

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  10/31/2024
NAME OF PROVIDER OR SUPPLIER  Rehab at Scottsdale Village Square		STREET ADDRESS, CITY, STATE, ZIP CODE  2620 North 68th Street Scottsdale, AZ 85257	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49399</p> <p>Based on observation, clinical record review, facility documentation and staff interviews, the facility failed to ensure that adequate supervision was provided to two residents (#3 and #4) to prevent abuse. The deficient practice could increase the risk of resident to resident abuse.</p> <p>Findings include:</p> <p>- Regarding Resident #3:</p> <p>Resident #3 was readmitted to the facility on [DATE] with the diagnosis that included Post-Traumatic Stress Disorder, anxiety disorder, other specified depressive episodes, restlessness and agitation, adjustment disorder with mixed disturbance of emotions and conduct.</p> <p>Review of care plan dated May 4, 2021 revealed a trauma informed care, post traumatic stress disorder (PTSD). The goal included to avoid triggers related to previous traumas throughout stay. The intervention includes to continue to monitor for triggers.</p> <p>A review of resident #3 clinical record revealed a progress note, eINTERACT SBAR (Situation, Background, Assessment, Recommendation) Summary for Providers, dated October 4, 2024 at 6:24 pm revealed that resident #3 was observed standing in dayroom with a bloody thumb, being yelled out by Resident #4.</p> <p>A review of resident #3 clinical record revealed a progress note, Alert Note, dated October 4, 2024 at 10:32 pm that a CNA (certified nursing assistant) reported to nurse that resident was screaming and said another resident hit him. The noted stated resident said another resident had gone into their room and started kicking them. Resident said he tried to push his wheelchair away and got an abrasion to his left thumb. Nurse did head to toe assessment and assessed injuries. Resident was able to move all extremities with and without resistance. Resident has abrasion to their left thumb with scant bleeding. Nurse cleaned wound with NS (normal saline), pat dry, and applied bandaid, resident stated 3/10 pain on their thumb and PRN (as needed) Tylenol was given. The note stated that the MD (Medical Director) and DON (Director of Nursing) were notified.</p> <p>- Regarding Resident #4:</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #4 was readmitted to the facility on [DATE] with diagnosis that included anxiety disorder, postural kyphosis, dysphagia and spinal stenosis.</p> <p>A review of resident #4 clinical record revealed a progress note, eINTERACT SBAR Summary for Providers, dated October 4, 2024 at 5:39 pm revealed Resident #4 was observed sitting in his wheelchair, yelling at another resident and was actively attempting to make his way to other resident but several staff members were observed intervening.</p> <p>A review of resident #4 clinical record revealed a progress note, Alert Note, dated October 4, 2024 at 10:39 pm stated CNA reported to nurse that resident was screaming that another resident hit them. Nurse and CNA separated the two residents and was assessed separately. Both residents had abrasions. Resident had two abrasions to the left arm and stated they are not aware of how it happened. Abrasions cleaned with NS. Resident continues to be aggressive and agitative despite redirection methods. Resident was given PRN hydroxyzine for agitation and was offered fluids and drinks. Resident continues to show aggressive nature and is not redirectable. The note stated 911 was notified and transported resident #4 out.</p> <p>An interview was conducted on October 31, 2024 at 11:05 am with a licensed practical nurse (LPN/Staff #118). Staff #118 stated when there is resident's altercation, they separate them, she will ask them what is the issue, they check on them and it is pass down through report. She stated that 2 weeks ago there was two residents that were fighting, they separated them and keep 15 minutes check.</p> <p>An interview was conducted on October 31, 2024 at 11:23 am with a CNA(Staff #42). Staff #42 stated that resident #3 and resident #4 got into an argument that happened in the courtyard. Staff #42 stated resident #4 is in a wheelchair, can stand but not on his own and resident #3 can walk and is pretty much independent. Staff #42 stated resident #3 was forgetful, did not come out to his room often, he did not socialize with other resident.</p> <p>An interview was conducted on October 31, 2024 at 11:31 am with a CNA(Staff #82). Staff #82 stated that Resident #4 liked his own space and did not like anybody bothering him. Staff stated that residents got into a verbal fight and Resident #4 was screaming in the dayroom at Resident #3. Resident #3 did not hang out in dayroom. Resident #3 was yelling at the nurse and complaint about something every day and yelled everyday out loud and it was disturbing the residents. Resident #4 was yelling at Resident #3. Resident #3 was loud and Resident #4 was trying to shut him down. She added that when residents are in the day room, they make sure no one gets close to Resident #3.</p> <p>An interview was conducted on October 31, 2024 at 11:45 am with Resident #3. Resident #3 stated that resident #4 is very mean, swore a lot, and at 08:00 am in the morning he pushed him away, at 3:30 pm Resident #4 tried to kick him in his leg and he hurt his thumb, and at about 5:00 pm the police arrested him for a week and then he was back now on the other side. Resident #3 did not remember when/where the incident happened.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on October 31, 2024 at 11:59 am with a CNA(Staff #91). Staff #91 stated that she was working on October 4. She remembered two residents were arguing in the eating area/dining room, one resident said another resident came in his room hitting him. Staff said they told the nurse LPN because of what happened in the resident's room in the afternoon around 4:30-5:00pm and one resident was hitting the other resident. Staff #91 said one of them who was able to walk had a bleeding finger and the resident in the wheelchair was very agitated. Staff #91 stated that she was in the dining room watching residents, the other CNA left to do something, and the nurse was on the other side of the dining room eating their lunch when that incident happened. The fire fighters came and took the resident who is in the wheelchair and then the police came. She stated that she did not know how residents are monitored in the court yard.</p> <p>An interview was conducted on October 31, 2024 at 12:45 pm with the director of nursing (DON/Staff #12) and during the interview, the assistant director of nursing (ADON/Staff #13) and the administrator (Staff #11) were present. The DON stated that the process on how residents are supervised or monitored is that they have surveillance camera and their staff monitor their residents. Their surveillance camera is in the other units while the other units have no surveillance camera but residents are supervised and monitored by staff. DON stated that the supervision by staff is reviewed based on acuity during their meetings such as less staff on other units with lower acuity. The DON stated that their inside units have higher acuity. The DON stated that their lower acuity unit is staffed with two CNAs and a nurse per shift with 15 to 20 residents and three CNAs and a nurse per shift for 25 to 30 residents. The DON stated that for the resident to resident altercation, Resident #3 reported to staff that Resident #4 wheeled in his room and started hitting him, and Resident #3 pushed Resident #4 out of his room. The DON stated that their staff do frequent rounds for visual supervision of residents and provide activity in the day room area. The DON stated that their intervention include resident #4 went out to the hospital then when he came back his room changed.</p> <p>A review of facility policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised April 2021 revealed residents have the right to be free from abuse. (1) protect residents from abuse, neglect by anyone including b. other residents.</p>