STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035217	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehab at Scottsdale Village Square	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)
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** 46606 Based on clinical record review, staff interviews, facility documentation, policies and procedures, the facility failed to ensure that one resident (#650) was free from abuse of another. The deficient practice could result in other residents being abused. Findings include: Resident #650 (alleged victim) was admitted to the facility on [DATE] with diagnoses that included bipolar disorder and mild cognitive impairment. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13 indicating that the resident is cognitively intact. The MDS also indicated that the resident had not exhibited psychosis, behavioral symptoms or wandering behavior during the assessment period. A care plan initiated on July 30, 2024 indicated that the resident is at risk for not meeting emotional, intellectual, physical, and social needs regarding bipolar disorder. Interventions included to ensure that activities resident attends are compatible with physical and mental capabilities, and to introduce resident to other residents with similar background, interests, and facilitate interaction. A care plan initiated on August 15, 2024 identified that the resident is at risk for psychosocial emotional distress related to resident to resident altercation. Interventions included to allow resident to answer question and verbalize feelings, perceptions, and fears; psych consult as needed; and room move to allow resident to be free from triggers. A physician's progress note dated August 8, 2024 documented that resident was transferred here for continued care following an altercation. His only complaint is redness in the rt(right) eye. Furthermore, the note indicated that the resident was involved in a resident-to-resident altercation but does not recall why, denies any pain/abrasions/swelling or concerns. (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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(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	Review of a behavior progress note dated August 8, 2024 documented that resident #650 told resident #625 to shut up while watching television in the day room. The note indicated that this angered resident #625 and led him to attack resident #650. According to the note, a nurse broke up the fight and resident #625 turned his anger on the nurse. The note documented that resident #625 squared up to the nurse, threatening, and spitting. However, the note did indicate that resident #625 was redirected and residents were separated. An interview with resident #650 was conducted on August 21, 2024 at 10:55 a.m. According to the resident, he has been in his current room for about 2-weeks. Resident #650 said that he has not had any issues in the facility. No one is mean or have tried to hurt him. During an interview with a Licensed Practical Nurse (LPN/staff #60) conducted on August 21, 2024 at 11:15 a.m., staff #60 stated that resident #650 transferred to the unit about a week ago. The LPN noted that they are not aware of why the resident was transferred to the unit, but that resident #650 was there when they returned to work. Staff #60 indicated that the transfer to the unit was not medical related. The LPN also stated that resident #650 is forgetful. According to staff #60 you can tell resident #650 something and the resident will quickly forget what was discussed. Resident #625 (alleged perpetrator) was admitted to the facility on [DATE] with diagnosis that included schizoaffective disorder, bipolar, dementia with agitation, and anxiety disorder. A behavior care plan initiated on April 9, 2018 and revised on August 23, 2021 indicated that resident may exhibit verbal aggression, being demanding, and psychotic thinking. Interventions included to administer medications as ordered, attempt to redirect behaviors, monitor resident for significant behavioral and medical changes to ensure proper placement, and psych follow-up as ordered. A care plan initiated on April 12, 2018 indicated that the resident has cognitive/communication deficits related to dementia with behaviors and schizoaffective disorder with delusions. Interventions included anticipate needs, encourage resident to participate in decision making, reality orientation, and verbal cues and reminders. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 4 indicating that the resident has severe cognitive impairment. The MDS also indicated that the resident was negative for psychosis, behavior symptoms, rejection of care, and wandering. A psych follow-up progress note dated August 8, 2024 indicated that the resident was seen for routine psychiatric follow-up. The note indicated a recommendation for a follow-up in 2-weeks. However, the note instructed to reach out sooner with any urgent needs or status change. According to the note, the staff reported that the resident had been irritable, short-tempered, and threatening. Additionally, the note indicated that another resident in the unit has been triggering him. The note documented that at the time of it was written, no physical aggression had been observed from the resident. Review of a physician's progress note dated August 8, 2024 documented that resident was involved in a resident-to-resident altercation. The note stated that the resident could not recall what happened. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A behavior progress note dated August 8, 2024 documented that resident #625 was observed assaulting resident #650. According to the note resident #650 told resident #625 to shut up while watching television in the day room. This angered resident #625 and he attacked resident #650. The note indicated that the nurse broke up the fight. Resident #625 then turned his anger on the nurse. According to the note, resident #625 squared up to the nurse, threatening, and spitting on him. The note also documented that the resident was redirected and both residents were separated. Review of eINTERACT progress note dated August 8 2024 documented that the resident was the physical aggressor in the altercation. The note stated that the resident# 625 did not sustain any injuries nor was he hit. The Primary Care Provider (PCP) Feedback section of the note indicated that the PCP did not have any recommendations, did not order any new testing, and did not order any new interventions. A care plan initiated on August 8, 2024 identified the resident's risk for psychosocial emotional distress regarding the resident to resident altercation. Interventions included psych evaluation as needed and to allow resident to verbalize and express any concerns regarding the incident. Review of a behavior note dated August 9, 2024 documented that resident continues to be demanding and exhibited aggressive tone. The resident was noted to ask multiple questions and argue with staff. The facility investigation report dated August 15, 2024 revealed that on August 8, 2024 residents #650 and #625 were involved in a resident-to-resident altercation. According to the report, resident #625 was in the day room when he became increasingly loud in response to what he was viewing on the television. Resident #650 who was sitting directly behind resident #625, told resident #625 to shut up. Resident #625 turned around in his wheelchair, approached resident #650 and punched resident #650 on the left shoulder. The investigation report concluded that the allegation of resident-to-resident allegation was substantiated. Further review of the facility investigation note dated August 15, 2024 revealed a screenshot of the nurse's text message which stated resident #650 told resident #625 to shut up which led to resident #625 turning around and assaulting resident #650. Additionally, the facility investigation dated August 15, 2024 included witness statements. A statement from a tech aide (staff #200) taken on August 8, 2024 revealed that resident #650 stated shut him up before I kill him referring to resident #625. Resident #650 then yelled at resident #625 to shut up. According to the statement this caused resident #625 to be upset and he ended up shoving/hitting resident #650 on the shoulder. Resident #625 was extremely upset that he tried to fight the nurse that was deescalating the situation. An interview with a Registered Nurse (RN/staff #110) was conducted on August 21, 2024 at 2:31 p.m. According to staff #110 the altercation started verbally due to resident #625 being riled up by what he was watching on the television and was told by resident #650 to shut up. Staff #110 said that this resulted in resident #625 hitting resident #650. The RN noted that there were no injuries to include skin tears on either resident when they were assessed. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Rehab at Scottsdale Village Square		STREET ADDRESS, CITY, STATE, ZIP CODE 2620 North 68th Street Scottsdale, AZ 85257	

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with a Licensed Practical Nurse (LPN/staff #60) conducted on August 21, 2024 at 11:15 a.m., staff #60 stated that the protocol following a resident-to-resident altercation is to ensure the residents are safe. The LPN said that they call the abuse coordinator/administrator to complete the steps for reporting. Staff #60 stated that residents are separated to ensure no contact, and then assessed. The LPN noted that it is the law so abuse allegations/incidents are reported. According to staff #60, any instance of abuse is terrible and leaves residents in fear. Additionally, the LPN said that it creates confusion for residents and leaves a mental impact on the victim. An interview with a Certified Nursing Assistant (CNA/staff #20) was conducted on August 21, 2024 at 12:31 p.m. According to staff #20 the protocol for a resident-to-resident altercation is to separate residents, have the nurse assess, and inform the administrator so the mandatory reporting and notification can be made. The CNA noted that they had heard about an incident involving resident #625. Staff #20 described resident #625 as mostly calm and minded his own business. The CNA said that they do abuse in-service and that they just did one last week. Staff #20 stated that it is important to protect residents from abuse because these people are someone's loved ones and you do not want them to be hurt. Furthermore, resident #20 said that abuse is a crime and no one wants to be around someone who is abusive. If a resident is not protected from abuse it will torment the resident and cause the resident to be scared and hurt. During an interview with the Director of Nursing (DON/staff #120) conducted on August 21, 2024 at 2:38 p.m. , staff #120 stated that the expectation is that staff follow abuse policy and procedures, ensure the safety or residents, and report allegations/incidents of abuse to the abuse coordinator. The DON said that this is important in order to ensure allegations/incidents of abuse are investigated and keep residents safe. Staff #120 noted that residents could suffer from physical or psychosocial distress if they are not protected from abuse. The facility policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program revised April 2021 indicated that resident have the right to be free from abuse. The facility policy titled Abuse and Neglect - Clinical Protocol revised March 2018 indicated that the physician and staff will help identify risk factors for abuse within the facility. Additionally, the policy stated that the facility management and staff will institute measures to address the needs of residents and minimize the possibility of abuse and neglect.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46606 Based on observations, staff interviews, facility documentation, review of the Centers for Disease Control (CDC) recommendations and policies and procedures, the facility failed to ensure infection control standards were followed by failing to ensure that Personal Protective Equipment (PPE) was donned. The deficient practice could result in the spread of infection, including COVID-19 to residents and staff. Findings include: Review of the COVID+ Residents facility bulletin board on the electronic record dashboard indicated that there were 12 residents that were COVID positive. The notice was posted on August 7, 2024 and listed the names of the residents and the date they tested positive. During sign-in at the front desk on August 19, 2024 at 10:56 a.m., an orange sign posted on the wall was observed. The sign read Attention! COVID-19 OUTBREAK. All visitors and staff are required to sign in at the kiosk located by the Reception Desk. All Staff are required to wear CDC recommended PPE including N95 Masks while in the Facility. However, during sign-in, the Concierge (staff #80) at the front desk was observed not wearing a mask. Furthermore, when the Concierge (staff #80) was asked if there is COVID, staff #80 noted that it was just on the East side of the facility so no mask needed inside the facility. Additionally, there were individuals in the reception area and hallway that were observed not wearing a mask. An entrance conference with the Director of Nursing (DON/staff #120) and Administrator (staff #215) was conducted on August 19, 2024 at 11:11 a.m., the DON noted that personnel and guests entering the resident area will have to wear a mask. However, the Administrator (staff#215) stated that the resident are out of isolation. During the entrance conducted on August 19, 2024 at 11:11, both the Administrator and the DON were observed entering the conference room with masks on. However, both of them took it off during the conference. During re-entry into the facility on [DATE] at 8:50 a.m., the concierge was observed not wearing a mask. Signs stating COVID outbreak were present. However, guest, residents at the reception area were not wearing masks. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Concierge (staff #80) was conducted on August 21, 2024 at 10:40 a.m. Staff #80 noted that her job entails greeting people when they enter the facility, answering questions over the phone, transferring calls, and letting guests know if there is an outbreak in the unit and the specific unit. The Concierge stated that she offers masks. Staff #80 stated that the COVID outbreak sign has been up for about 2-weeks. The Concierge stated that staff have to wear mask on the skill side but not on the assisted living side. Staff #80 noted that as soon as staff enters the facility they have to wear a mask and that includes her. When asked why she was seen not wearing a mask during check-in this morning and the other day, she admitted that Honestly, I forgot. The Concierge noted that she was not used to wearing a mask anymore. Staff #80 said that the importance of wearing a mask s to protect themselves and residents. Additionally, she noted that wearing a mask stops the spread of disease such as COVID. During an interview with a Certified Nursing Assistant (CNA/staff #40) conducted on August 21, 2024 at 12:10 p.m., staff #40 stated that the signs for COVID outbreak as been up for about 2-3 weeks. The CNA noted that the process for staff prior to reporting to their assigned unit is to check-in, take their temperature, fill out COVID questionnaire, and then clock in. Staff #40 stated that if you work at the East unit, you have to get COVID tested ,d+[DATE] times a week due to the outbreak. The CNA noted that the last time she was tested was last week. Staff #40 said that staff is supposed to wear a mask as soon as they enter the building. The CNA stated that wearing a mask is important in order to not spread the disease. Staff #40 said that not following the protocol can lead to somebody getting sick and spreading