

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  01/15/2025
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 - Minimal harm or potential for 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50553</b></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 (#13 and #22) to prevent elopement from the facility. The deficient practice can result in other residents to go missing and/or getting injured.</p> <p>Findings include:</p> <p>- Regarding Resident #13:</p> <p>Resident #13 was admitted to the facility on [DATE] with diagnoses including dementia with agitation, anoxic brain damage, and epilepsy.</p> <p>Review of the elopement evaluation completed by the facility on December 31, 2024 revealed a score of 3.0, indicating the resident was considered At-risk for elopement, due to having a history of elopements at home, history of attempting to leave the facility without staff, and wandering behavior.</p> <p>Review of the nursing note dated December 31, 2024 revealed that upon admission, the resident's sister informed the staff that the resident is an elopement risk and had eloped a couple of times before.</p> <p>Review of the physician's progress note dated January 2, 2025 revealed that the resident was alert and oriented to self only, had progressive dementia with sundowning at night, had seizures, and was non-verbal.</p> <p>Review of the careplan initiated on January 2, 2025 revealed a focus that Resident #13 was an elopement risk, with interventions including to distract the resident from wandering by offering diversions and providing structured activities.</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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the nursing progress notes revealed that on January 5, 2025, the resident was seen walking in the hallway at 08:05AM, while the nurse was administering medications to another resident. The nurse detailed that at approximately 08:09AM, the Certified Nursing Assistant (CNA) reported that the resident was missing from the unit. The facility was searched, but the resident was unable to be located, so police were called. At approximately 10:50AM, the police reported to the facility that the resident was found and that they were bringing him to the facility. The note stated the resident arrived back to the unit at approximately 11:00AM.</p> <p>Interview was conducted on January 15, 2025 at 10:36AM with the Licensed Practical Nurse (LPN)/ Unit Manager (Staff #26), who stated that the staffing typically included a nurse and three CNAs. She also included that someone had to be present in the dayroom at all times. She also stated that when Resident #13 eloped, no one had seen which door he had left through. She also reported that there were no alarms sounding on the Kiva unit, though she claimed that there was an alarm sounding somewhere else in the building, which could still be heard on the unit. The Unit Manager also stated that the residents were the responsibility of the facility, and identified risks associated with a resident eloping to be that the resident could be put in harm's way.</p> <p>Observation of the entry to the Kiva unit with the Unit Manager on January 15, 2025 at 11:12AM revealed that the door to the Kiva unit was a large door, locked with a keypad system, positioned next to the lobby front-doors. Observation revealed that when staff or visitors went through the doors by typing a code onto the keypad, the door could then be opened, indicated by the light on the keypad turning green. Observation revealed that the light stayed green for approximately ten to fifteen seconds, including after the door was shut. When asking the nurse unit manager if the door could still be opened after shutting, the Unit Manager assisted visitors through the door, waited for the door to shut, and then attempted to re-open the door. The door was able to be opened without re-entering a keycode. When asked if she thought this was a potential concern for elopement, the Unit Manager replied that she thought it could potentially be a concern and would bring it up to maintenance.</p> <p>Interview was conducted on January 15, 2025 at 1:12PM with the Director of Nursing (DON/Staff #41), who stated that measures in place to prevent elopements included monthly checks of secured doors and elopement assessments completed on admission and quarterly. He also elaborated that several new interventions are being added following the recent elopements. When asked about Resident #13's elopement, the DON described that he was called after the nurse reported that the nurse had not seen the resident on the unit in about five minutes. He reported that at that time, staff checked the whole facility. He noted that there were doors alarming on another unit, which he believed could have masked the alarm in the Kiva unit. The DON explained that it was unclear exactly what happened, but explained that the resident was very cognitive and was familiar with the building as he was a former employee, which may have made it easier for him to leave.</p> <p>- Regarding Resident #22:</p> <p>Resident #22 was admitted to the facility on [DATE] with diagnoses including dementia with behavioral disturbance, essential hypertension, and hyperlipidemia.</p> <p>A review of the elopement risk evaluation created on December 4, 2024 revealed that the resident scored a 0.0, indicating the resident was not at risk for elopement.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the careplan revealed a focus, initiated December 4, 2024, indicating that the resident was an elopement risk related to being disoriented to place and impaired safety awareness.</p> <p>Review of the nursing progress note dated December 5, 2025 at 3:40PM revealed that the resident was confused and was roaming into other residents' rooms, requiring constant re-direction. Further review of the nursing progress notes revealed that on December 9, 2024, the resident was wandering the unit and was seeking to leave the premises.</p> <p>Review of the Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 03, indicating severe cognitive impairment.