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	09/05/2024

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 - Some	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** 47910 Based on clinical record review, staff interviews, facility documentation and policy review, the facility failed to protect the rights of one resident (#40) to be free from sexual abuse by another resident (#49); and, failed to protect the rights of two residents (#25 and #5) to be free from abuse by another resident (#6). The deficient practice could result in the potential for harm and had placed residents at increased risk for further abuse, serious injury, harm and psychosocial harm. Findings include: -Resident #40 was admitted on [DATE] with diagnoses of Alzheimer's disease, dementia in other diseases with agitation, with anxiety, other behavioral disturbance, wandering in diseases classified elsewhere. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident had severe cognitive impairment, had physical and verbal behavioral symptoms directed towards others placing the resident at significant risk for physical injury that occurred 1-3 days of the lookback period. The care plan dated July 31, 2024 revealed the resident had impaired cognitive function and had a behavior of wandering aimlessly. The goal was that cognitive function and resident safety will be maintained. Intervention included keeping resident's routine consistent and try to provide consistent caregivers to decrease confusion, distraction from wandering and provide structured activities. The care plan dated August 28, 2024 included the resident had the potential for psychosocial emotional distress related to inappropriate behavior from another resident. Interventions included monitoring for 72 hours for psychosocial, emotional distress, nonverbal signs of psychosocial, emotional distress as exhibited by self-isolation, increased pain, increased behaviors and refer to psych as needed. A nurse note dated August 28, 2024 stated certified nurse assistant (CNA) found resident cornered outside with another resident (#49) who touched resident #40 inappropriately. Per the documentation, the CNA separated both residents,15-minute checks were initiated and the POA (power of attorney), DON (director of nursing) and physician were notified. A Psych Follow-Up Note dated August 28, 2024 included resident was seen for follow up after an incident where another resident (#49) grabbed the resident's breast. (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: 035217	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024
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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(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 - Some	-Resident #49 was admitted on [DATE] with diagnoses of vascular dementia with other behavioral disturbance, major depressive disorder, recurrent, moderate and anxiety disorder. The care plan dated July 17, 2024 had revealed the resident had cognitive deficit related to dementia; and, had a behavior problem related to pacing, sexually inappropriate behavior in public spaces, touching his genitalia in front of others, sexually explicit drawings and walking on the unit without clothing. The goal was that resident needs will be anticipated. Interventions included reality orientation, verbal cues and reminders, redirection of behaviors and when resident exposes himself to redirect to his room to ensure privacy and his safety. The quarterly MDS assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score 14 which indicated the resident had intact cognition. A behavior note dated August 8, 2024 revealed the housekeeper notified the nurse that resident #49 sitting next to resident #40 and was fondling her private parts. Per the documentation, both residents were immediately separated and the nurse instructed the CNAs to keep the two residents away; and that, plan of care was ongoing. However, there was no evidence of any new interventions put in place to address resident #49's behavior. A behavior note dated August 28, 2024 included that resident #49 cornered and inappropriately touched another resident (#40) outside of his room; and that, the certified nurse assistant (CNA) intervened immediately. Per the documentation, resident #49 reported to the nurse that he was just messing around. It also included that the nurse notified management; and, change of condition and 15 minute checks were initiated for resident #49. A communication note dated August 28, 2024 revealed that the unit manager was notified about resident's sexual behavior towards another resident (#40); and that, both residents were place on every 15 minute checks. A Psych Follow-Up Note dated August 21, 2024 revealed that the last reported behavior reported by staff was on August 10, 2010. Per the documentation, prior behavior included sexual inappropriateness with staff and verbal behaviors were documented. A physician order dated August 30, 2024 included for progesterone (hormone) 100 mg (milligrams) give 1 capsule by mouth once daily x 14 for increased sexual behavior. An interview was conducted with the Administrator (staff #239) on September 4, 2024 at 9:48 a.m. The administrator said that a report on the incident dated August 8, 2024 had not been filed to the SA nor reported to the police because the administrator was not aware of it. (continued on next page)

