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	02/05/2025

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 clinical record reviews, staff and resident interviews, facility documentation, and policy and procedures, the facility failed to ensure residents (#44, #33, #70 and #180) were free from abuse. The deficient practice could lead to further resident to resident abuse. Findings include: Resident #44 was admitted to the facility on [DATE] with diagnoses that included post-traumatic stress disorder, anxiety disorder, and adjustment disorder with mixed disturbance of emotions and conduct. The care plan dated October 4, 2024 revealed that resident #44 is at risk for psychological emotional distress related to a resident to resident altercation. Interventions included to monitor for any verbal or non-verbal serious symptoms of psychosocial emotional distress for 72 hours, allow resident to verbalize concerns as needed, and psych consult as needed if indicated. The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 15 indicating the resident was cognitively intact. The progress note dated February 2, 2025 revealed that at approximately 1:30 p.m. on February 2, 2025, a resident (#400) reported to the east unit nurse that there was an issue in the courtyard between resident #44 and resident #33. The nurse and CNA went to investigate and did not find the two residents together. Both were interviewed. Resident #44 had no recollection of the event. Resident #33 who was in his room reported that after lunch he confronted resident #33 regarding going into other people's rooms. He further stated that resident #33 swung at him and he lost his balance and fell . He stated that he did not swing back nor continue to engage with resident #33. Both residents were assessed head to toe. Resident #33 has no marks/injuries nor indication that he made contact with resident #44. Resident #44 has a scrape to his knee and shoulder that he equates to falling on the ground after losing his balance. The care plan dated February 3, 2025 revealed that the resident is at risk for psychological emotional distress related to a resident to resident altercation. Interventions included to monitor for 72 hours and monitor/document resident's usual response to problems: internal - how the individual makes own changes, External -expects others to control problems or leaves to fate, or luck. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident #33 was admitted to the facility on [DATE] with diagnoses that included unspecified dementia, moderate, with other behavioral disturbance, and hypertension. The care plan dated December 4, 2024 revealed that the resident is an elopement risk related to being disoriented, to place, impaired safety risk. Interventions included to one-to-one as needed to provide resident safety, and to distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, or book. The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 3 indicating the resident had a severe cognitive impairment. Behavior charting dated January 28, 2025 revealed that the resident displayed agitation/aggression (verbal/physical towards others - hitting, kicking, grabbing, throwing objects, etc.) The resident was exit seeking and physically aggressive with staff. A physician note dated February 3, 2025 revealed that the resident was transferred from an outside unit due to increased agitation and lability. He was at a memory care facility before and was sent out due to his agitation. He was transferred here for continued care. He denies any chest pain, shortness of breath, or fevers. He is confused and was guided to his room where he was happy to find his belongings. He denies any other issues at this time. The resident was apparently involved in an altercation with another resident on his previous unit. The resident was transferred to his new unit. The resident was seen and evaluated on his new unit. The resident was asked if he had any altercations over the weekend, but could not recall. He states that he was at a funeral type event. He denies any trauma injury or any recollection of an altercation. An interview was conducted on February 7, 2025 at 9:57 a.m. with a certified nursing assistant (CNA/staff #128) who stated she has received training on abuse and if a resident tries to hit another resident, and doesn't make contact, but the resident falls down and is injured, this is resident to resident abuse. She stated that they have residents who wander on the unit, which included resident #33, but he was moved to another unit over the weekend where resident's with increased behaviors can be watched more carefully. She received a report that resident #33 had an incident with resident #44. She stated that resident #33 has a history of wandering into other residents' rooms and is supposed to be checked on every 15 minutes. She stated that the CNA assigned to him is the one who signs the 15-minute check sheet, but any staff can check off that they saw the