

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 09/11/2024
NAME OF PROVIDER OR SUPPLIER Rehab at Scottsdale Village Square		STREET ADDRESS, CITY, STATE, ZIP CODE 2620 North 68th Street Scottsdale, AZ 85257	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49399</p> <p>Based on staff interviews, clinical record review, facility's documentation review, and facility policy review, the facility failed to ensure adequate supervision was provided for one resident (#200). The deficient practice resulted in resident wandering away and becoming lost in the community.</p> <p>Findings include:</p> <p>Resident #200 was admitted to the facility on [DATE] with diagnoses of amyotrophic lateral sclerosis, dementia with psychosis, and depressive disorder.</p> <p>The behavior monitoring & interventions note dated August 22, 2024 revealed that on the evening shift the resident exhibited behaviors of wandering and elopement.</p> <p>Review of the elopement risk evaluation dated August 23, 2024 revealed a score of 0 indicating the resident had no risk for elopement.</p> <p>The behavior monitoring & interventions notes from August 26, 27 and 28, 2024 included the resident exhibited wandering and elopement behaviors.</p> <p>A review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13 indicating the resident was cognitively intact. The assessment coded the resident for wandering behavior that occurred 1 to 3 days of the assessment; and that, the wandering does not place the resident at risk of getting to a potentially dangerous place nor intrude on the privacy or activities of others.</p> <p>The behavior monitoring & interventions on August 30, 2024 included that the resident exhibited wandering and elopement behaviors.</p> <p>A review the behavior monitoring & interventions notes dated September 2 and 3, 2024 revealed the resident exhibited behaviors of wandering and elopement.</p> <p>The behavior note dated September 3, 2024 included that the resident refused evening medication, was restless, pacing back and forth from his room to the hallway and stated that he was leaving because someone was coming to pick him up. Per the documentation, the resident looked tired but did not want to go to bed; and that, the resident was redirected with negative impact.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The behavior monitoring & interventions on September 4, 2024 revealed the resident exhibited wandering and elopement behaviors.</p> <p>The psych evaluation note dated September 4, 2024 revealed that the resident reported that he was leaving and was frustrated about being at the facility. Per the documentation, the resident reported that he was depressed and anxious because he wanted to be home.</p> <p>A review of the Care Area Assessment (CAA) Triggers Summary for behavioral symptoms dated September 4, 2024 revealed that the resident had wandered that occurred 1 to 3 days of the assessment. The summary also included that this was addressed in the care plan.</p> <p>However, a review of the care plan revealed no documentation of a care plan addressing resident's wandering and elopement behavior.</p> <p>The behavior monitoring & interventions on September 5, 2024 revealed the resident exhibited wandering and elopement behaviors.</p> <p>The behavior note dated September 5, 2024 included that the resident had been awake most of the night, seated on his chair and sometimes walked to the hallway just pacing back and forth.</p> <p>The behavior monitoring & intervention notes dated September 7 and 8, 2024 revealed the resident exhibited wandering and elopement behaviors.</p> <p>Despite documentation that the resident exhibited wandering and elopement behaviors, there was no evidence found of any interventions implemented to address this behavior.</p> <p>An alert note dated September 9, 2024 revealed the resident's room window was popped opened and the resident is no resident in the room. Per the documentation, the resident was missing; and that, the front desk staff reported that the police officers were with the resident about a block from the facility. It also included that the resident was taken to a hospital by the officers for checkup because he obtained minor injuries from a fall, as resident was dragged by a vehicle trying to get in to it while the vehicle was moving.</p> <p>In an interview nursing assistant (NA/staff #30) conducted on September 12, 2024 at 10:53 a.m., the NA stated that her role was to take care of the day room, deliver room trays, give resident water and snacks. The NA said that she cannot help a resident like changing and she calls a certified nursing assistant (CNA) for that. The NA said that for residents who have wandering behaviors, she will distract the resident, find something for them to do and ensure that they do not go into other resident rooms. She also said that she was on shift when resident #200 left the facility on Monday, September 9. She stated that she was in the day room caring for other residents and there were two CNAs scheduled to help with breakfast. She stated that another staff then came in and reported that resident #200 was nowhere to be found. She said that everyone started looking for resident #200; and that, the resident left using the window in his room. She stated the window in the resident's room had a latch and a screen; but, there was no alarm. She stated that she heard from another staff about resident #200 wanting to leave.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>An interview with another CNA (staff #14) was conducted on September 12, 2024 at 11:11 a.m. The CNA stated that resident #200 was calm, liked to keep self in his room, and did not have a roommate. She stated that she was surprised about the resident leaving by opening the window in his room. The CNA also said that she had not checked if it was easy to open the window in the room of resident #200.</p> <p>An interview was conducted on September 12, 2024 at 12:16 pm with the MDS nurse (staff #58) and the director of nursing (DON/staff #68). The MDS nurse stated her role for resident's care plan included reviewing medications, diagnoses, listening to their behaviors and other staff such as social services by attending behavioral meeting twice a week; then, she can readjust the resident's care plan to be more appropriate for the resident. The MDS nurse said that the care plan is completed within their 14-day period. During the interview, a review of the clinical record was conducted by the DON who stated that the resident was not care planned for wandering behaviors. The DON stated that the facility completed an elopement assessment at admission which showed that the resident had no risk. He stated that the resident had a BIMS score of 13 which indicated the resident had no cognitive impairment. Further, the DON stated that based on the assessment/tool used, the facility believes the resident had no risk for elopement.</p> <p>Review of facility policy on Wandering and Elopements revised March 2019 revealed that the facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. (1) If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain resident's safety.</p>		