

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 06/17/2025
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 - Some</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 clinical record review, staff interviews, and policy review, the facility failed to ensure that six residents (#67, #17, #97, #111, #77, and #50) did not abuse seven residents (#41, #14, #83, #36, #84, #21, and #2). The deficient practice could result in residents being physically harmed.</p> <p>-Regarding Resident #97 and Resident #84</p> <p>Resident #97 was admitted on [DATE] with diagnoses that included vascular dementia, unspecified mood affective disorder, depression, intracranial hypertension, major depressive disorder, anxiety, adjustment disorder with mixed disturbance of emotions, and presence of cardiac pacemaker.</p> <p>A Quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderate cognitive impairment.</p> <p>A nursing progress note dated August 30, 2022 at 3:59 p.m. revealed that the doctor was notified of the resident becoming more sexually inappropriate. The progress note further revealed that the resident was caressing female peers' arms and touching his private area in front of female peers.</p> <p>A nursing progress note dated August 31, 2022 at 4:08 p.m. revealed a resident to resident incident that occurred with an inquiry to move the resident to a higher acuity behavioral unit. The note also revealed the resident was to remain on one-on-one monitoring until the room change would occur.</p> <p>A behavioral care plan dated August 31, 2022 revealed that following the incident, the resident was never to be unsupervised with female residents, staff were supposed to keep him at a significant distance away from female peers at all times, female caregivers were to position themselves in a fashion as to not be in a position to be inappropriately touched by him, and he was not allowed to be near Resident #84 or another unnamed resident at any time.</p> <p>A care plan initiated on September 23, 2024 revealed a focus on sexually inappropriate behavior, groping residents and staff, walking on the unit without clothing, and touching his genitalia in front of others in public spaces with an intervention to redirect residents to his room when he exposed himself</p> <p>Resident #84 was admitted on [DATE] with diagnoses that included dementia, mood disorder due to known physiological condition with manic, hypertension, [NAME] ' s encephalopathy, anxiety, anoxic brain damage, mood disorder due to known physiological condition.</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 - Some</p>	<p>An admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 06, which indicated severe cognitive impairment.</p> <p>An Executive-Director progress note dated August 31, 2022 at 4:04 p.m. revealed a resident to resident incident that occurred, and a message was left to notify the family.</p> <p>A nursing progress note dated August 31, 2022 at 4:23 p.m. revealed a Certified Nursing Assistant (CNA) reported that the resident received physical aggression by a male resident. The note revealed that Resident #84 was going to her room when a resident pushed her against the wall and started to fondle her breasts. The progress note further revealed that the CNA stated the resident had a frightened look on her face, and she stated He is a pervert he is always touching me. The progress note revealed that the nurse confronted the male resident to leave the female resident alone and separated the female resident to another area.</p> <p>Review of a facility investigation dated September 6, 2022 revealed that on August 31, 2022 at approximately 1:50 p.m., the Executive Director was notified by a CNA that she witnessed Resident #84 being held up against the wall and touched on the breasts by Resident #97 in the smoking area. The investigation revealed that the CNA told Resident #97 to stop and go back to his room where he hid behind his divider curtain. The investigation revealed that a CNA, Staff #70, gave a statement that revealed she saw Resident #97 grabbed Resident #84 against the wall and rubbed on her breast before she yelled at him to stop. The investigation further revealed that the CNA grabbed Resident #84 who stated she was scared and told her that man is a perve, he ' s always bothering me, I need to get away from him. The investigation also revealed an interview with Resident #97 who stated that he had gotten to know Resident #84 fairly well over the last few weeks, she was married, so was he, and he thought she was pregnant. The investigation revealed that Resident #97 further stated It ' s nice to have the touch of another person being in here, you don ' t get that, and he stated that he asked if he could touch her breasts and she said yes. The investigation revealed an interview with Resident #84 who stated that he asked if he could touch her breasts and she said yes, and she further stated it ' s not like it was sex.