</p> <p>Review of the nursing progress notes revealed that on January 8, 2025, the resident was last seen at 4:30PM walking in the courtyard. At 4:40PM, staff noticed that the resident was not in his room or the neighboring room, so a search was begun of the unit. The resident was not found, so other units were searched. After the resident was still not found, police were notified. Further review of the nursing notes revealed no evidence of a nursing note entered when the resident was returned to the unit.</p> <p>A Change in Condition Evaluation with an effective date of January 8, 2025 at 4:40PM was completed by the Director of Nursing (DON) on January 10, 2025, which revealed that on January 8, 2025, the resident was noted missing at 4:40PM, and was found by the police and returned to the facility at 7:13PM with no injuries noted.</p> <p>Interview was conducted on January 15, 2025 at 09:56AM with a Registered Nurse (RN/Staff #9) who stated that on January 8, 2025, he had seen the resident walking the hall at about 4:30PM. About ten minutes later, the CNA (Certified Nursing Assistant) had left to check a call light and noticed the resident was not in his room. The RN reported that the facility was thoroughly searched and the resident was not located, so management was notified, who called the police. The RN explained that a woman had found him on the street and picked him up. The resident had mentioned a neighboring town, so the woman took him to the police station in the neighboring town. From there, the police were able to return the resident to the facility around 8:00PM. The RN explained that since the unit required a physical key to get in and out, the resident likely went out with someone, likely a visitor. He explained that the resident was wearing a winter jacket and hat, so visitors may have thought he was also a visitor and let him out.</p> <p>Interview was conducted on January 15, 2025 at 10:36AM with the Unit Manager (LPN/ Staff #26), who stated that the staffing typically included a nurse and three CNAs, and she felt this was adequate most days. She stated that she was present the day that Resident #22 eloped from the facility. She explained that he was last seen around 4:30PM on January 8, 2025 and was returned back to the facility by the police around 7:45PM or 8:00PM. She explained that a head to toe assessment was done, and no injuries were found on the resident. She stated that she was unsure how he had gotten out of the facility, but she explained that the resident often lingered near doors, and she assumed he may have followed someone out. She further explained that the resident was in one of the outdoor units, which had a gate that required a physical key. She described the gate door as slow-moving, and stated the resident may have followed someone out of the gate.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview was conducted with the Unit Manager (Staff #26) and a maintenance worker (Staff #55) on January 15, 2025 at 11:07PM at the gate leading from the lobby to the Vistas units. The gate hinge device was being worked on by the maintenance worker. The maintenance worker stated that he was fixing the gate, and that the gate was broken. He detailed that the device he was working on is supposed to keep the door from slamming, but he stated that it was causing the gate to not close completely. The Unit manager then stated that she guessed that was the answer on how Resident #22 got out.</p> <p>Interview was conducted on January 15, 2025 at 11:51AM with a Certified Nursing Assistant (CNA/Staff #14), who stated that she did not believe there was enough staff to watch residents closely. She stated that certain units are very busy and require staff to watch the residents closely, due to their behaviors. She further explained that it is often just two CNAs for the unit and it is not enough. She elaborated that sometimes there will be three CNAs, but then one CNA will have to go to an appointment with a resident, leaving just two CNAs. She also stated that the facility will often cancel staff's shifts, leaving the facility with not enough help. When asked about Resident #22, the CNA stated that she had heard that the resident had gotten out from the south gate, and that he had followed someone from the kitchen out of the gate, thinking it was family. The CNA also explained that she knew that the doors do not always lock when closed. She explained that on the units, the door does not always click, so when the staff notice, they close it. She also stated that she noticed the issue everywhere in the facility, including the electrically locked doors. The CNA stated that this has been brought up to maintenance.</p> <p>Interview was conducted on January 15, 2025 at 12:00PM with the Maintenance Director (Staff #67) ho stated that the maintenance team does monthly scheduled inspections for all doors and exits, though they are now doing daily inspections due to the recent elopements. He states that in these inspections, they check the full functions of all the doors, including a fifteen second delay egress for fire safety and making sure the magnets are energized and securing properly. He states that if a door is not functioning properly, staff should put in a work order, and that proper documentation is needed to be held accountable. When asked about the repairs being done to the gate leading to the outdoor Vistas units, the Maintenance Director insisted that the door has been functional. He explained that the closing mechanism, called a [NAME] Slam, was broken that day (January 15, 2025) when kitchen brought the trays to the unit, and it was caught and fixed immediately.</p> <p>Review of the maintenance work order requests from September 2024 to January 2025 revealed several work orders put in due to improperly functioning doors or doors that would not latch or lock. While most of the work orders were marked as completed quickly, the doors appeared to need frequent maintenance, as several work orders were put in due to door issues.</p> <p>(continued on next page)</p>		

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