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	12/11/2024

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** 40581 Based on documentation, interviews, and the facility policy and procedures, the facility failed to ensure that one resident (#26) did not abuse another resident (#32). The deficient practice could result in residents being physically and/or emotionally injured. Findings include: Resident #26 was admitted to the facility on [DATE] with diagnoses that included unspecified psychosis, generalized anxiety, dementia in other diseases classified elsewhere, anoxic brain damage, and disruptive mood dysregulation. The minimum data set (MDS) dated [DATE] included a staff assessment for mental status indicating the resident had a severe cognitive impairment. The care plan dated May 16, 2015 revealed that the resident has a problem with exessive yelling, history of sitting or forcefully placing herself on floor at times, intrusiveness, physically aggressive behaviors, being combative with care, exposing herself, and spitting. Interventions included to attempt to redirect behaviors, and see the behavior plan for up to date distractors. Behavior Charting dated November 30, 2024 revealed that the resident was agitated, aggressive, hitting staff, yelling out, mumbling words, and pacing in room. Behavior Charting dated December 2, 2024 revealed that the resident was agitated, aggressive, demonstrated poor boundaries, and hit another resident. The resident was removed from the common area to her room with a continued one-to-one staff. Snacks and fluids were given. A progress note dated December 2, 2024 revealed that during medication administration , the nurse was notified by staff that the resident was physically aggressive with another resident. Upon arrival to the dayroom the residents had been redirected and separated. The resident was unable to recount the incident. The residents were immediately separated by staff. The resident was reeducated on being at a minimum of arms length away from residents and other staff. The resident's baseline is confused, non compliant and is on psychoactive medications. A change of condition form dated December 2,2024 revealed that the resident made contact with another resident. (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 12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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	The care plan dated December 3, 2024 revealed that the resident is at risk for psychosocial emotional distress related to resident to resident altercation. Interventions included to monitor for nonverbal serious symptoms of distress, and a psych consult as needed if indicated. -Resident #32 was admitted to the facility on [DATE] with diagnoses that included vascular dementia with severe agitation, major depression, and anxiety disorder. The care plan dated September 3, 2024 revealed that the resident is at risk for psychosocial emotional distress related to resident to resident altercation. Interventions included to monitor for nonverbal serious symptoms of distress, and a psych consult as needed if indicated. A behavior plan dated November 8, 2024 revealed that the resident has a behavior problem related to posturing and physical aggression, attempting to take peers food/items, and disrobing without sexual intent. Interventions included monitoring behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. The (MDS) dated [DATE] included a staff assessment for mental status indicating the resident had a severe cognitive impairment. A progress note dated December 2, 2024 revealed that during medication administration , the nurse was notified by staff that the resident had an incident with another resident. Upon arrival to the dayroom the residents had been redirected and separated. When resident #32 asked what had happened, he grabbed the nurse's hand and placed it over his left eye/head area. An assessment was performed and no apparent injury or bleeding was noted. A Situation, Background, Assessment, and Recommendation (SBAR) summary dated December 2, 2024 included that the resident was ambulating in the hall when another resident made contact with his face. A change of condition form dated December 2, 2024 revealed that the resident had a resident to resident altercation. An interview was conducted on December 10, 2024 at 11:44 a.m. with a licensed practical nurse (LPN/staff #21), who stated that she has worked with resident #26 and the resident is supposed to have a one-to-one at all times. When she came back to work, she was told that resident #26 had hit resident #32. She stated that resident #26 is smart and fast, and she hits staff all the time. An interview was conducted on December 10, 2024 at 12:56 p.m. with the Director of Nursing (DON/staff #1), who stated that abuse includes a resident hitting another resident. He stated that resident #26 was having a behavior, flinging her arms around and staff was trying to redirect her when resident #32 walked into her path and her arm made contact with his left cheek. On December 10, 2024 at 12:56 p.m., an interview was conducted via phone with a certified nursing assistant (CNA/staff #5), who stated that it was his first day working with resident #26 and knows that she was his responsibility. He stated that he was focusing on resident #26 and didn't see resident #32 coming towards the resident. He stated that resident #26 reached out and hit resident #32 with an open hand in the face. He stated that resident #32 yelled, don't hit me. (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 - Few	The facility policy, Abuse, Neglect, Exploitaion and Misappropriation Prevention Program states that residents have the right to be free from abuse.