</p> <p>An interview was conducted with a Licensed Practical Nurse (LPN/Staff#33) on June 17, 2025 at 2:15 p.m. who stated that she could recall the incident occurring because one of the residents fondled the other residents ' breast, which resulted in a room change. The LPN stated that she was very good at documenting incidents like this one, and if she documented anything in the clinical record, it was right.</p> <p>An interview was conducted with a CNA, Staff #70 on June 17, 2025 at 2:33 p.m. who stated that she could recall that altercation between the two residents. The CNA further stated that she observed Resident #97 being very inappropriate with Resident #84 who was not all there. The CNA stated that she was walking in the hallway when she witnessed Resident #97 approach Resident #84 and push her up against the wall and touch her. The CNA also stated that Resident #84 talked to her after the incident and mentioned that Resident #97 had touched her inappropriately. The CNA stated that Resident #84 had a good recollection of the incident right after it happened. The CNA stated that she felt that Resident #97 knew what he was doing because he was inappropriate to staff and would make remarks such as I like your breasts and If I was your husband I would think you were so beautiful. The CNA stated that Resident #84 told her that she was scared after the incident.</p> <p>-Regarding Resident #111 and Resident #83</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 - Some</p>	<p>Resident #111 was admitted on [DATE] with diagnoses that included paranoid schizophrenia, vascular dementia, bipolar disorder, chronic obstructive pulmonary disease, psychotic disorder, major depressive disorder, anxiety, hypertension, history of traumatic brain injury, delusional disorders, alcohol dependence, and hallucinations.</p> <p>An Annual Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderate cognitive impairment.</p> <p>A behavior progress note dated August 26, 2022 at 7 p.m. revealed that Resident #111 was yelling at staff and one of her neighbors in the dayroom at the start of the shift. The progress note revealed that the resident was asked to leave the common area until she could calm herself.</p> <p>A behavior progress note dated August 26, 2022 at 7:40 p.m. revealed that Resident #111 was aggressive.</p> <p>A behavior progress note dated August 26, 2022 at 8:03 p.m. revealed that the Executive Director was notified of a resident-to-resident altercation, the residents were separated, and there were no injuries noted.</p> <p>A behavior progress note dated August 27, 2022 at 3:34 p.m. revealed that Resident #111 hit Resident #83 in the face while the two of them were in the dayroom. The progress note further revealed that Resident #111 stated I punched her ass because she talks too much, and further stated that she hit her two times in the face and she was lucky that she couldn ' t hit her with her stick. The progress note revealed that the police department was notified and a case was created.</p> <p>A care plan focus initiated on November 26, 2024 revealed a behavioral problem with physical and verbal behaviors as evidenced by a history of peer altercations.</p> <p>Resident #83 was admitted on [DATE] with diagnoses that included schizoaffective disorder bipolar type, borderline personality disorder, anxiety, epilepsy, traumatic brain injury history, bipolar disorder, insomnia, and hyperlipidemia.</p> <p>A Quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS also revealed that the resident exhibited verbal behaviors for 1-3 days.</p> <p>A behavioral care plan from August 19, 2022 revealed a history of physical aggression towards peers and staff at the facility. The care plan revealed that the resident needed to be closely monitored in public areas with peers present, she was not allowed to help peers in any fashion, if she was inciting another resident she would need to leave for no less than 30 minutes, and resident #83 should never be near resident #111 at any time.</p> <p>A behavior progress note dated August 27, 2022 at 4:12 p.m. revealed that Resident #83 was hit in the face by Resident #111 while the two were sitting in the day room. The progress note revealed that Resident #83 was talking loudly when Resident #111 suddenly hit her two times in the face. The progress note further revealed that Resident #83 stated it hurts a little, and there was no injury noted.</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 - Some</p>	<p>Review of a facility investigation dated September 1, 2022 revealed that on August 26, 2022 at approximately 7:30 p.m., Resident #83 reported that she was hit in the face by Resident #111 on the porch in the dayroom. The investigation further revealed that Resident #111 was questioned about why she hit the other resident and she stated that it was because Resident #83 would not shut up and kept talking about how rich her father was. The investigation revealed that before the staff member could get to Resident #83, Resident #111 stood up and hit the resident in the face per reports from both residents. The investigation revealed that a CNA, Staff #120, was interviewed and stated that before she could get to the residents, arms were swinging and the residents were yelling before she separated them and told the nurse. The investigation revealed that a CNA, Staff #40, was interviewed and stated that she saw Resident #111 outside and she ran outside because she hit Resident #83, and was unsure of exactly which body part was hit. The investigation also revealed an interview with Resident #111 who stated that she did not feel safe there, Resident #83 was making her life miserable, and she was going to hit her again. The investigation further revealed an interview with Resident #83 who stated that Resident #111 must have hit her 10 times, and she felt that Resident #111 would hit her again after she got out of her room.</p> <p>An interview was conducted with a CNA, Staff #40, on June 17, 2025 at 2:05 p.m. who stated that she could recall the incident between the two residents, she heard yelling, ran to see what was happening, and when she arrived at where the residents were, she witnessed Resident #111 with her hand outstretched towards Resident #83. The CNA stated that another staff member was near the altercation and they both worked to separate the residents by moving the resident in the wheelchair and the other with the walker.</p> <p>An interview was conducted with a CNA, Staff #120, on June 17, 2025 at 4:21 p.m. who stated that she could only somewhat recall the incident, but mostly she remembered that both of the residents had bad days.</p> <p>-Regarding Resident #50 and Resident #36</p> <p>Resident #50 was admitted on [DATE] with diagnoses that included major depressive disorder, anxiety, type 2 diabetes, epilepsy, antisocial personality disorder, emphysema, hypertension, and intermittent explosive disorder.</p> <p>A care plan initiated on December 28, 2020 revealed a focus on a behavioral problem targeting behaviors including verbal aggression, physical aggression to staff, and interfering with peers' care.</p> <p>A Quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition.</p> <p>A behavioral care plan dated August 18, 2022 revealed a history of physical and verbal aggression. Following the incident, the resident would not be allowed near Resident #36 at any time on the unit, and staff needed to be present at all times when the two residents were in the dayroom at the same time.</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 - Some</p>	<p>A nursing progress note dated August 18, 2022 at 5:43 p.m. revealed that resident peers informed staff that another peer was in the dayroom fighting over the TV remote when a resident was hit in the head by another resident for refusing to give up the TV remote. The progress note further revealed that Resident #50 stated I told that motherfucker to give me the remote control, and he put it in between his legs. I can ' t stand that motherfucking bastard. So yeah I hit him in his motherfucking head, and I ' ll do it again. Call the fucking police, I don ' t give a shit.</p> <p>A nursing progress note dated August 18, 2022 at 6:36 p.m. revealed that the police officer spoke with the resident and peer and a case was created.</p> <p>Resident #36 was admitted on [DATE] with diagnoses that included bipolar disorder, nontraumatic subdural hemorrhage, seizures, hypertension, major depressive disorder, alcohol dependence, insomnia, muscle spasms, and focal traumatic brain injury with loss of consciousness.</p> <p>A Quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated intact cognition.</p> <p>A nursing progress note dated August 18, 2022 at 5:25 p.m. revealed that resident peers informed staff that another peer was in the dayroom fighting over the TV remote when a resident was hit in the head by another resident for refusing to give up the TV remote. The progress note revealed that neuro checks were started and no injuries were noted. The progress note further revealed that the resident stated he refused to give the peer the TV remote and the peer hit him in the back of the head.</p> <p>A nursing progress note dated August 18, 2022 at 5:45 p.m. revealed that the police were notified of the incident.</p> <p>A nursing progress note dated August 18, 2022 at 6:35 p.m. revealed that the police officer spoke with the resident and peer and a case was created.</p> <p>Review of a facility investigation dated August 25, 2022 revealed that on August 18, 2022 at approximately 3:15 p.m., Resident #36 was watching tv in the dayroom in his wheelchair when Resident #50 accused him of having and hiding the TV remote. The investigation further revealed that Resident #50 got up, grabbed at Resident #36 ' s blankets looking for the remote, grabbed the remote, and slapped Resident #26 in the back of the head before the two residents were separated and assessed for injuries. The investigation revealed an interview was conducted with Resident #36 who stated that he had the remote in his lap, Resident #50 wanted it, and so he grabbed it out of his lap and slapped him on the back of his head before another guy came over and told him to leave him alone. The investigation also revealed an interview with Resident #50 who stated that he asked him