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	08/07/2025

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** Based on observations, interviews and record review, the facility failed to protect residents' rights to be free from physical abuse for 22 residents (#129, #123, #67, #127, #124, #32, #24, #130, #75, #36, #7, #29, #51. #182, #57, #112, #114, #43, #115, #117, #118, #59). The deficient practice could result in psychosocial or physical harm to residents. Findings Include:-Regarding residents #57 and #29: Resident #57 was admitted to the facility on [DATE] with diagnoses including: Alzheimer's disease, encounter for palliative care, major depressive disorder, and dementia. Review of the care plan focus dated October 2, 2023 revealed that resident #57 had a behavior problem regarding dementia. Staff was to intervene as necessary to protect the rights and safety of others, remove resident #57 from situation, and take to an alternate location. An admission minimum data set (MDS) assessment dated [DATE] revealed the resident had a brief interview for mental status (BIMS) score of 3, indicating severe cognitive impairment. The MDS further noted the resident #57 had exhibited physical behavior symptoms directed towards others four to six times a week. Resident #29 was admitted to the facility on [DATE] with diagnoses including: dementia, mild, with behavioral disturbance, metabolic encephalopathy, cognitive communication deficit, hyperlipidemia, symbolic dysfunctions, altered mental status, insomnia, adult failure to thrive, and abnormalities of gait and mobility. Review of the care plan focus dated June 4, 2021 revealed that resident #57 had an activity deficit related to the diagnosis of dementia. A quarterly minimum data set (MDS) assessment dated [DATE] revealed the resident had a brief interview for mental status (BIMS) score of 00, indicating resident #29 was unable to complete the interview. The MDS further noted the resident #57 had exhibited other behavior symptoms directed towards others one to three times a week. A nursing progress note on November 26, 2023 at 10:00 a.m. revealed that staff members observed residents #57 and #29 punching each other in the face. Residents were immediately separated. No injuries were noted in skin checks and each resident was placed on checks every fifteen minutes. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the facility Administrator (staff #9) on August 7, 2025, at 12:48 PM. The Administrator stated he considered the altercation between Resident #57 and Resident #29 as abuse. -Regarding residents #182 and #138 Resident #182 was admitted to the facility on [DATE] with diagnoses including: Alzheimer's disease, delusional disorders, unspecified mood affective disorder, peripheral vascular disease, restlessness and agitation, anxiety disorder, and insomnia. Review of a care plan focus, revised April 14, 2023 revealed that resident #182 had a history of dementia with behaviors and interventions included redirection of resident #182 and keep the resident away from other residents. A quarterly minimum data set (MDS) assessment dated [DATE] revealed the resident had a brief interview for mental status (BIMS) score of 00, indicating the resident was unable to complete the interview. Resident #138 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, depression, and dementia in other diseases classified elsewhere, severe, with agitation. Review of a care plan focus, revised January 17, 2024 revealed that resident #138 had behavior symptoms related to dementia. Interventions included positive attention and interaction by caregivers. An admission minimum data set (MDS) assessment dated [DATE] revealed the resident had a brief interview for mental status (BIMS) score of 00, indicating the resident was unable to complete the interview. The MDS further noted the resident #138 had exhibited physical behavior symptoms directed towards others one to three times a week. Review of an incident progress note dated February 10, 2024 at 10:34 a.m. revealed resident #138 was observed by staff walking in the dayroom with a snack. While walking to his chair, resident suddenly reached out and smacked resident #182 very forcefully. Resident #138 then became extremely aggressive and began punching a CNA in the stomach. Resident #182 attempted to strike back at resident #138 but both residents were separated and calmed down by staff. No physical injuries were noted to either resident. The facility investigation, dated February 15, 2024 further revealed that staff was actively guiding resident #138 through the dining room when the event occurred. Staff attempted to stay between resident #138 and other residents while he was ambulating. On this occasion, resident #138 was able to reach out and make contact with resident #182. An interview was conducted with the facility Administrator (staff #9) on August 7, 2025, at 12:48 PM. The Administrator stated he considered the altercation between Resident #182 and Resident #138 as abuse. -Regarding residents #51 and #125 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #51 