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Rehab at Scottsdale Village Square	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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581 Based on observation, clincal documentation, staff interviews, and the facility policy and procedures, the facility failed to administer medications within the required timeframe to six residents (#66, #55, #12, #2, #15, and #25). The deficient practice could result in symptoms not being managed effectively and/or adverse effects. Findings include: Resident #66 was admitted to the facility on [DATE] with diagnoses that included obsessive compulsive disorder unspecified, hemorrhoids, rectal prolapse, drug induced subacute dyskinesia, and Parkinson's disease with dyskinesia with fluctuations. The order summary revealed: -September 1, 2024, Benztropine Mesylate oral tablet 0.5 mg give one tablet PO every 12 hours related to drug induced subacute dyskinesia. -September 1, 2024, Docusate Sodium oral tablet 100 mg give two tablets PO two times a day for bowel movement care (BM). -September 1, 2024, Senna oral tablet 8.6 mg give 2 tablets PO two times a day for BC. -September 1, 2024, Sodium Chloride oral tablet 1 gm give one tablet PO three times a day for prophylaxis. -September 2, 2024, Multivitamin give one tablet PO one time a day for supplement. -September 2, 2024, Gabapentin oral capsule 100 mg give one capsule enterally four times a day related to obsessive compulsive disorder, unspecified. -September 2, 2024, Divalproex Sodium Capsule Delayed Release Sprinkle 125 mg give two capsules by mouth (PO) one time a day related to obsessive compulsive disorder, unspecified. -November 7, 2024, Fluoxetine HCl oral capsule 20 mg give PO one time a day related to obsessive compulsive disorder, unspecified. The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 4 indicating the resident had a severe cognitive impairment. Review of the medication administration record (MAR) dated December 2024 revealed that the above medications were scheduled to be administered at 8:00 a.m. During an observation of medication administration conducted on December 11, 2024, it was observed that the 8:00 a.m. medications for resident #66 were administered at 9:36 a.m. in the dining room. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident #55 was admitted to the facility on [DATE] with diagnoses that included hypertension, atherosclerotic heart disease of native coronary artery without angina pectoris, major depression disorder, gastro-esophageal reflux disease with esophgitis, without bleeding, Parkinson's Disease, and dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. The order summary revealed: -July 25, 2024, Allopurinol oral tablet 100 mg PO one time a day for joint pain and inflammation (gout). -July 25, 2024, Amlodipine Besylate oral tablet 10 mg PO one time a day for hypertension. -July 25, 2024, Aspirin tablet 81 mg give one tablet PO one time a day for coronary artery disease. -July 25, 2024, B-complex oral tablet (B-Complex with Biotin and Folic Acid give one tablet one time a day PO for supplement. -July 25, 2024, Bupropion HCl ER (SR) tablet extended release 12 hour 100 mg give one tablet PO a day for depression as evidenced by sad mood. -July 25, 2024, Ferrous Sulfate tablet 325 mg give one tablet PO one time a day for supplement. -July 25, 2024, Miralax Powder 17 gm/scoop give one scoop PO one time a day for bowel care. -July 25, 2024, Multivitamins tablet give one tablet PO one time a day for supplement. -July 25, 2024, Plecanatide Oral Tablet 3 mg (Plecanatide) give 1 tablet by mouth one time a day for gerd. -July 25, 2024, Docusate Sodium oral tablet 100 mg (Docusate Sodium) give 2 tablets PO two times a day for bowel care. -July 25, 2024, Omeprazole DR 20 mg capsule give 1 tablet PO two times a day related for gastro-esophageal reflux disease with esophgitis, without bleeding. -July 25, 2024, Carbidopa-Levodopa oral tablet 25-100 mg (Carbidopa- Levodopa) give 3 tablets PO three times a day for Parkinson's Disease. -September 9, 2024, Rivastigmine Transdermal Patch 24 Hour 9.5 mg/24 hr. Apply 1 patch transdermally one time a day related to unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, and remove per schedule. August 3, 2024, Acetaminophen tablet 325 mg give 2 tablets PO three times a day for pain. -October 