for the remote, he said he didn ' t have it even though he knew he had it between his legs, so he grabbed it and slapped him upside his head. The investigation revealed that Resident #50 stated he functioned higher than the other residents there and he wanted another place. The investigation also revealed an interview with the resident who witnessed and reported the incident who stated that the two residents were in the dayroom, there was an argument about the remote, Resident #50 hit Resident #36 on the back of the head and grabbed the remote with another witness named. The investigation revealed the other witness was interviewed and stated that the two residents used to be roommates, they never got along, and when they were in the dayroom Resident #50 said he knew where the remote was, grabbed the blankets off of Resident #36 ' s lap, grabbed the remote, and then began to slap the back of his head.</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 - Some</p>	<p>An interview was conducted with a former LPN, Staff #154, on June 17, 2025 at 2:41 p.m. who stated that she could recall the altercation between the two residents. The LPN further stated that Resident #50 hit Resident #36 in the head over a dispute regarding the television remote. The LPN stated that two other residents witnessed the incident and reported it to her immediately at the nurses station.</p> <p>An interview was conducted with the Director of Nursing (DON/Staff#65) on June 17, 2025 at 3:55 p.m. who stated that he would define sexual abuse as any unwanted sexual behavior, and it did not have to be physical. The DON further stated that if a resident was held against a wall and touched on their privates, he would consider it sexual abuse. The DON stated that he would define physical abuse as any unwanted touch, and there would not have to be physical injuries to consider an altercation abuse. The DON stated that he would define verbal abuse as speaking in a verbally threatening manner, and it could be considered abuse if a resident stated shut up or I ' ll hit you.</p> <p>An interview was conducted with the Administrator (Administrator/Staff#78) on June 17, 2025 at 4:06 p.m. who stated that he would define sexual abuse as unwanted touching, and if one resident had a high BIMS score and the other resident had a low BIMS score, any sexual contact would not be appropriate. The administrator stated that if a resident were [NAME] up against the wall and touched in the privates by another resident, it would be sexual abuse and was a reportable event. The administrator stated that he would define physical abuse as hitting, slapping, touching, throwing objects, and kicking, and abuse did not need to be witnessed to be considered abuse. The administrator defined verbal abuse as name calling, yelling, and cursing, and stated that if a resident stated shut up or I ' ll hit you, he would say it could be abusive and if they did hit them, it would be both physical and verbal abuse. The administrator stated that the definition of abuse was intent, and whether someone meant to do something.</p> <p>-Regarding Resident #67 and Resident #41</p> <p>Resident #67 was admitted on [DATE] with diagnoses that included unspecified dementia with other behavioral disturbance, anxiety disorder, and major depressive disorder.</p> <p>A Quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 03, which indicated severe cognitive impairment.</p> <p>A nursing alert progress note dated June 9, 2025 at 11:03 p.m. revealed that resident #67 was involved in an altercation with another resident. Licensed Practical Nurse (LPN/staff #48) stated resident #67 hit resident #41 at the back of his head with his open hand, because he was sitting on his seat in the dayroom. Residents were separated and redirected.</p> <p>Review of resident #67's care plan revealed a focus for resident #67's potential to be physically aggressive. Interventions included monitoring as needed for any signs of resident posing danger to self and others.</p> <p>Behavioral charting for resident #67 revealed behaviors including agitation/aggression and poor boundaries displayed on June 8 and 9, 2025. The interventions implemented by staff included redirection of the resident.</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 - Some</p>	<p>Resident #41 was admitted on [DATE] with diagnoses including unspecified dementia with agitation, major depressive disorder, and insomnia.</p> <p>An admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 03, which indicated severe cognitive impairment.</p> <p>A nursing progress note dated June 9, 2025 at 11:19 p.m. revealed that resident #41 was observed sitting in the dayroom when resident #67 hit resident #41 on the back of the head with an open hand.</p> <p>Review of the facility's investigation, initiated June 9, 2025 revealed a conclusion that both residents lacked the intent to cause harm. Additionally, the investigation concluded that all current care plan interventions for resident #67 were in place at the time of the incident.