement in daily decision making and activity (specify: limit choices, use cueing, task segmentation, written lists, instructions). Review of the Comment and Concern Form dated November 25, 2024 at 9:30 a.m. revealed that the resident reported that her wallet was missing. The Property Response and Investigation Form dated November 25, 2024 at 9:45 a.m. revealed that after completing a thorough search of the resident's room with the resident, the wallet was not located. (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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nurse practitioner (NP) note dated November 25, 2024 revealed that the resident was was referred for an evaluation of mental status. The resident is a [AGE] year old female, appears stated age, alert and oriented times three, with good eye contact. The resident reported a possible visual hallucination (VH) of seeing someone stealing her ID and cards from her wallet. The resident reports being unsure if this was a VH or if someone actually stole from her. The resident states seeing this the other night. Documentation of a letter dated November 29, 2024 by the Administrator in Training (AIT/staff #3) revealed that the facility was not able to locate the resident's wallet with $53.00 and the resident's identification. The resident's room and personal belongings were searched with the resident present and the wallet was not located. An interview was conducted on December 4, 2024 at 10:27 a.m. with the Senior [NAME] President of Clinical Operations and Compliance, who is currently the Acting Administrator (staff #1). She stated that the staff who completes the admission process with the resident also, completes the inventory of personal effects form and talks about the lock box, where valuables can be stored, in the resident's room with the resident. If the resident wants to use the lock box, the resident can request a key. On December 4, 2024 at 11:30 a.m., resident (#22) was interviewed. She stated that when she was admitted to the facility, she had her purse with a wallet. She stated that she put her purse with her wallet in the top side table drawer next to the bed and the wallet was gone from her purse the next morning. She stated that there was $150.00, a credit card, insurance card, and her Social Security card in the wallet. It was observed that the resident still had a black purse and it was empty. She stated that she was more upset about her identity being stolen than the money. She stated that she thinks she remembers a women going through her belongings and completing an inventory list, but the woman never told her about a safe or a key to lock to the bedside table drawer. There was no key observed in the lock of the bedside table drawer and she stated that there was never a key to the drawer. She stated that the facility gave her daughter $50.00 for the money that was missing. She stated that she thinks that she saw a man by her room door during the night, but she may have been dreaming. An interview was conducted on December 4, 2024 at 11:54 a.m. with (CNA/staff #7), who stated that the Admission Checklist form is reviewed and completed when a resident is being admitted to the facility. It was observed that the checklist included to unpack the resident's possessions and place appropriately in the room, and if valuables are noted, inform the nurse. Staff #7 also stated that the CNA usually completes the inventory of personal effects form with the resident and typically identifies the belongings in the purse and the wallet. She stated that ID cards, debit cards, and social security cards should be documented on the inventory form. Staff #7 stated that sometimes she offers a key to the bedside table drawer to secure valuable belongings and if a family member is present she tells the resident that the family may want to take valuable belongings home. Then she stated that she does advise the resident to lock up personal information, money, and credit cards in the bedside table drawer and if the resident refuses to lock up valuables, she probably should document the refusal, but usually just tells the nurse. She stated that the resident can: lock valuables in the bedside table drawer, store in the locked medication cart, or keep in the facility safe. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on December 4, 2024 at 12:08 p.m. with a licensed practical nurse (LPN/staff #10), who stated that when a resident has valuable personal property, he asks the resident if he or she wants to keep the items, lock in the medication cart, or give the items to family to take home. He stated that if the resident is not oriented, he contacts the family about the valuables. He stated that the above should be documented in a progress note. On December 4, 2024 at 1:43 p.m. it was observed that five out of ten rooms did not have keys in the bedside table drawers. The (CNA/staff #68) stated that the keys are usually in the locks of the bedside table drawer and she did not know where the keys had gone. The (CNA/staff #7) joined the interview and stated that if the key is missing from the bedside table drawer, staff has to report it to the Guest Services Director, so she can have maintenance replace the key; she stated that the keys are not always in the rooms. An interview was conducted on December 4, 2024 at 2:10 p.m. with the Guest Services Director (staff #79), who stated that when staff report a key is missing from the bedside table drawer, she contacts maintenance to make a new one. She does not know what staff do on Sunday and Monday because she doesn't work on those days, but residents can store valuable belongings in the facility safe or in the medication cart until a family member can pick it up. An interview was conducted on December 4, 2024 at 2:24 p.m. with the Maintenance Director (staff #104), who stated that if resident's don't ask for a key for the bed side table, they don't give them one and keys go missing all the time. During a second interview conducted on December 4, 2024 at 2:36 p.m. with the Senior [NAME] President of Clinical Operations and Compliance, who is currently the Acting Administrator (staff #1). She stated that the inventory of personal effects form dated November 