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	05/29/2025

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** 50166 Based on clinical record review, staff interviews, and policy review, the facility failed to ensure one resident (#76) did not abuse another resident (#81). The deficient practice could result in residents being physically harmed. Findings include: -Resident #81 was admitted on [DATE] with diagnoses that included type 2 diabetes, chronic atrial fibrillation, hypertension, major depressive disorder, vascular dementia, schizoaffective disorder, panic disorder, and obsessive-compulsive disorder. An Annual Minimum Data Set (MDS) dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderate cognitive impairment with no behaviors exhibited. A skin assessment dated [DATE] at 2:52 p.m. revealed a new skin tear with a flap measurement of 2x2 to the back of his left hand following the resident-to-resident altercation. A progress note dated May 20, 2025 at 3:08 p.m. revealed that Resident #81 reported that his roommate (#76) hit him with his fist while inside of their room while he was attempting to open the door to leave. The note revealed that the resident sustained a skin tear on the left hand due to the altercation, and the incident was reported. A care plan focus initiated on May 21, 2025 revealed a focus on the resident having a potential psychosocial well-being problem related to a resident to resident altercation. -Resident #76 was admitted on [DATE] with diagnoses that included dementia, hypertension, major depressive disorder, personal history of traumatic brain injury, and anemia. A care plan focus initiated on April 24, 2025 revealed a focus on the resident having potential to be physically and verbally aggressive due to his dementia. An Admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 06, which indicated severe cognitive impairment with behaviors exhibited 1 to 3 days. (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	A progress note dated May 20, 2025 revealed that another resident (#81) reported that Resident #76 hit him while inside their room. The note further revealed that the other resident (#81) was attempting to leave the room when resident #76 struck him with a fist, and the altercation resulted in a skin tear on the left hand of other resident (#81). A progress note dated May 20, 2025 at 5:03 p.m. revealed that the resident had a room change due to an incident that occurred with his roommate. A care plan focus initiated on May 21, 2025 revealed a focus on the resident having a psychosocial well-being problem related to his lack of acceptance to his current condition and a resident to resident altercation. Review of the facility investigation dated May 20, 2025 revealed that it was reported that Resident #76 hit the left hand of Resident #81 which resulted in a skin tear to the left hand of resident #81. The investigation revealed that both residents were interviewed and gave conflicting nonsensical recollections of the incident, which resulted in the facility investigation being unsubstantiated. The investigation further revealed that Resident #81 reported to a nurse that Resident #76 hit him when he was trying to get into his room; and when the nurse asked the resident #76 as to why he hit his roommate (resident #81), reisdent #76 replied that resident #81 had the keys to his airplane, he was concerned about its location. It also included that Resident #76 reported that Resident #81 hit him first. The investigation also included that Resident #76 approached resident #81 in an aggressive manner and Resident #81 protected himself by making contact with his knuckles, which sustained a skin tear with blood before the residents were separated and the skin tear was assessed and cleaned. An interview was conducted on May 29, 2025 at 1:18 p.m. with a Licensed Practical Nurse (LPN/Staff#41) who stated that she was not in the room for the altercation that occurred, but she found it evident that an altercation did occur between the residents because of the bloody knuckle and skin tear on Resident #81. The LPN stated that Resident #81 went to the dayroom to tell her what happened, she took him to the nurses station to treat his hand wound, and she asked Resident #76 why he hit Resident #81. The LPN stated that Resident #76 told her he hit Resident #81 because he hit him first, and the resident again lunged at Resident #81 who then put up a defensive stance to protect himself from a second physical altercation. The LPN stated that the residents ' explanations of the altercation were clear and sensible. An interview was conducted on May 29, 2025 at 2:23 p.m. with the Administrator and Abuse Coordinator (Administrator/Staff#41) who stated that Resident #81 was entering the room when Resident #76 told him that he wanted the keys to his airplane back. The administrator stated that Resident #81 reported the altercation immediately to the nurse who then asked Resident #76 why he touched Resident #81, and Resident #76 stated that it was because he had the keys to his airplane. The administrator further started that Resident #76 attempted to make contact with Resident #81 again in the dayroom when the residents were reporting the altercation to the nurse, and the facility decided to do a room change immediately. The administrator stated that there was an injury in the altercation which was a skin tear to the left hand of Resident #81, and the facility knows there was an exchange of words between the residents. The administrator further stated that because the altercation was unwitnessed, they could not substantiate their investigation. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A follow-up interview was conducted on June 5, 2025 at 3:07 p.m. with a Licensed Practical Nurse (LPN/Staff#41) who stated that the residents did not have prior issues with each other, but Resident #76 had another altercation with a different resident prior to this altercation. The LPN also stated that Resident #76 had a history of taking Resident #81 ' s belongings and would say they were his. Review of a policy revised in September of 2022 titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revealed a definition of abuse being the willful infliction of injury with resulting physical harm, pain or mental anguish. The policy further revealed a definition for willful being that an individual acted deliberately. Review of a policy revised in April of 2021 titled, Abuse, Neglect, Exploitation or Misappropriation - Prevention Program, revealed that residents have a right to be free from abuse, and the facility was committed to ensuring residents were protected from abuse by anyone, including other residents. Review of a policy revised in February of 2021 titled, Resident Rights, revealed that residents had the right to be free from abuse, neglect, misappropriation of property, and exploitation.