</p> <p>An interview with LPN #48 on June 17, 2025 at 10:29 a.m. revealed that on the day of the incident, LPN #48 overheard resident #67 tell resident #41 to get out of his chair in the dayroom. A few seconds later LPN #48 observed resident #67 hit resident #41 in the back of the head knocking the resident's hat off his head. LPN #48 assisted in separating the residents immediately.</p> <p>-Regarding Resident #77 and Resident #21</p> <p>Resident #77 was admitted on [DATE] with diagnoses including Alzheimer's disease, dementia in other diseases classified elsewhere, anoxic brain damage, major depressive disorder, unspecified psychosis, delusional disorders, and disruptive mood dysregulation disorder.</p> <p>A quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 06, which indicated severe cognitive impairment.</p> <p>Review of resident #77's clinical record revealed a behavior progress note on July 11, 2022. This note stated at 6:10 a.m. a loud boom was heard from resident #77's room and upon entering the room resident #77 was observed hovering over his roommate and punching him twice. Resident #77 was removed from the room and redness was noted on the back of his right hand. The roommate was noted to be bleeding from the head.</p> <p>Review of resident #77's care plan revealed a focus for behavior problems, initiated March 19, 2018. Interventions included monitoring resident #77 for significant behavioral and medical changes to ensure proper placement of resident.</p> <p>Resident #21 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, delusional disorders, unspecified mood disorder, peripheral vascular disease, epilepsy, restlessness and agitation, anxiety disorder, insomnia, generalized anxiety disorder, difficulty in walking, muscle weakness, and sensorineural hearing loss.</p> <p>A review of resident #21's clinical record revealed a nursing progress not dated July 11, 2022 at 7:30 a.m. that stated resident #21 was attacked by another resident while laying in bed. Resident #21 was assessed and noted to be bleeding from a laceration to the left side of the head. 911 was called and resident #21 was transported by ambulance to the emergency room. A change in condition assessment dated [DATE] at 7:32 a.m. revealed that resident #21 was bleeding and suffered trauma.</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 - Some</p>	<p>An interview was conducted with Licensed Practical Nurse (LPN/staff #11) on June 17, 2025 at 2:53 p.m. LPN #11 stated that she does not recall the specific altercation but recalled that resident #17 struggled with roommates and needed to have his own room. LPN #11 further stated that resident #14's blindness caused significant vulnerability.</p> <p>-Regarding Resident #17 and Resident #2</p> <p>Resident #17 was admitted on [DATE] with diagnoses including vascular dementia, Alzheimer's disease with early onset, alcohol dependence in remission, type 2 diabetes mellitus, bipolar disorder, and other psychoactive substance dependence in remission.</p> <p>A quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 04, which indicated severe cognitive impairment.</p> <p>A behavior progress note dated September 18, 2022 at 7:38 p.m. revealed that resident #2 had wandered into resident #17's room and a peer to peer resulted due to the intrusive wandering.</p> <p>Resident #2 was admitted on [DATE] with diagnoses including unspecified dementia, major depressive disorder, and insomnia.</p> <p>An admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 03, which indicated severe cognitive impairment.</p> <p>Record review revealed an assessment communication form titled SBAR Communication Form dated September 19, 2022. The evaluation noted that resident #2 was evaluated for skin wound and change in condition after resident-to-resident altercation with skin tears and redness to left side of face. The advance care planning recommendations stated staff is to monitor resident #2 while wondering and treatments for skin tears to left side of face.</p> <p>An alert progress noted dated September 20, 2022 at 2:20 p.m. revealed slight redness and facial swelling to left side of his face. Left eye was slightly redden with blood clot present to lower aspect his left eye, with eye clear eye drainage and left squinting. Resident #2 was complaining of pain to left side. He remained on observation post peer to peer altercation.</p> <p>Review of the facility investigation dated September 22, 2022 revealed that on September 19, 2022 at around 8:30 p.m. resident #17 was observed with blood on his hands and told staff that he threw a guy out of his room.</p> <p>An interview was conducted with Licensed Practical Nurse (LPN/staff #11) on June 17, 2025 at 2:53 p.m. LPN #11 stated that she does not recall the specific altercation but recalled that resident #17 struggled with roommates and needed to have his own room.</p> <p>Review of a policy revised in March of 2018 titled, Abuse and Neglect - Clinical Protocol, revealed that sexual abuse was defined as non-consensual sexual contact of any type with a resident. The policy also revealed that abuse included verbal abuse, sexual abuse, physical abuse, and mental abuse.</p> <p>(continued on next page)</p>		