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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 - Some	An interview was conducted on September 4, 2024 at approximately 9:55 a.m. with a licensed practical nurse (LPN/staff #92) who stated that resident #49 had sexually inappropriate behaviors, mostly directed at female staff. She stated that resident #49 had taken off his brief and was dancing outside of the break room, would fondle himself in front of other residents and/or staff and would need to be redirected back to his room. The LPN stated that resident #49 was closely monitored when awake; and, no concerns related to monitoring the resident at night as the resident sleeps through the night. She also stated that resident #49 was moved to a different unit due to his sexually inappropriate behaviors. The LPN stated that when there was allegation of abuse, she had to report the incident immediately after ensuring the residents are safe. An interview was conducted with a CNA (staff #246) on September 4, 2024 at 10:19 a.m. The CNA stated that another CNA witnessed resident #49 groping one of the female residents; and that, was instructed that if anything else happened staff need to write the incident up. The CNA said that resident #49 would make sexually inappropriate comments towards the female staff, residents and family; and that, in one instance, resident #49 was lying in bed naked and had asked her to lay down with him while she was providing him assistance. The CNA stated that resident #49 was not on 1:1 supervision; but, staff were told to keep a close eye on him. She stated that CNA's rely on the nurses to also monitor the residents; and that, there was a need for more staff for extra monitoring of the residents and the halls/unit. The CNA also said that more staff would give them more eyes and hands, because sometimes when both CNA's on shift were in a room assisting another resident, the nurse cannot always be there to watch the unit. In an interview with the administrator and the Director of Nursing (DON/staff #200) conducted on September 4, 2024 at 11:05 a.m., both staffs stated that they had documentation regarding the incident involving residents #49 and #40 on August 8, 2024. The DON said that stated he had a text message regarding the incident and he had just interviewed the housekeeper. The DON said that resident #49 was sitting with his pants pulled down to his pelvic area and had his hands in his pants pleasuring himself and was sitting near the other resident (#40). The DON further stated that resident #40 did not have the capacity to be affected by what was being done in front of her; and that, resident #49's behavior was about the intent which was to self-gratify and not cause harm. The DON further stated how can this incident be sexual abuse or abuse when resident #40 did not even know what was happening because of her cognitive status. An interview with Director of Nursing (DON/staff #200) and the Administrator (staff #239) was conducted on September 4, 2024 at 12:33 p.m. Both staffs stated that their process for implementing interventions for residents with behaviors was for staff to redirect the resident review the behavior to determine if the behavior affected others and come up with an intervention. The DON stated that interventions were determined based on a review of the resident's chart, medications and an interdisciplinary team meeting if needed; and, an appropriate intervention is put in place and the care plan is revised. The DON said that the interventions implemented are entered in the resident's electronic record, care plan and behavioral tracking on the units. Regarding resident #49, the DON said that the inappropriate behaviors of resident #49 was based on his intent behind the behavior. Both the DON and the administrator stated that they were the ones who make the decisions on whether or not information was to be shared with the state agency. An observation of resident #49 was conducted on September 4 at 2:45 p.m. The resident was in his room with a CNA who was providing 1:1 supervision. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted September 4, 2024 at 2:48 p.m. with staff #105 who stated resident #40 had moved to the unit from another unit to keep her safe due to her wandering and able to keep a closer eye on her; and that, resident #40 can be resistive with care, aggressive, hitting at others who may be close by, but has not caused anyone any injuries or injured herself. An interview was conducted on September 4, 2024 at 3:23 p.m. with the housekeeper (staff #128) who stated that she was cleaning the dining room on the unit when she saw resident #49 walking into the dining area and sat down on one side of the dining room. She stated she continued cleaning in the dining room and then saw resident #49 sitting in the chair with his pants down, his penis exposed and making a jerking motion with his hand on his penis. The housekeeper said that resident #49 then got up and to a female resident (#40) who was seated upright in a recliner; and that, resident #49 touched the legs and arms of resident #40 and motioned resident #40 to look at his exposed penis. The housekeeper said that resident #40 looked over at resident #49 exposed penis twice. The housekeeper further stated that she immediately reported the incident to the staff that were in the area and moved on with her work. In an interview was conducted with an LPN (staff #158) conducted on September 4, 2024 at 4:01 p.m., the LPN stated she was familiar with residents #40 and #49. The LPN stated that she did not observe the incident herself; but, she was the assigned nurse on the unit and the housekeeper reported the incident to her. She stated the housekeeper told her that resident #49 was touching himself near another resident (#40) with his pants down; so, she immediately went into the dayroom. The LPN said that she saw resident #49 with his pants zipped up and was seated next to resident #40. She stated she informed the CNAs that resident #49 was touching himself near another resident (#40) with his pants down, but had pulled them up at some point. The LPN said that she instructed the CNAs to keep the two residents separated the remainder of the shift. She said that she then reported in the facility clinical chat that the resident #49 was touching himself in the vicinity of another resident (#40); and, had his pants pulled down, but did not inform that the resident had his penis exposed. Further, the LPN stated that she was aware that resident #49 had a history of being sexually inappropriate with staff; but, was unaware of any prior incidents with other residents. An interview was conducted September 5, 2024 at 10:27 a.m. with the administrator and the DON. The DON stated that residents had a right to privacy and personal space; and, the expectation was that residents that had cognitive capacity need for staff to respect the resident's space; and, there was no facility culpability for residents without the cognitive ability and capacity. The administrator stated that wandering mentally ill residents does not fit in a skilled nursing facility, which is an institution and not the residents' home. Further, the DON stated that the facility does not have sufficient staffing to prevent residents from entering and wandering into other resident's rooms and to prevent it from occurring. The DON stated that it felt like it was an expectation of perfection but, it was not; and that, the facility's current population does not have the cognitive ability to understand the consequences of their actions. Review of the facility policy on Abuse, Neglect, Exploitation and Misappropriation Program revised April 2021, included that residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This included but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. 40581 (continued on next page)

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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 - Some	-Regarding resident #25 and #6 Resident #25 was admitted to the facility on [DATE] with diagnoses that included vascular dementia with agitation, major depressive disorder, and an anxiety disorder. The care plan dated November 5, 2024 revealed that the resident had a behavior problem related to posturing, physical aggression, verbal aggression, sexually inappropriate gestures, intrusive wandering, and attempting to take peers food/items. Interventions included to administer medications as ordered, monitor and document for side effects and effectiveness, assist the resident to develop more appropriate methods of coping and interacting, and monitor behavior episodes and attempt to determine underlying cause, consider the location, time of day, persons involved, and situations. The minimum data set (MDS) dated [DATE] included a brief interview for mental status (BIMS) score of 3 indicating the resident had severe cognitive impairment. It also included that the resident exhibited physical and verbal behaviors towards others for 4- 6 days during the lookback period. A psych note dated August 8, 2024 revealed the following documentation: -July 30, 2024 - the resident was wandering and hitting; -July 31, 2024 - the resident threatened to knock the staff's teeth out when being redirected from walking through the gate; -August 1, 2024 - the resident was hitting staff; -August 1, 2024 - the resident became extremely combative when being redirected out of another resident's room and threatened to kill staff; and, -August 5, 2024 - the resident was wandering, aggressive with staff, hitting staff, grabbing staff, pinching staff, kicking staff, yelling at staff, trying to hit other residents, entering other residents' rooms and refusing to leave, and cussing. A progress note dated August 8, 2024 revealed the resident continued to wander along the hallway and day room; and that, he was aggressive, hitting and kicking staff when being redirected. A progress note dated August 16, 2024 at 5:48 a.m. revealed that resident #25 was touching a sleeping female's thighs; and that, the resident was physically aggressive towards staff (hitting). A progress note dated August 16, 2024 at 6:22 p.m. revealed that resident #25 was aggressive, yelling on the unit and used a fork to try and stab another resident. Per the documentation, the resident was stopped, redirected and medications were administered and tolerated. A progress note dated August 16, 2024 at 10:47 p.m. revealed that resident #25 was wandering the hall and came into proximity of another wandering resident (#6); and that, as staff began to intervene, resident #6 tapped resident #25's chest. Per the documentation, resident #25 placed his hand on resident #6's forehead and gave it a push. Staff redirected the two residents to separate areas. (continued on next page)

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F 0600

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

The care plan August 20, 2024 included the resident was at risk for psychosocial emotional distress related to a resident to resident altercation.

-Resident #6 was admitted to the facility on [DATE] with diagnoses of dementia, agitation, psychotic disorder with delusions, unspecified psychosis and conduct disorder.

Review of the care plan dated May 21, 2015 revealed that the resident had a behavior problem related to excessive yelling, history of sitting or forcefully placing self on the floor at times, intrusiveness, physically aggressive behaviors, being combative with care, exposing herself, and spitting. Interventions included to administer medications as ordered, attempt to determine cause of behaviors, and to attempt to redirect behaviors.

The minimum data set (MDS) dated [DATE] included a BIMS score of 3 indicating the resident had severe cognitive impairment. It also included that the resident exhibited physical behaviors towards others daily during the lookback period.

A progress note dated August 16, 2024 at 6:24 a.m. revealed that the resident was hitting staff and attempting to hit other residents. The resident was redirected when possible.

A progress note dated August 16, 2024 at 10: 50 p.m. revealed that the resident hit another resident.

The care plan dated August 26, 2024 revealed that the resident was at risk for psychosocial emotional distress related to resident to resident altercation. Interventions included to monitor for 72 hours for psychosocial emotional distress and allow the resident to verbalize any concerns related to this event.

Review of the SBAR Communication Form dated August 16, 2024 revealed that the change of condition, symptoms, or signs observed and evaluated are behavioral symptoms (e.g. agitation, psychosis). Resident #6 was involved in a resident to resident altercation where a male resident (resident #25) pushed her in the head after she pushed him in the chest.

A psych note dated August 28, 2024 revealed the following information:

-August 21, 2024 - the resident was pacing up and down the hall, and hitting staff and other residents; and,

-August 22, 2024 - the resident was very aggressive and loud today, hitting anyone or anything in sight the entire shift and getting other residents to be aggressive.

Regarding resident #5 and #6

-Resident #5 was readmitted on [DATE] with diagnoses of Alzheimer's disease, dementia, other behavioral disturbance, and an anxiety disorder.

The MDS dated [DATE] included a BIMS score of 3 indicating the resident had a severe cognitive impairment. Physical and verbal behaviors were exhibited for one to three days during the lookback period.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A care plan dated October 2, 2023 revealed that the resident had a behavior problem related to dementia as evidenced by wandering/intrusive, exit seeking, moving furniture, physical/verbal aggression towards staff, destroying property, peer altercation, resistive to care, and resistive to medications. Interventions included psych evaluation for medication management, intervene as necessary to protect the rights and safety of others, approach and speak in a calm manner, divert attention and to remove from situation and take the alternate location as needed. The care plan dated August 26, 2024 included that the resident had the potential for psychosocial emotional distress related to resident to resident altercation. Interventions included for resident to verbalize any concerns related to this incident, a psych consult as needed if indicated, and to monitor for signs and symptoms of psychosocial emotional distress for 72 hours. The progress note dated August 25, 2024 revealed that at approximately 11:22 a.m., the licensed practical nurse (LPN/staff #85) was sitting at the nursing station when resident #5 was standing in the hallway, and resident #6 came into proximity with resident #5. Per the documentation, as the LPN began to intervene, resident #6 reached around staff #85 and hit resident #5 in the face on the left side near his eye; and that, resident #6 was unprovoked. It also included that both residents were separated, and redirected away from one another; and, the Administrator and power of attorney were notified. A psych note dated August 29, 2024 revealed that on August 26, 2024, resident #6 keeps getting attacked by resident in room [ROOM NUMBER]. No bad or harmful reaction has been shown by the resident. -Resident #6 was admitted to the facility on [DATE] with diagnoses of dementia, agitation, psychotic disorder with delusions, unspecified psychosis and conduct disorder. Review of the care plan dated May 21, 2015 revealed that the resident had a behavior problem related to excessive yelling, history of sitting or forcefully placing self on the floor at times, intrusiveness, physically aggressive behaviors, being combative with care, exposing herself, and spitting. Interventions included to administer medications as ordered, attempt to determine cause of behaviors, and to attempt to redirect behaviors. The minimum data set (MDS) dated [DATE] included a BIMS score of 3 indicating the resident had severe cognitive impairment. It also included that the resident exhibited physical behaviors towards others daily during the lookback period. A progress note dated August 16, 2024 at 6:24 a.m. revealed that the resident was hitting staff and attempting to hit other residents; and that, the resident was redirected when possible. A progress note dated August 16, 2024 at 10: 50 p.m. included that resident #6 hit another resident. A progress note dated August 25, 2024 revealed that the resident was restless for the most part of the shift, was unable to sleep and all pharmacological interventions were ineffective. Per the documentation, the resident was pacing in the day room and had two hours of sleep all night. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A progress note dated August 25, 2024 revealed that at approximately 11:22 a.m., the licensed practical nurse (LPN/staff #85) was sitting at the nursing station when resident #5 was standing in the hallway, and resident #6 came into proximity with resident #5. As (LPN/staff #85) began to intervene, resident #6 reached around staff #85 and hit resident #5 in the face on the left side near his eye, unprovoked. The residents were separated, and redirected away from one another. Resident #5 followed staff to the nurse's station, with good affect. The Administrator and power of attorney were notified. The resident has a history of hitting others. The care plan dated August 26, 2024 revealed that the resident was at risk for psychosocial emotional distress related to resident to resident altercation. Interventions included to monitor for 72 hours for psychosocial emotional distress and allow the resident to verbalize any concerns related to this event. A psych note dated August 28, 2024 revealed the following information: -August 21, 2024 - The resident was pacing up and down the hall, and hitting staff and other residents; and, -August 22, 2024 - The resident was very aggressive and loud today, hitting anyone or anything in sight the entire shift and getting other residents to be aggressive. An interview was conducted on September 3, 2024 at 11:16 a.m. with a certified nursing assistant (CNA/staff #186), who stated that resident #25 can be aggressive with other residents and staff have to redirect him. She stated that he just heads for a resident and can also get upset when another resident was being loud. The CNA said that resident #25 gets irritated and angry with resident #6mwho was loud; and that, resident #25 would tell resident #6 to be quiet. Regarding resident #6, the CNA stated that the resident was non-verbal, hits and pulls staff hair all the time, also heads towards residents and tries to hit them, was tall and strong and cannot be redirected, so staff just get hit. She stated that resident #6 had a one-to-one staffing ratio because she hit a resident last week. The CNA further stated that it was difficult to watch the halls; and that, the facility have hospitality staff to help out in the unit, but the hospitality staff were not allowed to touch the residents. An interview was conducted on September 3, 2024 at 11:49 a.m. with a licensed practical nurse (LPN/staff #85), who stated that there had been a decline in the number of staff scheduled, so they did not have the ability to redirect residents as needed. She stated that she had seen an increase in the behaviors of the residents since the reduction in the number of staff. She stated that resident #25 does not like anyone in his space and will raise a closed fist to warn other residents; and that, resident #25 walks around and there was a possibility that he could hurt someone. Regarding resident #6, the LPN stated that resident #6 was very intrusive, fast, and strong; and that, staff never know if she was going to tap or hit. The LPN said that resident may tap and then hit a person. She stated that she heard the two residents had an altercation; and, when she came to work today, there were three CNAs assigned to the unit. The LPN said that one CNA may have been assigned as a one-to-one for one for residents #6 and #25. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on August 5, 2024 at 10:27 a.m. with the (DON/staff #200), who stated that all staff, including himself and the Administrator, have received training on abuse. He stated that abuse can be physical, verbal, sexual, fiduciary, neglect, and seclusion. He stated that all resident to resident incidents were documented in the change of condition form and the clinical team, which included himself. The administrator also said that the clinical team were responsible for reviewing the change of condition forms, so they were aware of the number of resident to resident incidents occurring on a daily basis. He also stated that the population that they serve was not able to understand when staff try to explain what they cannot do; and that, their facility assessment included that the facility was able to provide the supervision and care needed for the population that they serve. During an interview with the Administrator (staff #239) conducted on August 26, 2024 at 4:00 p.m., she stated that the facility provides adequate supervision for the residents. She stated that the regulation pertaining to supervision did not fit when you have wandering mentally ill residents in a skilled nursing facility (SNF). She stated that the facility was an institution where the resident carry out their last days and not a home. However, the administrator said that it was the facility's responsibility to protect the residents .