resident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on February 7, 2025 at 11:48 a.m. with a nurse (staff #43), who stated that staff check the residents every two hours, but may check sooner, every 30 minutes. She stated that staff do not check on the residents every 15 minutes unless something happened and resident (#33) was not on 15-minute checks the day that he hit resident #44 because he had been calm that day, but he is aggressive and always trying to leave. She stated that resident #33 has pushed her and other staff. She stated that resident (#400) came into the dining room and said that resident #33 punched someone and he is laying on the floor. Then resident #44 came into the dining room and had scrapes on his knee and elbow and stated that staff had to do something about resident #33 because he was a danger to the staff and the residents. Resident #44 stated that resident #33 had hit him in the jaw and there was a big red area around the jaw going up around the cheek area. She stated that you could tell that he had been punched in the face. She said she called the police. While she was cleaning resident #44's injuries, (CNA/staff #136) was outside with resident #33 and she sent another CNA to help monitor the resident; resident #400 told the CNAs that he hit resident #33 because he was going to hit him. Staff #43 stated that this was abuse. A phone was made to resident (#400's) case manger on February 7, 2025 at 1:12 p.m. and she stated that resident #400 discharged from the facility to the assisted living section at the same address. During an interview conducted on February 7, 2025 at 1:50 p.m. with resident #44, his voice was elevated and he appeared agitated and upset. He stated that last Sunday (February 2, 2025) a man with dementia kept going into peoples' rooms and he told the man to stop. Resident #44 pointed to the right side of his chin and stated that the man hit him near the right side of his chin. There was no injury observed to the chin area and the resident stated that it was better. He stated that he fell down and hit his right elbow and right knee. He stated that his knee was still hurting and pulled back the blanket where a bandage approximately 3 inches by 3 inches was observed on his right knee. He didn't want to pull back the blanket to show the right elbow. He stated that the new Administrator came to see him and told him that it was an incident, but he thinks that it was a felony assault. An interview was conducted on February 7, 2025 at 2:23 p.m. with resident (#400), who stated that she was sitting by the doorway getting some fresh air and saw resident #33 trying to open bedroom doors and the other male resident told him to stop and resident #33 said, I heard you. Resident #33 hit the other male resident whose name starts with a D. in the face with a closed fist. Resident #400 closed her fist and demonstrated by making contact with the right side of her chin. She stated that the male resident's chin was big and red and he fell on the ground and hurt his knee and his arm. She stated that she told the nurse that resident #33 hit the other male resident in the face. An interview was conducted on February 7, 2025 at 2:53 p.m. with the Director of Nursing (DON/staff #29), who stated that there are usually three CNAs on the Vista East Unit unless a resident has behaviors. He stated that all the residents are supposed to be checked every 15 minutes, but the staff would only document that the checks occurred if staff was assigned to a specific resident as a one-to-one. He stated that resident #44 was interviewed and stated that he was not hit by resident #33, but when the incident occurred, resident #44 was yelling that resident hit him and wanted to know what staff was going to do about it. He stated that there was a resident (#400) who witnessed the incident between resident #44 and resident #33, but he was not able to interview her because discharged from the facility. He stated that he heard that resident (#400) said resident #44 and resident #33 were arguing. He stated that from what he understands and from the interviews, resident #33 swung at resident #44, but did not hit him, but resident #44 fell and it was observed that he scraped his knee and elbow. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	50595 Regarding Resident #70 and #180: - Regarding Resident #70: Resident #70 was admitted to the facility on [DATE] with diagnoses including unspecified dementia, unspecified severity, with agitation; major depressive disorder. Review on Resident #70 Behavior assessment dated on January 18, 2025, shows that the resident displayed behaviors such as, Agitation, Exit seeking, and physically aggressive towards another resident. The resident was monitored by staff by frequently checking the resident every two hours. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 0, severe cognitive impairment. Review of the care plan revealed, initiated on January 31, 2025, indicated that the resident has potential to be physically aggressive r/t Dementia. This entry addressed that the Resident will not harm self or others initiated on January 31, 2025. - Regarding Resident #180 Resident #180 was admitted to the facility on [DATE] with diagnoses including vascular dementia, severe, with agitation, anxiety disorder, unspecified, major depressive disorder. Review of the care plan revealed, initiated on September 03, 2024 indicated that the Resident at risk for psychosocial emotion distress r/t resident to resident altercation. This entry addressed on January 18,2025, that Resident will not have signs and symptoms of psychosocial emotion distress. Review on Resident #180 Behavior assessment dated on January 18, 2025, shows that the resident displayed sundowning behavior. The resident was on every fifth teen minutes checks. Review on the skin evaluation dated on January 18, 2025, for Resident #180 indicated there is no head injuries, skin still intact, no swelling, drainage or bruising noted. Review of the nursing progress note for Resident #70 and Resident #180 revealed that on January 18, 2025, at approximately five thirty pm, Resident #70 walked past Resident #180 and punched the resident at the back of his head. The incident was witnessed by the CNA staff while she was emptying the plates in the trash from dinner when the incident occurred. The Residents were separated right away. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 0, severe cognitive impairment. An interview was conducted on February 06, 2025 at 1:31 PM with a CNA (Staff #120) who defined abuse as verbal, mental, physical, sexual, money, property, and neglect. The staff stated that resident to (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident abuse can happen in the facility. She added that she receives training on residents' rights, abuse, and misappropriation of property. The CNA stated that her day starts by receiving shift report from the from the previous shift if there's any change of condition on the residents. She added that they provide one to one to the resident who like to elope, wanders, and agitated. The CNA added that they redirect the resident by doing activities, or providing snacks. She added that they work with the residents everyday, so they learn what tactics work best work with each residents. The CNA staff stated that she wasn't working the day the incident happened, but it was reported to her that Resident #70 hit Resident #180 in the back of the head while Resident #180 was seated in the day room of the south five hundred of the building. An interview was conducted on February 6, 2025, at 2:14 PM, with the LPN (Staff #34). She stated that she didn't witness the incident. The LPN mentioned that the CNA (Staff #121) reported cleaning the dining room where the residents ate. She added that it was Resident #70 who punched Resident #180 in the back of the head. The LPN noted that she went right away when she heard the commotion. The LPN redirected Resident #180, while the CNA pulled Resident #70 away from the incident. She stated that those two residents were combative and exit-seeking. The LPN mentioned that no one-to-one supervision was provided. She also indicated that staffing is always short and emphasized the need for more CNA staffing at the facility. An interview was conducted on February 6, 2025, at 3:17 PM CNA (Staff #121) witnessed Resident #70 hit Resident #180 in the head. Resident #70 passed by Resident #180 and struck him on the head with an open hand, while Resident #180 appeared ready to fight back. CNA #121 took Resident #70 out of the dining room, and the LPN redirected Resident #180 out of the dining room as well. This incident marks the first time the two residents have encountered such a situation. The CNA stated that Resident #70 has a history of hitting staff members. An interview was conducted on February 7, 2025, at 2:53 PM with the DON (Staff #29), who stated that all staff were trained on physical, sexual, misappropriation, verbal, restraints, and seclusion types of abuse. The DON added that CNAs typically check on residents every fifteen minutes but would only document their checks if assigned as a one-to-one. The DON mentioned that Resident #70 and Resident #180 are still on fifteen-minute checks and are under close supervision by the CNAs. However, the checks for these two residents are not documented because they have not exhibited abusive behavior toward other residents. The DON added that the interpretation of abuse is subjective and, from his understanding and the interviews he conducted, if a resident fall, that doesn't necessarily indicate that abuse occurred. If one resident swings at another but does not make contact, and the other resident falls, the swinging resident may have unintentionally caused the fall. However, if a resident hit another resident, it is considered abuse. Review of the facility policy titled, Abuse, Neglect, Exploitation and Misappropriation prevention program indicated that Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation.