

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  035105	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/13/2024
NAME OF PROVIDER OR SUPPLIER  Shea Post Acute Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  11150 North 92nd Street 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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49199</p> <p>Based on clinical record review, facility documentation, policy review and interviews, the facility failed to ensure two residents (#71 and #51) were free from abuse from other residents ( #263 AND #261).</p> <p>The deficient practice could result in residents suffering from psychosocial harm.</p> <p>Findings include:</p> <p>Regarding Resident #51 and #261:</p> <p>- Regarding Resident #51:</p> <p>Resident #51 was admitted to the facility on [DATE] with a diagnosis of schizophrenia, anxiety disorder, cognitive functions, traumatic brain injury and bipolar disorder.</p> <p>A review of the residents current MDS (Minimum Data Set) dated August 29, 2024, revealed a BIMS (Brief Interview of Mental Status) score of 00, which indicates severe cognitive impairment.</p> <p>- Regarding Resident #261:</p> <p>Resident #261 was admitted to the facility on [DATE] with a diagnosis of atrial fibrillation and major depressive disorder.</p> <p>A review of the residents current MDS, dated [DATE], revealed a BIMS score of 14, which indicates no cognitive impairment.</p> <p>A facility reported incident was reported to the state agency claiming a staff member had witnessed an inappropriate interaction between two residents. The report stated that resident #261's hand was on the left thigh, under the shorts of resident #51.</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 035105
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on December 11, 2024 at 11:22 AM with staff member #42. She stated that on Thursday, February 29, 2024 at approximately 12:00 PM she was walking down the hall looking around, walking past the day room where she saw resident #261 with his hand on resident #51's left thigh but it was under resident #51's shorts. She stated she stopped and was shocked at what she saw, and as soon as resident #261 realized staff #42 saw it, he immediately removed his hand from under resident #51's shorts. She stated she separated them and went to the DON (Director of Nursing) and the ED (Executive Director) and told them what she saw.</p> <p>Review of a physician's progress note dated February 29, 2024 at 12:55 PM stated Staff reported that the patient was found resting his hand on another resident's thigh recently. When asked about this, the patient states that he placed his hand on his thigh but did not touch any other areas of the patient's body. Staff made the DON aware who reported this incident. Both the DON and I had a lengthy conversation with the patient regarding inappropriate behaviors to include touching someone on their thigh without consent and the patient understands and states that he will not do this again. The patient appears apologetic for his actions.</p> <p>An interview was conducted on December 12, 2024 at 8:54 AM with Social Services Director (staff #163). She stated that resident #261 said he was only trying to comfort resident #51 because he was trembling. She stated even though his hand was under his shorts, he claimed he was only trying to comfort him. When she asked why resident #261 was discharged to another facility on March 7, 2024, staff #163 stated that it was a direct result of the incident.</p> <p>Regarding Resident #71 and Resident # 263:</p> <p>- Regarding Resident #71:</p> <p>Resident #71 was admitted to the facility on [DATE] with a diagnosis of rheumatoid arthritis, major depressive disorder, mood disorder, anxiety disorder and cognitive communication disorder.</p> <p>A progress note dated March 13, 2024 stated that resident #71 was involved in an altercation with a male resident on 3/12/2024. The note stated resident #71 accused the male resident of purposely bumping into the back of her right knee with his manual wheelchair after exchanging words. The note further included that resident #71 expressed concern regarding the male residents' actions and has been placed on 72 hour change of condition monitoring. The note stated on March 13, 2024 resident #71 was showing no signs of distress or anxiety and verbalized satisfaction with the outcome following the investigation into the altercation.</p> <p>A review of the most recent MDS dated [DATE] revealed a BIMS score of 11, which indicates moderate cognitive impairment.</p> <p>- Regarding Resident #263:</p> <p>Resident # 263 was admitted to the facility on [DATE] with a diagnosis of aftercare following a surgical amputation, cerebral infarction and aphasia.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the most recent MDS dated [DATE] revealed a BIMS score of 14, which indicates no cognitive impairment.</p> <p>Review of documentation for resident #263 revealed he was verbally abusive toward staff, especially female staff.</p> <p>A progress note dated March 6, 2024 for resident #263 stated that When CNA (Certified Nursing Assistant) came back resident was rude and told her she took to long and didn't want her to help. The note included that another CNA tried to assist resident and resident had stated that women didn't know anything and told her to leave. The note stated the CNA stayed outside door of shower room to monitor for safety and when a male CNA came to assist, resident stated, get them bitches out of here. The note stated the male CNA took over assisting resident.</p> <p>Review of progress note dated March 13, 2024 stated that resident was involved in altercation with female resident where the resident #71 accused resident #263 of purposely bumping her in the back of her right knee with his manual wheelchair after exchanging words. The note stated resident #71 expressed concern regarding resident #263's actions. With resident #263's consent, the note stated the facility sought alternate placement for him to support his psychosocial wellbeing as well as to support the psychosocial wellbeing of other residents.</p> <p>Review of the facility's five-day investigation of this incident, the report states It is acknowledged that there may have been an altercation or disagreement between two cognitively capable adults without eyewitnesses. Consequently, educational initiatives will be implemented for both staff and residents to promote appropriate behavior and mutual respect between residents within the facility.</p> <p>The facility's policy, Freedom From Abuse, Neglect, Exploitation, dated April 2019 with the latest revision on September 2024, statesIt is the policy of this Facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. Residents also have the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. Abuse is willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.</p>		