23, 2024 was signed by (CNA/staff #15), who worked from 6:00 p.m. to 6:30 a.m. on November 23, 2024. During the interview, staff #1 stated that the licensed practical nurse (LPN/staff #39) worked on November 23, 2024 and completed the resident's skin assessment at 4:02 p.m., but there was no documentation regarding the resident's personal belongings in staff #39's progress notes. She also stated that the registered nurse (RN/staff #57) worked the noc shift on November 23, 2024 and there was no mention of the resident's personal belongings in her progress notes. An interview was conducted on December 4, 2024 at 3:50 p.m. with the (CNA/staff #15), who stated that she completed the inventory of personal effects form with the resident, which included going through the resident's purse and wallet with the resident and documenting the items on the inventory form. She stated that she tells the nurse when money, credit cards, and personal information needs to be locked up, but if the resident doesn't want the items locked up, she doesn't tell the nurse because that is the resident's right to keep his or her valuable belongings. She stated that she never looked to see if there was a key in the bedside table drawer, but there usually is a key, and never asked the resident if she wanted a key to lock up her personal belongings. She stated that after she put everything back into the wallet, she put the resident's wallet into the purse and left the room. She then stated that she told the charge nurse that the resident had a purse and wallet, but doesn't remember if she told her that the resident had money, credit cards, or medical information. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on December 5, 2024 at 9:04 a.m. with a licensed practical nurse (LPN/staff #24), who stated that she has worked as the charge nurse on November 23, 2024 during the noc shift. She stated that it is her expectation that the CNA goes over the resident's personal belongings with the resident in the resident's room, completes the inventory form, and both are supposed to sign and date the form. She stated that the CNA is supposed to inform the resident that valuables can be locked up in the medication cart, contact the family to pick up the valuables, or lock the valuables in the bedside table drawer. She was not sure if the key to the bedside table drawer is always in the lock or left in the room, and staff should ask the nurse if a key is not present. She stated that the CNA should report to her if the resident wants to keep her valuable personal belongings, so she can go over the options for safe storage with the resident. Staff #24 stated that she knows the resident and the CNA did not tell her that the resident wanted to keep valuable personal belongings. She reiterated that the conversation between her and (CNA/staff #15) never took place. She stated that the resident was not admitted during her shift and she was not aware that (CNA/staff #15) completed the inventory of personal effects form with the resident during her shift. She also stated that if the resident's belongings are gone, she considers this misappropriation. An interview was conducted on December 5, 2024 at 9:45 a.m. with the Administrator in Training (AIT/staff #3), who stated that resident #22 told him that her wallet was in her purse on the table. Staff #3 found the resident's purse hanging on the bedside table, but did not locate the wallet. He stated that he searched the room, including the trash, and had the laundry room searched, but did not locate the wallet. Then he called the police because it could have been theft to report a missing wallet, but he did not believe the wallet was stolen. He stated that the CNA is supposed to complete the inventory of personal effects form with the resident in the resident's room and if there are things of value that the resident wants to keep, the CNA should offer the resident a key to the bed side drawer, so the valuables can be locked up, or have the family come to pick the items up. He stated that if there is no key, the CNA should notify maintenance to get a key and maintenance is available on weekends. The CNA should also report that the resident has valubles in the room to the nurse and the nurse should document this information, follow up with the resident, and should encourage the resident to lock up the valuables in the room. He stated that if the CNA never checked for a key or offered a key to lock valuables in the bed side drawer, it created a risk for misappropriation. The facility policy, Admitting the Resident: Role of the Nursing Assistant states to give the original copy of the Inventory of Personnel Effects Record to the nurse supervisor. Encourage the resident to not keep any valuables with them. Valuables can be given to their family member or individual of choice. If they prefer to keep the valuables in their possession, offer the locked drawer in the resident's room and obtain the key from the housekeeper supervisor. The facility policy, Abuse Prevention Program states that the facility will develop and implement policies and procedures to aid the facility in preventing abuse, neglect, or mistreatment of the residents.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581 Based on documentation, staff and resident interviews, and the facility policy and procedures, the facility failed to complete a thorough investigation regarding an allegation of misappropriation for one resident (#22). The deficient practice could result in the misappropriation of the residents' property. Finding include: Resident #22 was admitted to the facility on [DATE] with diagnoses that included periprosthetic fracture around internal prosthetic left hip joint, fall on the same level, Parkinson's Disease, and dementia. The inventory of personal effects dated November 23, 2024 revealed: one black purse, one brown wallet, one credit card, two forms of identification (ID), #53.00, and a medical card. The form was signed by a certified nursing assistant (CNA/staff #15). Review of the schedule dated November 24, 2025, revealed the following staff worked the noc shift from 6:00 p.m. to 6:30 a.m.: -licensed practical nurse (LPN/staff #82) -certified nursing assistant (CNA/staff #15) was assigned to rooms #200 to #205 and #219 to #225 -(CNA/staff #90) was assigned to rooms #206 to #218 Review of the time card from November 24, 2024 through November 30, 2024 for (LPN/staff #82) revealed that staff worked: -November 24, 2024 from 7:26 p.m. to 6:31 a.m. -November 25, 2024 from 6:08 p.m. to 6:32 a.m. -November 26, 2024 from 6:24 p.m. to 7:44 a.m. -November 29, 2024 from 6:08 p.m. to 6:46 a.m. Review of the time card from November 23, 2024 through November 30, 2024 for (CNA/staff #15) revealed that staff worked: -November 23, 2024 from 6:13 p.m. to 6:36 a.m. -November 24, 2024 from 6:08 p.m. to 6:35 a.m. Review of the time card from November 23, 2024 through November 30, 2024 for (CNA/staff #90) revealed that staff worked: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-November 23, 2024 from 5:55 p.m. to 6:14 a.m. -November 24, 2024 from 5:54 p.m. to 6:26 a.m. -November 26, 2024 from 6:13 p.m. to 6:05 a.m. -November 28, 2024 from 5:59 p.m. to 6:00 a.m. Review of the schedule dated November 25, 2025, revealed the following staff worked the day shift from 6:00 a.m. to 6:30 p.m.: -LPN/staff #10) -(LPN/staff #94) -(LPN/staff #117) -(CNA/staff #99) was assigned to the 200 hall -CNA/staff #118) was assigned to the 200 hall -(CNA/staff #205) was assigned to the 200 hall Review of the Comment and Concern Form dated November 25, 2024 at 9:30 a.m. revealed that resident #22 reported that her wallet was missing. The Property Response and Investigation Form dated November 25, 2024 at 9:45 a.m. revealed that after completing a thorough search of the resident's room, #204, with the resident, the wallet was not located. Review of the 5-day investigation revealed that Administrator in Training (AIT/staff #3) was notified on November 25, 2024 at 9:30 a.m. that resident #22 was unable to locate her wallet with $53.00 and her identification (ID) the previous day. Immediately after receiving the notification, he went to the resident's room and searched the room, including her personal belongings with the resident present. He was unable to locate the wallet and started his investigation. CNAs and nurses involved in care and was unable to determine a staff member as the perpetrator due to a lack of evidence. The investigation included interviews with a licensed practical nurse (LPN/staff #10), (LPN/staff #94), and (LPN/staff #117). The investigation did not reveal any CNA interviews or any staff interviews from the noc shift on November 24, 2024 even though the resident reported not seeing the wallet since the day prior. During a second interview conducted on December 4, 2024 at 2:36 p.m. with the Senior [NAME] President of Clinical Operations and Compliance, who is currently the Acting Administrator (staff #1). She stated that the inventory of personal effects form dated November 23, 2024 was signed by (CNA/staff #15), who worked from 6:00 p.m. to 6:30 a.m. on November 23, 2024. She also stated that the registered nurse (RN/staff #57) worked the noc shift on November 23, 2024. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Note that the 5-day investigation did not reveal staff interviews for (CNA/staff #15) or (RN/staff #57). An interview was conducted on December 5, 2024 at 9:45 a.m. with the Administrator in Training (AIT/staff #3), who stated that he was in charge of the investigation. He stated that resident #22 told him that her wallet was in her purse on the table. Staff #3 found the resident's purse hanging on the bedside table, but the wallet was not there. He stated that he searched the room, including the trash, and had the laundry room searched, but did not locate the wallet with the contents. Then he called the police because it could have been theft, to report the missing wallet, but he did not believe that it was theft. He stated that he interviewed residents and staff that worked on the prior shift. During the interview, the staff schedule dated November 24, 2024 was reviewed and staff #3 stated that (LPN/staff #82), (CNA/staff #15), and (CNA/staff #90) were assigned to the resident's hall on November 24, 2025 from 6:00 p.m. to 6:30 a.m. (Note that review of the 5-day investigation did not reveal interviews for LPN/staff #82), (CNA/staff #15), and (CNA/staff #90).) Then staff #3 stated that during the investigation, he was only looking at all the staff that worked on the noc shift on November 23, 2024 even though the wallet with the contents was not reported missing until November 25, 2024. Staff #3 confirmed that (CNA/staff #15) worked the noc shift on November 23, 2024 and November 24, 2024 and staff #15 had been the CNA who completed the inventory sheet in the room with the resident on November 23, 2024. He stated that it took him five days to complete the investigation and (LPN/staff #82), (CNA/staff #15), and (CNA/staff #90) weren't suspended during the investigation. He stated that he contacted the Administrator for sister facility and asked if the above staff should be suspended pending the investigation and was told that it was not necessary. Then staff #3 stated that he was not in charge of the investigation and the Director of Nursing was in charge and the DON told him that that the above staff didn't need to be suspended pending the investigation. He stated that he didn't think the staff should be suspended pending the investigation because the resident stated that the wallet could have fallen in the trash or on the floor, but did not document the interview with the resident. Then staff #3 stated that number 3 on the 5-day investigation was the resident's statement, which stated that, The Administrator-in-Training (AIT) met with the resident to discuss the incident, the room was searched with the resident and nothing was found. The inventory sheet was referencced and the wallet was mentioned. Note that an interview for (CNA/staff #90) and (CNA/staff #15) was not included in the 5-day investigation. (RN/staff #57) was from an agency and the facility was not able to contact her for an interview. The facility policy, Abuse Prevention Program states that the facility will investigate and report any allegations of abuse within the timeframes as required by federal requirements and protect residents during abuse investigations.