2, 2024, Lorazepam oral tablet 0.5 mg (Lorazepam) give 0.25 mg by mouth two times a day as evidenced by restlessness related to unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-October 9, 2024, Senna tablet 8.6 mg (Sennosides) give 1 tablet PO one time a day for constipation -October 16, 2024, Diclofenac Sodium External Gel 1 % (Diclofenac Sodium (Topical)) apply to both shoulders topically three times a day for pain. The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 5 indicating the resident had a severe cognitive impairment. Review of the medication administration record (MAR) dated December 2024 revealed that the above medications were scheduled to be administered at 8:00 a.m. During an observation of medication administration conducted on December 11, 2024, it was observed that the 8:00 a.m. medications for resident #50 were administered at approximately 10:07 a.m. in the dining room. -Resident 12 was admitted to the facility on [DATE] with diagnoses that included major depression, history of transient ischemic attack (TIA), gastro-esophageal reflux disease, and hypertension. The order summary revealed: -October 18, 2024, Miconazole Powder apply to Bil groin folds topically two times a day for fungal rash. Apply lightly and brush away excess. -October 18, 2024, Venelex External Ointment apply to buttocks, groin, scrotum topically two times a day for skin integrity. -October 19, 2024, Aspirin oral capsule 81 mg give 81 mg by PO one time a day for DVT ppx. -October 19, 2024, Cholecalciferol oral tablet give 25 mcg PO one time a day for supplement. -October 19, 2024, Fluoxetine HCl oral capsule give 80 mg PO one time a day for depression. -November 3, 2024, Omeprazole oral capsule delayed release 20 mg give 2 capsules PO one time a day for GERD. Take two capsules (40 mg total) by mouth every morning. November 2, 2024, Sucralfate tablet 1gm give 1 tablet PO four times a day for gastric protection take one tablet by mouth four times daily before meals and at bedtime. The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 11 indicating the resident had a mild cognitive impairment. Review of the medication administration record (MAR) dated December 2024 revealed that the above medications were scheduled to be administered at 8:00 a.m. During an observation of medication administration conducted on December 11, 2024, it was observed that the 8:00 a.m. medications for resident #12 were administered at 10:36 a.m. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident #2 was admitted to the facility on [DATE] with diagnoses that included history of other venous thrombosis and embolism, olecranon bursitis right elbow, type II diabetes, major depression, gasto-esophageal reflux disease without esophagitis. The order summary revealed: -October 8, 2024, Apixaban oral tablet 5 mg give 5 mg PO two times a day for anticoagulant. -October 8, 2024, Metformin HCl oral tablet 500 mg give 500 mg PO two times a day for DM. -October 8, 2024, Spironolactone oral tablet 25 mg give 25 mg PO two times a day for edema, hold if SBP <100. -October 8, 2024, Simethicone oral tablet 80 mg give 80 mg PO four times a day for gas. -October 9, 2024, Folic Acid oral tablet 1 mg give 1 tablet by mouth one time a day for supplement October 9, 2024, Multi Vitamin oral tablet give 1 tablet PO one time a day for supplement. -November 4, 2024, Diclofenac Sodium External Gel 1 % apply to Lower back topically two times a day for Pain. -November 7, 2024, Fluoxetine HCl oral tablet 20 mg give 1 tablet PO one time a day for depression. -November 24, 2024, application of betadine to right foot 2nd digit toe two times a day d/c when resolved. The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 15 indicating the resident was cognitively intact. Review of the medication administration record (MAR) dated December 2024 revealed that the above medications were scheduled to be administered at 8:00 a.m. During an observation of medication administration conducted on December 11, 2024, it was observed that the 8:00 a.m. medications for resident #2 were administered at 10:45 a.m. -Staff was observed taking medication to Resident #15's room to administer at 10:55 a.m. -Resident #25 was admitted to the facility on [DATE] with diagnoses that included The order summary revealed: -October 28, 2024, Cyproheptadine HCl oral tablet 4 mg give 1 tablet PO three times a day for allergies. -October 28, 2024, Potassium Chloride ER oral tablet extended release 20 meq give 1 tablet PO two times a day for electrolyte imbalance/hypokalemia. