

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  07/11/2024
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47911</b></p> <p>Based on a closed record review, staff interviews, review of facility documentation, policy and procedures, the facility failed to ensure that a resident's representative was notified of an injury for one resident (#7). The deficient practice could result in resident representatives not being aware of the resident's injuries.</p> <p>Findings include:</p> <p>Resident #7 was admitted on [DATE] with diagnosis including dementia, hypertension, type 2 diabetes mellitus, post-traumatic stress disorder, atherosclerotic heart disease, hyperlipidemia, dysphagia and a personal history of traumatic brain injury and transient ischemic attacks.</p> <p>A review of the electronic health record revealed progress note entries noting that the resident #7 would wander and take other resident's belongings. It was noted that the resident required frequent redirection. The progress notes further revealed that the resident #7 sustained an injury to his left lower leg on March 19, 2024; however, the progress notes revealed no documentation that family had been notified subsequent to the injury.</p> <p>A review of the MDS (minimum data set) dated June 3, 2024 revealed a BIMS (brief interview of mental status) score of 6, suggesting severe cognitive impairment.</p> <p>An interview was conducted on July 11, 2024 at 9:54 A.M. with the former resident's sister, individual #200. Individual #200 stated that the resident had been injured at the facility and that she had received no notification.</p> <p>An interview was conducted on July 11, 2024 at 10:33 A.M. with a LPN (licensed practical nurse/ staff #152). Staff #152 stated that if a resident sustains an injury residing at the facility, then notifications to the doctor, case manager and family would take place. She stated that per facility guidelines, these notifications are required.</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A telephonic interview was conducted on July 11, 2024 at 10:45 A.M. with another LPN (staff #151). Staff #151 stated that change of condition, falls and injuries would all warrant notifications to the POA (power of attorney), DON (director of nursing), administrator, doctor, social worker and corporate nurse. Staff #151 stated that she was familiar with resident #7 and did not recall any falls associated with this resident. Staff #151 stated that she did recall an injury that resident #7 had incurred on March 19, 2024. She stated that the resident did not hit the ground but had bumped into another resident's wheelchair which resulted in a wound to his lower leg. Staff #151 was unable to recall which leg. She stated that she wasn't sure if the injury to the leg would require notifications to the POA/family. She stated that she is new and did not know whether family should have been notified. She stated that she did not recall if she notified the family of the injury. She stated that she always documents the notifications when they occur; however, the electronic health record revealed no evidence that a notification to the family had occurred.</p> <p>An interview was conducted on July 11, 2024 at 10:51 A.M. with staff #83 (DON/ Director of Nursing). Staff #83 stated that when a resident sustains an injury, the expectation is that family would be notified and that this would be documented in the electronic health record. Staff #83 reviewed the record for resident #7 and was unable to locate any evidence that the family had been notified of the injury that resident #7 sustained. The DON stated that she would further review the record to see if perhaps someone else had conducted the notification to the family. On July 11, 2024 at 12:12 P.M., staff #83 returned and stated that she was unable to find evidence that anyone had contacted the family regarding injury of resident #7. The DON stated that the risk for not notifying the family and documenting the notification could include the family not being aware of what had occurred as well as other staff not being aware that the notification had occurred.</p> <p>A review of the facility policy entitled accidents and incidents-investigating and reporting, revised July 2017 revealed that the nurse supervisor/ charge nurse and or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. The policy further revealed that documentation includes the date and time that the person's family was notified and by whom; however, facility documentation revealed no evidence that the family of resident #7 had been notified for the injury incurred on March 19, 2024.</p>		