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47910 Based on clinical record reviews, resident/staff interviews, facility documentation and policy review and the State Agency (SA) complaint tracking system, the facility failed to report allegations of abuse to the State Agency (SA), Adult Protective Services (APS) and local law enforcement for three sampled residents (#40, #25 and #5). The deficient practice could result in abuse not identified and investigated and place all residents at risk for further abuse. Findings include: Resident #40 admitted on [DATE] with diagnoses including Alzheimer's disease, unspecified, dementia in other diseases classified elsewhere, unspecified severity, with agitation, with anxiety, dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance, wandering in diseases classified elsewhere. A nurse note dated August 28, 2024 stated certified nurse assistant (CNA) found resident cornered outside with another resident (#49) who touched resident #40 inappropriately. Per the documentation, the CNA separated both residents,15-minute checks was initiated and the POA (power of attorney), DON (director of nursing) and physician were notified. A Psych Follow-Up Note dated August 28, 2024 included resident was seen for follow up after an incident where another resident (#49) grabbed the resident's breast. -Resident #49 was admitted on [DATE] with diagnoses of vascular dementia with other behavioral disturbance, major depressive disorder, recurrent, moderate and anxiety disorder. A behavior note dated August 28, 2024 included that resident #49 cornered and inappropriately touched another resident (#40) outside of his room; and that, the certified nurse assistant (CNA) intervened immediately. Per the documentation, resident #49 reported to the nurse that he was just messing around. It also included that the nurse notified management; and, change of condition and 15 minute checks were initiated for resident #49. A communication note dated August 28, 2024 revealed that the unit manager was notified about resident's sexual behavior towards another resident (#40); and that, both residents were place on every 15 minute checks. A Psych Follow-Up Note dated August 21, 2024 revealed that the last reported behavior reported by staff was on August 10, 2010. Per the documentation, prior behavior included sexual inappropriateness with staff and verbal behaviors were documented. Despite documentation that resident #49 grabbed the breast of resident #40, there was no evidence that this incident was reported to SA, APS and local law enforcement. (continued on next page)