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-October 28, 2024, Guaifemesin ER tablet extended release 12 hour 600 mg give 1 tablet by mouth two times a day for allergies. -October 29, 2024, Bumetanide oral tablet 1 mg give 1 tablet PO one time a day for congestive heart failure (CHF). -October 29, 2024, Famotidine oral tablet 20 mg give 1 tablet PO one time a day for GERD. -October 29, 2024, Finasteride oral tablet 5 mg give 1 tablet PO one time a day for benign prostatic hyperplasia (BPH). -October 29, 2024, Nebivolol HCl oral tablet 10 mg give 1 tablet PO one time a day for hypertension (HTN). Hold for systolic blood pressure (SBP) less than 110. -October 29, 2024, prednisone oral tablet 10 mg give 1 tablet PO one time a day for COPD. -October 29, 2024, Roflumilast oral tablet 250 mcg give 1 tablet by PO time a day for COPD. -October 30, 2024, Azithromycin oral tablet 250 mg give 1 tablet PO one time a day every Mon, Wed, Fri for a history of pneumonia (PNA). -November 7, 2024, Myrbetriq oral tablet extended release 24 hour give 25 mg PO one time a day for BPH. -December 5, 2024, Breo Ellipta Inhalation Aerosol Powder Breath Activated 200-25 MCG/ACT 1 inhalation inhale orally one time a day for chronic obstruction pulmonary disease (COPD) * Rinse mouth with water and spit back into cup after use* -December 9, 2024, Morphine IR 5 mg capsule PO (BID) two times a day for shortness of breath. -December 25, 2024, Senna oral tablet 8.6 mg give 1 tablet PO two times a day for constipation. The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 6 indicating the resident had a severe cognitive impairment. Review of the medication administration record (MAR) dated December 2024 revealed that the above medications were scheduled to be administered at 8:00 a.m. Facility documentation revealed that medications are administered at 8:00 a.m. and 8:00 p.m. During an observation of medication administration conducted on December 11, 2024, it was observed that the 8:00 a.m. medications for resident #25 were administered at 11:21 a.m. A registered nurse (RN/staff #8) told resident #25 that she was not going to administer his blood pressure medication because his blood pressure (BP) was low. The surveyor had to intervene and asked staff #8 when she took the resident's BP and she stated that she had taken the resident's BP at 7:15 a.m. Then, she stated that it was possible that the BP level had changed since that time and would take the resident's BP again. The BP was 124/71. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview conducted on December 11, 2024 at 9:25 a.m. with resident #25, he stated that he had not received his morning medications. An interview was conducted on December 11, 2024 at 9:30 a.m. with a registered nurse (RN/staff #8), she stated that she had started administering the morning medications at 6:15 a.m. She stated that medications are administered at 8:00 a.m. and she can administer medications one hour before and one hour after. Then, she looked at her watch and stated that it was 9:27 a.m. and she still had to give medications to five more residents. An interview was conducted on December 11, 2024 at 9:55 a.m. with a certified nursing assistant (CNA/staff #68), who stated that breakfast was served around 8:15 a.m. Note: medications that need to be administered prior to breakfast, such as resident 12's Sucralfate tablet 1gm give 1 tablet PO four times a day for gastric protection take one tablet by mouth four times daily before meals and at bedtime was adminstered at 10:36 a.m. An interview was conducted on December 11, 2024 at 3:09 p.m. with the Director of Nursing (DON/staff #1), who stated that medications are administered at 8:00 a.m. and 8:00 p.m. He stated that medications can be administered one hour before and one hour after 8:00 a.m. He stated that if a medication is not administered on time, there is a risk of impacting efficacy, potentiation, as well as physical side effects if medication is not received timely. The facility policy, Administering Medications states that medications are adminstered within one hour of their prescribed times, unless otherwise specified (for example, before and after meals).

