

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  035217	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/06/2024
NAME OF PROVIDER OR SUPPLIER  Rehab at Scottsdale Village Square		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<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> 48932</p> <p>Based on facility documentation, staff interviews, and review of facility policy and procedures, the facility failed to ensure one resident (#1) was not abused by another resident (#2) The deficient practice could result in residents being physically and psychologically harmed.</p> <p>Findings include:</p> <p>Regarding resident #1:</p> <p>Resident #1 was admitted to the facility on [DATE] with diagnoses of Dementia, Post Traumatic Stress Disorder (PTSD), and Adjustment Disorder with Mixed Disturbance of Emotions and Conduct.</p> <p>The annual Minimum Data Set (MDS) dated , January 22, 2024 revealed that the resident was not able to complete the Brief Interview for Mental Status (BIMS). However, staff were able to complete the Staff Assessment for Mental Status and it was determined that resident #1 had both short-term and long-term memory problems. The assessment also indicated the resident's Cognitive Skills for Daily Decision making was moderately impaired.</p> <p>Regarding resident #2:</p> <p>Resident #2 was admitted to the facility on [DATE] with diagnoses of Dementia, PTSD, and Major Depressive Disorder.</p> <p>The quarterly MDS dated , January 2, 2024 revealed resident #2 had a BIMS score of 03 which indicated the resident was severely cognitively impaired with behaviors.</p> <p>Review of resident #1's progress notes revealed a note dated February 27, 2024 at 8:33 PM. The note indicated resident # 1 was standing outside near a sliding glass door entry way yelling. Resident #2 was standing on the inside of the entry way. Resident #2 then slapped resident #1. The note indicated the nurse and the CNA (Certified Nursing Assistant) then separated the resident and did a skin assessment on resident #2 which revealed no injuries on the resident's face and chest.</p> <p>Review of resident #2's progress notes revealed a psych follow-up note dated February 28, 2024 at 7:00 AM. The provider indicated they assessed the resident and determined the current risk to be low. The note also indicated that a safety plan was not required for the resident.</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
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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>Further review of both resident's progress notes indicated staff continued to monitor each resident's behavior, via 15-minute checks through February 29, 2024.</p> <p>Review of both residents' care plan revealed there were no changes made to the care plan after this incident.</p> <p>Review of both residents' census revealed both residents continued to live in the same unit after the incident.</p> <p>Review of resident #1's progress notes revealed a note dated April 18, 2024 at 7:20 PM. The progress note indicated it was a late entry for an incident that occurred at 10:30 AM that same day. The progress note continues to reveal that resident #1 was yelling at resident #2 as they walked past resident #1. Resident #2 then hits resident #1 with an open hand. The noted stated resident #1 received a superficial scratch to left forehead.</p> <p>A review of resident #2's progress note revealed an Alert Note dated April 18, 2024 at 7:46 PM. The note indicated that a psychological evaluation was ordered due to increased aggression. The noted revealed that the resident #2 was put on 15-minute checks and was moved to another unit for the safety of the other resident.</p> <p>A review of resident #2's care plan revealed it was updated on April 25, 2024 to include triggers that causes some behavior issues. Triggers were identified as loud noises/shouting. Interventions to address those triggers were to move the resident away from the situation and to identify the cause of the trigger and address it to resolve the issue.</p> <p>An interview was conducted on May 6, 2024 with a Licensed Practical Nurse (LPN/Staff #5) at 1:13 PM. Staff #5 indicated they receive training on abuse annually. They also receive refreshers throughout the year during staff meetings. Staff #5 indicated that resident-to-resident abuse does not happen frequently so they remember the incident that took place between resident #1 and #2. Staff #5 pointed out that they were not present during the altercations but remembers being briefed on it. They stated that the residents were getting into altercations so both residents were moved to different units.</p> <p>An interview was conducted on May 6, 2024 at 2:20 PM with the facility administrator (Staff #16). Staff #16 indicated that the MDS coordinator along with the Director of Nursing is responsible to update the care plan. When asked about how the care plan is updated when there is a change in condition, staff #16 indicated they would have to look at the policy since they had only been working at the facility for a month. When asked what would be a reasonable expectation for the updating of the care plan, staff #16 stated in my judgement, as soon as possible but within 72 hours. Staff #16 also was not able to explain why both residents were not separated or placed in different units after the first altercation took place on February 27, 2024.</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>An interview was conducted on May 6, 2024 at 3:00 PM with Social Services (Staff #24). Staff #24 was not able to identify why resident #2's care plan was not updated in February to include interventions to address the physical behaviors of the resident. Staff #24 indicated they were not the primary person investigating the incident as it was the previous Social Services Director who is no longer with the facility. They did state that it was tough to follow-up with both residents because neither of the residents were able to remember either incidents due to their Dementia diagnosis. Staff #24 also indicated that the wife of resident #2 alerted the facility that a possible trigger was yelling and it was when they discovered this information, the care plan was updated to include it.</p>		