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 09/05/2024
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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with the Administrator (staff #239) on September 4, 2024 at 9:48 a.m. The administrator said that a report on the incident dated August 8, 2024 had not been filed to the SA nor reported to the police because the administrator was not aware of it. In an interview with the administrator and the Director of Nursing (DON/staff #200) conducted on September 4, 2024 at 11:05 a.m., both staff stated that they had documentation regarding the incident involving residents #49 and #40 on August 8, 2024. The DON said that stated he had a text message regarding the incident and he had just interviewed the housekeeper. The DON said that resident #49 was sitting with his pants pulled down to his pelvic area and had his hands in his pants pleasuring himself and was sitting near the other resident (#40). The DON further stated that resident #40 did not have the capacity to be affected by what was being done in front of her; and that, resident #49's behavior was about the intent which was to self-gratify and not cause harm. The DON further stated how can this incident be sexual abuse or abuse when resident #40 did not even know what was happening because of her cognitive status. An interview with Director of Nursing (DON/staff #200) and the Administrator (staff #239) was conducted on September 4, 2024 at 12:33 p.m. Both staff stated that their process for implementing interventions for residents with behaviors was for staff to redirect the resident review the behavior to determine if the behavior affected others and come up with an intervention. The DON stated that interventions were determined based on a review of the resident's chart, medications and an interdisciplinary team meeting if needed; and, an appropriate intervention is put in place and the care plan is revised. The DON said that the interventions implemented are entered in the resident's electronic record, care plan and behavioral tracking on the units. Regarding resident #49, the DON said that the inappropriate behaviors of resident #49 was based on his intent behind the behavior. Both the DON and the administrator stated that they were the ones who make the decisions on whether or not information was to be shared with the state agency. An interview was conducted on September 4, 2024 at 3:23 p.m. with the housekeeper (staff #128) who stated that she was cleaning the dining room on the unit when she saw resident #49 walking into the dining area and sat down on one side of the dining room. She stated she continued cleaning in the dining room and then saw resident #49 sitting in the chair with his pants down, his penis exposed and making a jerking motion with his hand on his penis. The housekeepr said that resident #49 then got up and to a female resident (#40) who was seated upright in a recliner; and that, resident #49 touched the legs and arms of resident #40 and motioned resident #40 to look at his exposed penis. The housekeeper said that resident #40 looked over at resident #49 exposed penis twice. The housekeeper further stated that she immediately reported the incident to the staff that were in the area and moved on with her work. In an interview was conducted with an LPN (staff #158) conducted on September 4, 2024 at 4:01 p.m., the LPN stated she was familiar with residents #40 and #49. The LPN stated that she did not observe the incident herself; but, she was the assigned nurse on the unit and the housekeeper reported the incident to her. She stated the housekeeper told her that resident #49 was touching himself near another resident (#40) with his pants down; so, she immediately went into the dayroom. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted September 5, 2024 at 10:27 a.m. with the administrator and the DON. The DON stated that residents had a right to privacy and personal space; and, the expectation was that residents that had cognitive capacity need for staff to respect the resident's space; and, there was no facility culpability for residents without the cognitive ability and capacity. The DON stated that wandering mentally ill residents does not fit in a skilled nursing facility, which is an institution and not the residents home. Further, the DON stated that the facility does not have sufficient staffing to prevent residents from entering and wandering into other resident's rooms and to prevent it from occurring. The DON stated that it felt like it was an expectation of perfection but, it was not; and that, the facility's current population does not have the cognitive ability to understand the consequences of their actions. 40581 -Resident #25 was admitted to the facility on [DATE] with diagnoses that included vascular dementia with agitation, major depressive disorder, and an anxiety disorder. The care plan dated November 5, 2024 revealed that the resident had a behavior problem related to posturing, physical aggression, verbal aggression, sexually inappropriate gestures, intrusive wandering, and attempting to take peers food/items. Interventions included to administer medications as ordered, monitor and document for side effects and effectiveness, assist the resident to develop more appropriate methods of coping and interacting, and monitor behavior episodes and attempt to determine underlying cause, consider the location, time of day, persons involved, and situations. A progress note dated July 9, 2024 revealed that the resident continued to wander along the hallway, and to other residents' room; and that, the resident was redirected several times with a negative impact. A progress note dated July 12, 2024 revealed that the resident was pacing the hall, refusing care, and entering others rooms. The minimum data set (MDS) dated [DATE] included a brief interview for mental status (BIMS) score of 3 indicating the resident had severe cognitive impairment. It also included that the resident exhibited physical and verbal behaviors towards others for 4- 6 days during the lookback period. A progress note dated August 15, 2024 revealed that resident #25 was found in another resident's room naked. A progress note dated August 16, 2024 at 5:48 a.m. revealed that resident #25 was touching a sleeping female's thighs; and that, the resident was physically aggressive towards staff (hitting). -Resident #36 was admitted to the facility on [DATE] with diagnoses of post-traumatic stress disorder (PTSD), dementia in other diseases classified elsewhere, severe, with agitation, and aphasia. The care plan dated January 31, 2024 revealed the resident had a behavior problem related to physical aggression with peers, impulsive, and restless. Interventions included to intervene as necessary to protect the rights and safety of others, approach/speak in a calm manner, divert attention, remove from situation and take to alternate location. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The MDS dated [DATE] included a staff assessment that the resident had a severe cognitive impairment. Review of a complaint filed in the SA dated September 3, 2024 included that resident #25 was found in another resident's (#36) room undressed. The report also included that resident #36 was asleep and had no knowledge of resident #25 being in the room; and that, the CNAs dressed resident #25 by the bathroom for privacy and dignity and took him out of the room in approximately 2 to 3 minutes. The clinical record revealed no documentation of behavior of resident #25 wandering and being found undressed in the bathroom of resident #36. Despite documentation of behaviors on August 15 and August 16, 2024, there was no evidence found that the facility self-reported the incidents on August 15 and August 16, 2024 to the SA, APS and local law enforcement. An interview was conducted on September 3, 2024 at 10:10 a.m. with the Director of Nursing (DON/staff #200), who stated that there had been some type of disconnect with the staff; and that, training was being completed this day and the following day with all staff regarding the difference between baseline behaviors and reportable events. He stated that he was going to explain that the behaviors of resident's that affect other residents was a reportable event. He stated that one staff had been spoken to multiple times about reporting events. He stated that he and the Administrator were not being notified by staff when an allegation/reportable event occurs; and, both he and the administrator need to receive this information to determine what should be done. An interview was conducted on August 3, 2024 at 2:53 p.m. with the Administrator (staff #239), who stated that she did not have any information regarding the incident on August 15, 2024 when resident #25 was found in another resident's room naked. The administrator then stated that one CNA reported that resident #25 was naked and another CNA reported that resident #25 was naked because he needed to use the bathroom. An interview was conducted on August 3, 2024 at approximately 3:00 p.m. with a certified nursing assistant (CNA/staff #226), who stated that she found resident #25 in the bathroom of resident #36. She stated that it was approximately 4:30 p.m. to 5:00 p.m. just before dinner time. She stated that resident #36 had his call-light on, so she went to see what he needed and she found resident #36 standing by his bed with his pants down around his ankles. She stated that he appeared distressed and she thought he was frustrated and irritated by his facial expressions. She stated that resident #36 was flinging his hands around and pointing to the bathroom, but she could not understand what he was saying, it sounded like gibberish. The CNA said that she then saw resident #25 come out of the bathroom; and that, she asked resident #25 what happened, but resident #25 did not answer and appeared confused. She observed that there were feces in the toilet and thought that resident #36 was going to the bathroom when resident #25 came in and startled resident #36. She stated that she went to get another staff to help redirect resident #25 and resident #36 did end up having a bowel movement. She reported the incident to the nurse, but she does not remember what the nurse told her. She stated that she has had training on abuse and resident rights, including the resident's right to privacy. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on September 4, 2024 at 9:11 a.m. with a licensed practical nurse (LPN/staff #92), who stated she had been told that she does not need to contact the Administrator or the Director of Nursing to report incidents if the behavior was a part of the resident's baseline behaviors. An interview was conducted on August 5, 2024 at 10:27 a.m. with the (DON/staff #200), who stated that all staff, including himself and the Administrator, have received training on abuse. He stated that abuse can be physical, verbal, sexual, fiduciary, neglect, and seclusion. He stated that all resident to resident incidents were documented in the change of condition form and the clinical team, which included himself. The administrator also said that the clinical team were responsible for reviewing the change of condition forms, so they were aware of the number of residents to resident incidents occurring on a daily basis. He also stated that the population that they serve was not able to understand when staff try to explain what they cannot do; and that, their facility assessment included that the facility was able to provide the supervision and care needed for the population that they serve. Review of the facility policy on Abuse, Neglect, Exploitation and Misappropriation Program with revision date of April 2021 included that all reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulation) and thoroughly investigated by facility management. Findings of all investigations are documented and reported.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47910 Based on resident and staff interviews, clinical record review, and facility policy, the facility failed to ensure an allegation of abuse for two residents (#40 and #36) by another resident (#49 and #25) were thoroughly investigated. The deficient practice could result in appropriate corrective action not taken to prevent further abuse. Findings include: -Resident #40 was admitted on [DATE] with diagnoses of Alzheimer's disease, dementia in other diseases with agitation, with anxiety, other behavioral disturbance, wandering in diseases classified elsewhere. A nurse note dated August 28, 2024 stated certified nurse assistant (CNA) found resident cornered outside with another resident (#49) who touched resident #40 inappropriately. Per the documentation, the CNA separated both residents,15-minute checks were initiated and the POA (power of attorney), DON (director of nursing) and physician were notified. A Psych Follow-Up Note dated August 28, 2024 included resident was seen for follow up after an incident where another resident (#49) grabbed the resident's breast. -Resident #49 was admitted on [DATE] with diagnoses of vascular dementia with other behavioral disturbance, major depressive disorder, recurrent, moderate and anxiety disorder. A behavior note dated August 28, 2024 included that resident #49 cornered and inappropriately touched another resident (#40) outside of his room; and that, the certified nurse assistant (CNA) intervened immediately. Per the documentation, resident #49 reported to the nurse that he was just messing around. It also included that the nurse notified management; and, change of condition and 15 minute checks were initiated for resident #49. A communication note dated August 28, 2024 revealed that the unit manager was notified about resident's sexual behavior towards another resident (#40); and that, both residents were place on every 15 minute checks. A Psych Follow-Up Note dated August 21, 2024 revealed that the last reported behavior reported by staff was on August 10, 2010. Per the documentation, prior behavior included sexual inappropriateness with staff and verbal behaviors were documented. Despite documentation that resident #49 grabbed the breast of resident #40, there was no evidence that the facility conducted a thorough investigation to include observations, interviews with other residents, staff or witnesses to the incident, reporting of the incident to appropriate agencies, conclusion of the investigation and the corrective actions taken. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Administrator and the Director of Nursing (DON/staff #200) was conducted September 5, 2024 at 10:27 a.m. Both the administrator and the DON stated that reporting timelines were two hours. The DON said that this was global practice regardless of the allegation and four hours for all other allegations; and that, the timeline to complete investigation was five days. The DON stated that any staff with allegations were taken off the floor, cleared from any patient area, office area and responsible staff were notified. The DON stated that the reason for the removal of the alleged staff was to ensure the safety of the residents until completion of the investigation. The DON stated that residents had a right to privacy and personal space; and, the expectation was that residents that had cognitive capacity need for staff to respect the resident's space; and, there was no facility culpability for residents without the cognitive ability and capacity. 40581 -Resident #25 was admitted to the facility on [DATE] with diagnoses that included vascular dementia with agitation, major depressive disorder, and an anxiety disorder. The minimum data set (MDS) dated [DATE] included a brief interview for mental status (BIMS) score of 3 indicating the resident had severe cognitive impairment. It also included that the resident exhibited physical and verbal behaviors towards others for 4- 6 days during the lookback period. A progress note dated August 15, 2024 revealed that resident #25 was found in another resident's room naked. A progress note dated August 16, 2024 at 5:48 a.m. revealed that resident #25 was touching a sleeping female's thighs; and that, the resident was physically aggressive towards staff (hitting). -Resident #36 was admitted to the facility on [DATE] with diagnoses of post-traumatic stress disorder (PTSD), dementia in other diseases classified elsewhere, severe, with agitation, and aphasia. The MDS dated [DATE] included a staff assessment that the resident had a severe cognitive impairment. Review of a complaint filed in the SA dated September 3, 2024 included that resident #25 was found in another resident's (#36) room undressed. The report also included that resident #36 was asleep and had no knowledge of resident #25 being in the room; and that, the CNAs dressed resident #25 by the bathroom for privacy and dignity and took him out of the room in approximately 2 to 3 minutes. There was no evidence that the facility conducted a thorough investigation to include observations, interviews with other residents, staff or witnesses to the incident, reporting of the incident to appropriate agencies, conclusion of the investigation and the corrective actions taken. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on September 3, 2024 at 10:10 a.m. with the Director of Nursing (DON/staff #200), who stated that there had been some type of disconnect with the staff; and that, training was being completed this day and the following day with all staff regarding the difference between baseline behaviors and reportable events. He stated that he was going to explain that the behaviors of resident's that affect other residents was a reportable event. He stated that one staff had been spoken to multiple times about reporting events. He stated that he and the Administrator were not being notified by staff when an allegation/reportable event occurs; and, both he and the administrator need to receive this information to determine what should be done. An interview was conducted on August 3, 2024 at 2:53 p.m. with the Administrator (staff #239), who stated that she did not have any information regarding the incident on August 15, 2024 when resident #25 was found in another resident's room naked. The administrator then stated that one CNA reported that resident #25 was naked and another CNA reported that resident #25 was naked because he needed to use the bathroom. An interview was conducted on August 3, 2024 at approximately 3:00 p.m. with a certified nursing assistant (CNA/staff #226), who stated that she found resident #25 in the bathroom of resident #36. She stated that it was approximately 4:30 p.m. to 5:00 p.m. just before dinner time. She stated that resident #36 had his call-light on, so she went to see what he needed and she found resident #36 standing by his bed with his pants down around his ankles. She stated that he appeared distressed and she thought he was frustrated and irritated by his facial expressions. She stated that resident #36 was flinging his hands around and pointing to the bathroom, but she could not understand what he was saying, it sounded like gibberish. The CNA said that she then saw resident #25 come out of the bathroom; and that, she asked resident #25 what happened, but resident #25 did not answer and appeared confused. She observed that there were feces in the toilet and thought that resident #36 was going to the bathroom when resident #25 came in and startled resident #36. She stated that she went to get another staff to help redirect resident #25 and resident #36 did end up having a bowel movement. She reported the incident to the nurse, but she does not remember what the nurse told her. She stated that she has had training on abuse and resident rights, including the resident's right to privacy. An interview was conducted on September 4, 2024 at 9:11 a.m. with a licensed practical nurse (LPN/staff #92), who stated she had been told that she does not need to contact the Administrator or the Director of Nursing to report incidents if the behavior was a part of the resident's baseline behaviors. An interview was conducted on August 5, 2024 at 10:27 a.m. with the (DON/staff #200), who stated that all staff, including himself and the Administrator, have received training on abuse. He stated that abuse can be physical, verbal, sexual, fiduciary, neglect, and seclusion. The DON said that allegations of sexual abuse are to be reported to the state agency within two hours and all other allegations are to be reported within four hours and the written investigation is to be completed within 5 days. In a facility policy entitled Abuse, Neglect, Exploitation and Misappropriation-Reporting and Investigating, last revised in April 2021 stated that the individual conducting the investigation as a minimum: a. Reviews the documentation and evidence; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Reviews the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident; c. Observes the alleged victim, including his or her interactions with staff and other residents; d. Interviews the person(s) reporting the incident; e. Interviews any witnesses to the incident; f. Interviews the resident (as medically appropriate) or the resident's representative; g. Interviews the resident's attending physician, as needed, to determine the resident's condition; h. Interviews staff members (on all shifts as needed) who have had contact with the resident during the period of the alleged incident; i. Interviews the resident's roommate, family members, and visitors, j. Interviews other residents to whom the accused employee provides care or services; k. Reviews all events leading up to the alleged incident; and l. Documents the investigation completely and thoroughly

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F 0725

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47910

Based on clinical record review, staff interviews, and policy review, the facility failed to ensure there was sufficient staffing to provide adequate supervision for multiple residents. The deficient practice could result in residents' not receiving the supervision needed to ensure resident safety.

Findings include:

-Resident #40 was admitted on [DATE] with diagnoses of Alzheimer's disease, dementia in other diseases with agitation, with anxiety, other behavioral disturbance, wandering in diseases classified elsewhere.

A nurse note dated August 28, 2024 stated certified nurse assistant (CNA) found resident cornered outside with another resident (#49) who touched resident #40 inappropriately. Per the documentation, the CNA separated both residents,15-minute checks were initiated and the POA (power of attorney), DON (director of nursing) and physician were notified.

A Psych Follow-Up Note dated August 28, 2024 included resident was seen for follow up after an incident where another resident (#49) grabbed the resident's breast.

-Resident #49 was admitted on [DATE] with diagnoses of vascular dementia with other behavioral disturbance, major depressive disorder, recurrent, moderate and anxiety disorder.

A behavior note dated August 8, 2024 revealed the housekeeper notified the nurse that resident #49 sitting next to resident #40 and was fondling her private parts. Per the documentation, both residents were immediately separated and the nurse instructed the CNAs to keep the two residents away; and that, plan of care was ongoing.

A behavior note dated August 28, 2024 included that resident #49 cornered and inappropriately touched another resident (#40) outside of his room; and that, the certified nurse assistant (CNA) intervened immediately. Per the documentation, resident #49 reported to the nurse that he was just messing around. It also included that the nurse notified management; and, change of condition and 15 minute checks were initiated for resident #49.

A communication note dated August 28, 2024 revealed that the unit manager was notified about resident's sexual behavior towards another resident (#40); and that, both residents were place on every 15 minute checks.

A Psych Follow-Up Note dated August 21, 2024 revealed that the last reported behavior reported by staff was on August 10, 2010. Per the documentation, prior behavior included sexual inappropriateness with staff and verbal behaviors were documented.