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581 Based on facility documentation, staff interviews, and the facility policy and procedures, the facility failed to ensure that one resident #100 did not elope from the facility. The deficient practice could result in residents eloping and being physically and/or emotionally harmed. Findings include: Resident #100 was admitted to facility on June 1, 2015 and readmitted [DATE] with diagnoses that included schizophrenia, anxiety disorder, adjustment disorder with mixed disturbance of emotions and conduct, major depressive disorder, unspecified psychosis, and vascular dementia. The care plan dated February 5, 2016 revealed that the resident was an elopement risk associated with schizophrenia and associated impaired safety awareness. The patient attempts putting different codes in the keypad to leave the unit and pushes the door setting off the alarm. There was an elopement attempt on March 9, 2021. Interventions included to conduct Wanderguard safety check; staff will ambulate the resident up to/through all door(s) one time a week (Thursday) to ensure proper functioning of alarm. Also, check to ensure doors are engaged and working properly every shift, and redirect the resident from the doors. The Wandering Risk Evaluation dated August 9, 2023 revealed a score of 13 and the resident was a high risk for wandering. The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 9 indicating the resident had a mild cognitive impairment. An orders administration note dated September 9, 2023 revealed to monitor for behaviors, physical aggression to staff. Document the number of episodes observed. Intervention Codes: 1=redirect, 2=1:1, 3=refer to nurse's note, 4=activity, 5=return to room, 6=toilet, 7=offer food, 8=offer fluids, 9=reposition, 10=adjust room temp, 11=give back rub, 12=behavior plan every shift. The patient is punching and screaming at staff when being redirected from exiting unit more than five times. The patient has refused medication. The medical director is aware. A progress note dated September 14, 2023 revealed that the resident was observed pacing in an out of his room. The resident was redirected a couple of times when seeking an exit. Staff will continue to monitor for changes during the shift. A progress note dated September 21, 2023 revealed that the resident eloped around 7:45 a.m. after the last 15-minute check. Staff found him outside and he was redirected back to the facility. A head-to-toe assessment was done upon arrival, vitals were within normal limits. There was no sign of distress noted and the resident denies pain at this time. A further review showed the exit door malfunctioned during the time of his elopement. Staff will continue 15-minute checks. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility documentation dated September 21, 2023 revealed that a registered nurse (RN/staff #99) found the resident south of the facility on 68 68th Street. When the resident returned, the main door alarm system was tested and did not work consistently. An interview was conducted on December 12, 2024 with a certified nursing assistant (CNA/staff #74), who stated that the residents have to be supervised so they leave or fight, so staff should be aware of what the residents are doing. Staff are constantly watching the residents and are required to complete 15-minute checks on the residents. She stated that there is an alarm on the exist door which should go off if a resident tries to exit the unit. When she exits the unit, she waits until she hears a clicking noise, so she knows that the door is closed and secured. An interview was conducted on December 11, at 2:59 p.m. with the Maintenance Director (staff #93), who stated that the current practice is to check the doors on the secured units daily. He stated that the door where resident #100 exited needed the electrical wiring replace about a year ago, but did not have documentation to confirm the date. An interview was conducted on December 11, at 3:09 p.m. with the Director of Nursing (DON/staff #1), who stated that all residents are assessed for elopement risk and the current practice is for all secured doors to be maintained. He stated that staff should wait to hear the door click to make sure the door is shut and make sure that a resident doesn't follow the staff out of the unit. The facility, Wandering Residents & Elopement Policy states that it is the duty of the nurse to account for each resident on their unit at the beginning of the shift. Each CNA is then responsible to ensure that the residents are accounted for during their shift.