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 06/17/2025
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 - Some</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>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>		

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 06/17/2025
NAME OF PROVIDER OR SUPPLIER Rehab at Scottsdale Village Square		STREET ADDRESS, CITY, STATE, ZIP CODE 2620 North 68th Street Scottsdale, AZ 85257	

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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>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and facility policy, the facility failed to ensure one resident (#67) was provided with adequate supervision. The deficient practice could result in residents being subjected to preventable accidents and sustaining injuries.</p> <p>Findings include:</p> <p>Resident #67 was admitted to the facility on [DATE] with diagnoses including: dementia with other behavioral disturbance, hypertension, anxiety disorder, hyperlipidemia, and major depressive disorder.</p> <p>Resident #67's care plan initiated on January 28, 2025 revealed that the resident was at risk for psychosocial emotional distress regarding resident-to-resident altercation. The interventions included one-on-one care as needed.</p> <p>Another care plan initiated on March 12, 2025 stated that resident #67 had the potential to be physically aggressive in regards to dementia. Interventions included monitoring, documenting and reporting behaviors as needed.</p> <p>Review of the facility's 2024-2025 Incident Log revealed resident to resident altercations involving resident #67 on January 28,2025, February 2,2025, and May 30, 2025.</p> <p>A nursing alert progress note dated June 9, 2025 at 11:03 p.m. revealed that resident #67 was involved in another altercation with another resident. The note documented that resident #67 hit resident #41 at the back of his head with his open hand because the other resident was sitting on his seat in the dayroom.</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>Further review of the MDS dated [DATE] revealed that the resident exhibited physical behavioral symptoms directed towards others 1-3 days during the assessment period. Additionally, the resident also exhibited other behavioral symptoms not directed towards.</p> <p>A revised care plan dated May 30, 2025 pertaining to psychosocial emotional distress directed an intervention for frequent observation.</p> <p>A Behavior Charting assessment dated [DATE] revealed that resident #67 exhibited agitation, aggression, and poor boundaries. Interventions implemented by staff included redirection. The assessment did not indicate 1:1 monitoring.</p> <p>A Behavior Charting assessment dated [DATE] documented that resident #67 exhibited agitation, aggression, poor boundaries, yelling/screaming/cursing/abrasive tone, and delusions. The assessment indicated that interventions implemented included encouraged activity, redirection, and offered food/beverage.</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>Another Behavior Charting assessment dated [DATE] indicated that resident exhibited agitation, aggression, sundowning, exit seeking, and intrusive behavior. Interventions implemented included 1:1 monitoring, encouraged activity, and redirection.</p> <p>A progress note dated June 10, 2025 documented that resident continues to be on 1:1 monitoring post physical aggression behavior.</p> <p>A Behavior Charting assessment dated [DATE] revealed that resident exhibited agitation, aggression, poor safety, disorganized thinking, repetitive behavior, delusions, and exit seeking behavior. The assessment noted that the interventions implemented included emotional support, education on alternative behaviors, review of positive coping skills, redirection, reduced emotional stimuli, and 1:1 monitoring.</p> <p>An interview with a Certified Nursing Assistant (CNA/staff #44) on June 17, 2025 at 10:01 a.m. revealed that staff gets to know the residents in the behavior unit and gets to learn their behavior triggers. She stated that resident #67 is now receiving one-on-one care by CNA staff.</p> <p>An interview with Licensed Practical Nurse (LPN/staff #11) on June 17, 2025 at 10:21 a.m. revealed that the one-on-one care is now provided to resident #67 during all shifts. This care is scheduled for when the resident is in his room or out of his room.</p> <p>An Interview with the Director of Nursing (DON/Staff #65) was conducted on June 17, 2025 at 3:55 p.m. Staff #65 stated that one-on-one care is provided to residents when the resident could potentially harm themselves or others.</p> <p>Review of the facility policy titled Abuse and Neglect - Clinical Protocol, revised March 2018, revealed the facility management and staff will institute measures to address the needs of residents and minimize the possibility of abuse. The policy further states the physician and staff will address appropriately causes of problematic resident behavior where possible.</p>