COVID. An interview with a Certified Nursing Assistant (CNA/staff #20) was conducted on September 21, 2024 at 12:31 p.m. Staff #20 stated that the signs for COVID outbreak have been up for 3-weeks. The CNA noted that mostly the staff assigned to the East unit are not allowed to clock in or out and reports directly to the unit. Staff #20 said that if staff is not assigned to the East unit, then they mask up and use hand sanitizer. Temperature is checked every morning and if you are symptomatic then you have to get tested prior to going to the unit. The CNA also said that every morning staff completes a questionnaire that assesses if the member has a temperature or symptoms. Staff #20 said that this is important so they can stop the spread of COVID and protect everyone, especially those with a weak immune system. The CNA noted that not following the protocol can lead to the spread of COVID and not protecting others. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Infection Preventionist (IP/staff #100) was conducted on August 21, 2024 at 12:59 p.m. According to the IP it has been approximately 2-3 weeks since the outbreak in the facility began. Staff #100 noted that this coming Friday (8/23/24), they will test and it will be 10 days since the last positive. The IP said that staff used N95 masks on the first night of the outbreak, they did COVID testing and it was determined that the outbreak was limited to one unit. Since then the Director of Nursing (DON/staff #120) had taken over oversight for and implementation of infection control and prevention protocols for the outbreak. Staff #100 noted that when she was at the facility, the staff were wearing N95 masks. She said that she was last in the facility last week (Wednesday, 8/14/24). The IP indicated that due to the shared entry and the Assisted Living (AL) side being owned by another company, she can understand the potential concern of cross-contamination and guests not necessarily being able to identify or know that the people are not their facility's staff. The IP indicated that she had their staff wear N95 masks-they especially had to have one while at the East unit. Staff working at the East unit went straight to East and they treated the entire East unit as a hot zone. Staff #100 noted that the receptionist at the shared front desk is not their employee but the AL's staff. The receptionist works at the desk. Although, they expect her to mask up, it is hard to enforce since she is not their staff. The receptionist is supposed to provide education and provide mask to guests. The IP acknowledged that having two companies operating in the shared space can be problematic when it comes to identifying staff and residents that should be masking up. Staff #100 stated that she understands the concern about the staff from two companies intermingling and can see the concern of spreading, and cross-contaminating. This is the reason why they do testing and also there is multiple ways to get to the unit. Although, the dining room is one that both companies' staff can pass through, they do discourage their staff from doing so since there are multiple-ways to get to the units. During an interview with a Registered Nurse (RN/staff #110) conducted on August 21, 2024 at 2:31 p.m., staff #110 noted that they have had a COVID outbreak for approximately 2-weeks. The RN stated that as soon as staff step into the building they are required to wear a mask. In an interview with the Director of Nursing (DON/staff #120) conducted on August 21, 2024 at 2:38 p.m., staff #120 stated that staff have been educated about current policy and protocols and are expected to follow them while on shift. The DON stated that current staff use questionnaire and get their temps taken and don N95 when walking to the units. He stated he would like for them to wear the mask before they enter the unit so there is isolation supplies handy. The DON stated that it is important to prevent the spread of bacteria since it can be passed to anyone. If infection control protocols are not followed then there can be a spread of infection/disease. Staff #120 noted that the receptionist has the responsibility to educate visitor and there is signage and provide PPE (personal protective equipment). It is up to the guest to comply. When asked why the receptionist did not provide the surveyor a brief on the status of the building regarding COVID, he responded that the surveyor is not a guest, the surveyor is a surveyor. Per the Center for Clinical Standards and Quality/Survey & Certification Group Red: QSO-20-39 -NH regarding Nursing Home Visitation - COVID-19 revised May 8, 2023. On April 10, 2023, the President signed legislation that ended the COVID-19 national emergency. On May 11, 2023, the COVID-19 public health emergency (PHE) is expected to expire. While the PHE will end, CMS still expects facilities to adhere to infection prevention and control recommendations in accordance with accepted national standards. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Policies and Practices - Infection Control dated October 2018 indicated that the facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. Additionally, the policy stated that the objective of the policy is to maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public.