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	05/14/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident representative and staff interviews, and policy review, the facility failed to ensure that an incident involving staff to resident abuse was documented completely in the clinical record for 1 of 3 sampled residents (#14). The deficient practice could result in incomplete documentation in resident medical records and continued abuse. Findings include: Resident #14 was admitted to the facility on [DATE] with diagnoses that included entercolitis due to clostridium difficile, fracture of the left ulna, fracture of nasal bones, fracture of the left radius, anxiety, female genital prolapse, major depressive disorder, vaginal enterocele, and dysphagia. An admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderate cognitive impairment. Review of the facility investigation dated April 30, 2025 revealed that at 3:45 p.m. on April 30, 2025, an Occupational Therapist (OT/Staff#127) reported to the Director of Nursing (DON/Staff#30) that a male Certified Nursing Assistant (CNA/Staff#72) frightened Resident #14 on the previous night and removed her brief while threatening not to change her if she did not stop yelling. The investigation revealed that the resident was upset and reported to the facility that she called her son on the night April 29, 2025 following the incident. The investigation further revealed that the facility suspended the CNA pending the investigation, and the social worker interviewed the resident who further stated that the CNA told her he was sick of her, he said who do you think you are?, and the resident alleged that he left her naked in a dark room. The investigation revealed that the facility called the family and they came to the facility to speak with the social worker and the resident further stated that the CNA told her I hate you, you are so stupid, and I am not going to take care of you anymore. The investigation revealed that the Abuse Coordinator and Executive Director (ED/Staff#110) interviewed the CNA who told her that the resident began yelling on April 29, 2025 around 9:00 p.m. and expressed frustration about the door being closed, the resident called the CNA a name, she said she would report him, and the CNA educated the resident on using her call light for future needs. The investigation revealed that the CNA documented multiple care interactions throughout the shift including deescalation efforts. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035143	A. Building B. Wing	05/14/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An allegation of staff to resident abuse that occurred on April 30, 2025 was investigated by the facility on April 30, 2025. However, review of the resident ' s clinical record dated April 10, 2025 to May 14, 2025 revealed no evidence or documentation of the incident occurring. An interview was conducted on May 14, 2025 at 10:40 a.m. with Resident #14 ' s family member who stated that they talked to the resident on April 29, 2025 around 9:30 p.m. and again on April 30, 2025 at 12:45 a.m. regarding her being left in the dark and asking the family to call the facility. The resident ' s family stated that they made several calls to the facility on April 29, 2025 and the final calls were from 8:47 p.m. until 8:52 p.m An interview was conducted on May 14, 2025 at 11:16 a.m. with a CNA, Staff #72, who stated that on the night of April 29, 2025 between 8-10 p.m. he went into Resident #14 ' s room to answer her call light and she requested to have a brief change. The CNA further stated that the resident said something mean to him and he told her he did not feel like he deserved it. The CNA stated that the resident told him to just do your job already, he tried to explain to her that he treated residents with respect, he wanted respect from her, and the resident stated she was going to report him. The CNA stated that he told the resident you ' re angry and yelling, I am going to be right back, he covered her up, and told her that she could report him if she needed to. The CNA stated that he did not raise his voice, yell at the resident, close the door, or remove her brief during the 1-minute interaction. The CNA stated that he left the room and notified the unit nurse, who he could not remember the name of, and explained he would return in five minutes to help the resident. An interview was conducted on May 14, 2025 at 11:42 a.m. with a Registered Nurse (RN/Staff#56) who stated that allegations of abuse needed to be documented in the clinical record under progress notes and risk management as per the facility policy. The RN stated that progress notes needed to include what happened, a statement from the patient, who the perpetrator was if applicable, the nature of the abuse, and the status of the patient. The RN further stated that a resident being yelled at by a staff member, or a threat to not change a resident ' s brief because of their behavior would without a doubt be considered abuse, and should be documented. An interview was conducted on May 14, 2025 at 12:50 p.m. with an RN, Staff #40, who stated that allegations of abuse would need to be documented in the progress notes. The RN stated that the progress notes would include the details of the allegation, including any updates or changes as per the facility policy. The RN stated that the risk of allegations not being documented in the clinical record could be that the facility would fail to address the issue, which would be a big problem in protecting the resident. An interview was conducted on May 14, 2025 at 1:43 p.m. with the DON, Staff#30, who stated that an allegation of abuse would be documented by the nurse in a progress note under an incident note as per the facility policy. The DON stated that the risk of not documenting an allegation of abuse in the clinical record would be that the staff who failed to document would be fired because they did not document a liability for a patient's life and for the facility. An interview was conducted on May 14, 2025 at 1:54 p.m. with the ED, Staff #110, who stated that if the allegation could have a psychosocial impact she would expect staff to do a progress note including the allegation or concerns, and who the staff reported to. The ED stated that the risk of not documenting an allegation of abuse in the clinical record would be that they might not report it, or they could forget to report it. (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	05/14/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a policy titled, Nursing Documentation, was revised on September 5, 2024 and revealed that the facility would ensure that nursing documentation was consistent with professional standards of practice. The policy also revealed that the medical record should reflect the resident's progress toward achieving their person-centered plan of care objectives and goals. The policy revealed that staff must document a resident ' s medical and non-medical status when any positive or negative condition change occurred, and the resident record must reflect the resident ' s condition and care and services provided across all disciplines to ensure information was available to facilitate communication among the interdisciplinary team. The policy further revealed that the medical record must contain an accurate representation of the actual experience of the resident and include enough information to provide a picture of the residents progress, including their response to treatment and services and changes in their condition, plan of care goals, objectives, and interventions. Review of a policy titled, Abuse - Conducting an Investigation, was issued on October 4, 2022 and revealed that the facility must thoroughly collect evidence to allow the Administrator to determine what actions were necessary to protect residents, and the investigation was expected to include, but was not limited to, record review for pertinent information regarding the alleged violations such as progress notes from nursing, social services, physicians, therapists, or consultants.