

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 06/06/2025
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 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, review of records, and review of facility policy and procedure, the facility failed to ensure a resident (#27) was not abused by another resident (#13). The deficient practice could lead to physical and psychosocial harm to residents.</p> <p>Findings Include:</p> <p>-Regarding resident #27:</p> <p>Resident #27 was admitted to the facility on [DATE] with diagnoses that included dementia with other behavioral disturbance, hypertension, post-traumatic stress disorder, adjustment disorder with mixed disturbance of emotions and conduct, migraine, Alzheimer's disease, and major depressive disorder.</p> <p>A Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a brief interview for mental status (BIMS) score of 06, indicating severe cognitive impairment.</p> <p>A nursing progress note dated May 30, 2025 at 10:21 a.m. revealed that resident #27 was in the dayroom awaiting breakfast when resident #13 tapped him on the shoulder and told him to move before resident #13 hit resident #27. The nurse de-escalated the situation and removed each resident to their respective rooms and reported the incident. Resident #27 was noted to have had two discolorations on the right eye.</p> <p>An observation of Resident #27 was conducted on June 6, 2025 at 11:48 a.m. and revealed discoloration to his right eye.</p> <p>An interview was conducted on June 6, 2025 at 11:48 a.m. with resident #27 who stated that he was punched by a person that he did not know and was punched for no reason at all.</p> <p>-Regarding resident #13:</p> <p>Resident #13 was admitted to the facility on [DATE] with diagnoses that included unspecified dementia, behavioral disturbance, anxiety disorder, and major depressive disorder.</p> <p>A Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a brief interview for mental status (BIMS) score of 03, indicating severe cognitive impairment.</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>Review of a care plan focus dated January 28, 2025 revealed that resident #13 was at risk for psychological emotional distress following a resident-to-resident altercation, and interventions included 1 on 1 as needed, and to monitor for verbal and nonverbal symptoms of psychosocial emotional distress.</p> <p>Multiple behavior charting nursing assessments dated May 25, 26, 28, and 29 of 2025 revealed that the resident displayed agitation, aggression, disorganized thinking, yelling, delusions, and exit seeking behaviors. The documented interventions for those dates included: emotional support, redirection and reduced emotional stimuli.</p> <p>An observation of resident #13 was conducted on June 6, 2025 at 12:00 p.m. who was observed in the dining area eating lunch and seated between two other residents.</p> <p>An interview was conducted on June 6, 2025 at 12:36 p.m. with Resident #13 who stated that he had no concerns about the facility and stated he had not had any conflicts with any other residents. Resident #13's daughter was also present during the interview and she stated that she, too, had no concerns.</p> <p>An interview was conducted on June 6, 2025 at 12:51 p.m. with a licensed practical nurse (LPN/staff #82) who stated that on May, 30, 2025 in the morning she was assisting another resident when she overheard resident #13 tell resident #27 to move out of his way or he was going to punch him in the face. The LPN immediately turned to deescalate the situation and witnessed resident #13 punch resident #27 in the right eye. As she approached the residents, resident #27 was using his hands to defend himself. The LPN stated she was able to separate the two residents before any further harm. The LPN stated that resident #13 can often be verbally and physically aggressive with staff and other residents and feels the facility could better assess residents to have them placed into the proper units.</p> <p>Review of the facility's investigation revealed that they concluded that both residents lacked the intent to cause harm or understand the consequences of their actions. The review further stated that the facility continued to keep all residents safe and follow all facility policies and procedures related to behavioral management and abuse reporting and investigation.</p> <p>Facility policy titled Abuse and Neglect-Clinical Protocol stated the facility management and staff will institute measures to address the needs of residents and minimize the possibility of abuse. Further the physician and staff will address appropriately causes of problematic resident behaviors where possible.</p> <p>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.</p> <p>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.</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>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.</p>