Review of the facility assessment, dated January 25, 2024, revealed that the facility had determined it needed 56 CNAs (8 hour shifts) working daily to meet residents' needs.

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The staff schedule for Wednesday, August 28, 2024 revealed that Licensed Practical Nurses (LPN) and Registered Nurse (RN) worked 12-hour shifts. Further review of the schedule revealed the following: -Day shift: 12 Certified Nursing Assistants (CNAs), 1 Restorative Nursing Assistant (RNA), 7 LPNs, one RN and, 1 Licensed Practical Nurses (LPN) on training; Evening Shift: 16 CNAs, 1 CNA orientee, 1 CNA providing 1:1, 3 LPNs and 2 RNs; and, Night shift: 12 CNAs and 1 CNA providing 1:1. An interview was conducted on September 3, 2024 at 9:17 a.m. with a certified nursing assistant (CNA/staff #186), who stated that the staffing ratios had been lowered and there were not enough staff to monitor all the residents. She stated that she was not able to get to the residents on time to prevent falls or to provide activities of daily living (ADLs) timely. She also stated that it was difficult to monitor the halls, and even though, they have hospitality staff to help, the hospitality staff were not allowed to touch the residents. An interview was conducted with a CNA (staff #246) on September 4, 2024 at 10:19 a.m. The CNA stated that the CNA's rely on the nurses to also monitor the residents; and that, there was a need for more staff for extra monitoring of the residents and the halls/unit. The CNA also said that more staff would give them more eyes and hands, because sometimes when both CNA's on shift were in a room assisting another resident, the nurse cannot always be there to watch the unit. An interview with the Administrator and the Director of Nursing (DON #200) was conducted September 5, 2024 at 10:27 a.m. The DON stated that he supervises the Staffing Coordinator (staff #225) who was provided training on scheduling by himself, the Administrator, and the prior Staffing Coordinator; and that, the staffing coordinate was receiving ongoing training on how to use the scheduling software. The DON said that the team makes the determination regarding staffing needs on each unit and was usually determined daily. He stated that staffing was based on current behaviors and the number of residents on each unit; and that, he communicates with the staff to determine their staffing needs and what they feel was needed for staffing, and acuity. The DON said that acuity includes the behaviors of the residents, the assistance needed for activities of daily living, and if one-to-one staffing was needed. He stated that if staff call to ask for one-to-one staffing, he helps to evaluate the need. The DON also said that the Staffing Coordinator completes the staffing schedule and he and the Administrator review the schedule and authorize it if they agreed. He stated that behaviors, the needs and concerns regarding the residents were discussed during the morning meeting and the information was used to determine the staffing needs, but the behaviors, needs, and concerns were not documented. The DON stated that residents had a right to privacy and personal space; and, the expectation was that residents that had cognitive capacity need for staff to respect the resident's space; and, there was no facility culpability for residents without the cognitive ability and capacity. The DON stated that residents had a right to privacy and personal space; and, the expectation was that residents that had cognitive capacity need for staff to respect the resident's space; and, there was no facility culpability for residents without the cognitive ability and capacity. (continued on next page)

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	09/05/2024

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on September 3, 2024 at 11:49 with (CNA/staff #85), who stated that there had been a change in the staff to resident ratio. The CNA stated that she was no longer able to redirect residents as needed; and, there were not enough staff to provide care in pairs. She stated that two staff may be required depending the residents' behaviors and needs. She also stated since the number of staffs has decreased, she had seen an increase in the number of behaviors exhibited by the residents. She stated that she discussed the concern about staffing with the prior Administrator; but, the new Administrator and new Director of Nursing have not asked about staffing concerns. She stated that the CNAS were complaining daily about the low staffing ratios and they had too much to do. During an interview conducted on September 3, 2024 at 12:20 p.m. with the Administrator (staff #239), she reviewed the Facility Assessment Tool, Staffing Plan dated January 25, 2024 and stated that she has not had time to review or update the assessment and did not understand the staffing plan. An interview was conducted on September 3, 2024 at 12:59 p.m. with the Staffing Coordinator (staff #425), who stated that the facility did not use registry staff, does not offer incentives, and staff were not required to come into work if they were not scheduled to work. She stated that there were a lot of call-offs; and that, she had staff call off every day since she started working at the facility. She stated that when she was hired, she interviewed a few nurses and observed every unit for approximately 45 minutes except one unit was for 2 hours to determine staffing needs. She stated that she just goes off what the staff tell her about the residents and has not reviewed the clinical records to determine the needs of the residents. She stated that without knowing the behaviors of each resident and the incidents that were occurring, she was not able to accurately determine the number of staffs that is needed on each unit. During an interview with the Administrator (staff #239) conducted on August 26, 2024 at 4:00 p.m., she stated that the facility provides adequate supervision for the residents. She stated that the regulation pertaining to supervision did not fit when you have wandering mentally ill residents in a skilled nursing facility (SNF). She stated that the facility was an institution where the resident carries out their last days and not a home. However, the administrator said that it was the facility's responsibility to protect the residents. An interview with an LPN (staff #158) was conducted September 4, 2024 at 4:01 p.m. The LPN stated there was not enough staff, more specifically CNAs on the units to safely and effectively monitor the residents; and that, there were not enough CNA's to monitor the residents. The LPN said that the risks associated with not having sufficient staff to monitor the residents are neglect in their care, fall risks and might make a resident be vulnerable to sexual acts, because of residents not alert and oriented and the history of wandering. The LPN also said that there were two CNAs on the unit; and, sometimes a CNA providing 1:1 on the floor in the morning shift, but not in the evening shift. She further stated there was a need for more staff due to the behaviors on the unit and not being able to monitor the residents as they should be. Further, the LPN said that if the CNA's are providing care in pairs, she will at times step down and assist with resident care or help with monitoring, but it was not always possible.