was admitted to the facility on [DATE] with diagnoses including: Alzheimer's disease, unilateral primary osteoarthritis of the left hip, and insomnia. Review of the care plan focus dated July 9, 2021 revealed that resident #51 had history of abuse with a goal of eliminating or avoiding triggers that may cause re-traumatization. A quarterly minimum data set (MDS) assessment dated [DATE] revealed the resident had a brief interview for mental status (BIMS) score of 3, indicating severe cognitive impairment. Resident #125 was admitted to the facility on [DATE] with diagnoses including: Neurocognitive disorder with Lewy bodies, dementia in other diseases classified elsewhere, severe, with agitation, sensorineural hearing loss, major depressive disorder, and insomnia. Review of the care plan focus dated May 23, 2023 revealed that resident #125had a behavior problem as evidenced by physical and verbal aggression to staff. A quarterly minimum data set (MDS) assessment dated [DATE] revealed the resident had a brief interview for mental status (BIMS) score of 00, indicating resident #125 was unable to complete the interview. A nursing progress noted dated October 20, 2023 at 7:44 p.m. revealed that resident #125 was physically aggressive and combative with other residents. Resident #125 was observed throwing shoes, clothes, brief and cups at staff. Resident#125 was not alert and oriented to his surrounds at that time. Three staff members helped resident to the bathroom, and resident was intrusive with other residents, touching and throwing their food. Resident #125 had staff walking with him outside of the dayroom when he suddenly turned and hit another resident (#51) on the left eye, unprovoked. The facility investigation, dated October 26, 2023 further revealed that when resident #125 struck resident #51, resident #51’s glasses were knocked off of her face. Both residents were assessed but no physical injures were noted. An interview was conducted with the facility Administrator (staff #9) on August 7, 2025, at 12:48 PM. The Administrator stated he considered the altercation between Resident #125 and Resident #51 as abuse. -First Incident Regarding Resident #111 and Resident #24 Resident #111 was admitted on [DATE] with diagnoses that included schizoaffective disorder (bipolar type), schizoaffective disorder, bipolar disorder, Asperger's syndrome, anxiety disorder, autistic disorder, and hypertension. A care plan focus initiated on March 8, 2023 revealed a behavior problem as evidenced by physical aggression and history of peer altercations. A progress note dated April 25, 2023 at 7:37 p.m. revealed that the executive director was notified of a resident-to-resident altercation and an investigation was initiated. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note and behavior note dated April 25, 2023 at 8:30 p.m. revealed that the nurse was told by a CNA that Resident #111 was involved in a physical altercation with a female peer, and when the nurse arrived on the unit they observed Resident #111 being verbally and physically aggressive with staff and peers. The note further revealed that one of the CNA’s held the resident to redirect her and prevent her from hurting her peer. The note revealed that the nurse left the CNA’s in the hallway for 20-30 minutes before one of them reported to the nurse the Resident #111 was on the floor in the hallway. The note also revealed that when the nurse arrived in the hallway, Resident #24 was already bitten by Resident #111 on the forearm and lower leg while walking in the hallway. An admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. Resident #24 was admitted on [DATE] with diagnoses that included schizoaffective disorder (bipolar type), psychotic disorder with delusions, systemic lupus erythematosus, major depressive disorder, vascular dementia, extrapyramidal and movement disorder, generalized anxiety disorder, and major depressive disorder. A Quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated intact cognition. A progress note dated April 25, 2023 at 7:39 p.m. revealed that the executive director was notified of a resident-to-resident altercation and an investigation was initiated. A progress note dated April 25, 2023 at 8:30 p.m. revealed that the nurse was notified by a CNA that Resident #24 was involved in a physical altercation with a female peer. The note further revealed that when the nurse arrived on the unit, Resident #130 was already bitten by Resident #111 on his left forearm and left lower posterior leg while he was walking in the hallway. The note further revealed that the left arm and left leg were assessed and cleaned with dressings applied and orders for amoxicillin. Review of a facility investigation dated April 28, 2023 that was submitted to the Arizona Department of Health Services (AZDHS) revealed that Resident #111 was trying to call her mom for over 30 minutes and was unsuccessful. The investigation further revealed that the CNA told Resident #111 her phone usage time was up, which upset her, and resulted in her throwing items at the staff and another resident in the dayroom. The investigation revealed that the staff told her to go to her room, and at that time, Resident #24 was walking in the hallway past Resident #111’s door. The resident opened her door and tried to go after Resident #24, which resulted in her biting his arm and causing a circular mark that was bleeding. The investigation also revealed that when staff came up behind Resident #111 to lower her to the floor, she bit Resident #24’s lower calf and left a small mark. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The investigation revealed an interview that was conducted on April 25, 2023 at 7 p.m. with the CNA’s who witnessed the incident, Staff #43 and Staff #91, who documented that Resident #111 tried to call her mom and was unsuccessful, so staff asked for the phone back to place it at the nurses station. When staff were speaking with another resident, Resident #111 became angry and started to yell and curse at staff while throwing items into the hallway before storming into the dayroom and throwing a chair at another resident. The investigation revealed that Staff #91 got ahold of the chair and hugged Resident #111 from the back to keep her from hitting the other resident before assisting her back to her room. The CNA’s documented that while Resident #111 was in her room, she opened the door while Resident #24 was walking by, she took a hold of him, and bit his arm. Staff #91 went behind the resident again and lowered her to the floor where she then leaned forward and bit Resident #24 in the leg before the nurse came over to assist and assess Resident #24. A request was made for the facility to provide a copy of the investigation, and the facility verified that they were unable to provide any investigation documents beyond 12 months. An interview was conducted on August 7, 2025 at 12:48 p.m. with the Administrator and abuse coordinator (Administrator/Staff #9) who stated that an altercation involving a resident who bites another resident on the arm and leg would be considered abuse and would need to be reported. -Second Incident Regarding Resident #111 and Resident #24 Resident #111 was admitted on [DATE] with diagnoses that included schizoaffective disorder (bipolar type), schizoaffective disorder, bipolar disorder, Asperger's syndrome, anxiety disorder, autistic disorder, and hypertension. A care plan focus initiated on March 8, 2023 revealed a behavior problem as evidenced by physical aggression and a history of peer altercations. A Quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. A progress note dated August 20, 2023 at 11:07 p.m. revealed that the nurse was attempting to administer Resident #111’s medication when she told the nurse to give Resident #24 his medications first because she wanted to continue to walk the hallways. The note further revealed that the nurse explained that she could continue to walk after receiving her medications, which resulted in Resident #111 yelling at the nurse and pointing her finger close to her face before turning around and charging at Resident #24. The note revealed that Resident #111 grabbed Resident #24’s left arm, attempting to drag him to the floor, and 3 staff members attempted to separate the two residents with difficulty. The note revealed that the resident grabbed a chair and attempted to throw it, but was stopped by staff. The note further revealed that the nurse told the resident she cannot abuse other residents, and the resident stated that she did not care and that Resident #24 should not have been in the hallway. A progress note dated August 21, 2023 at 12:08 p.m. revealed that an investigation was initiated and all parties were notified. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated August 22, 2023 at 12:35 p.m. revealed that the facility spoke with the resident’s family due to concerns with behaviors, resident-to-resident altercations, and to seek alternation placement if the resident continued to exhibit the behaviors. Resident #24 was admitted on [DATE] with diagnoses that included schizoaffective disorder (bipolar type), psychotic disorder with delusions, systemic lupus erythematosus, major depressive disorder, vascular dementia, extrapyramidal and movement disorder, generalized anxiety disorder, and major depressive disorder. A Quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. A progress note dated August 20, 2023 at 11:58 p.m. revealed that Resident #24 was pacing in the hallway when the nurse was trying to give another resident her medication. The note further revealed that the other resident refused her medication and turned toward Resident #24 and grabbed his left arm to drag him to the floor, and he did not fight back or fall to the floor. The note revealed that staff attempted to separate the residents with difficulty because she would not let go of his arm, but eventually they successfully separated the residents. The note revealed that upon assessment, Resident #24’s left arm had slight discoloration noted and the sleeve to his shirt was ripped off. The progress note also revealed that the doctor, power of attorney, and behavioral manager were notified. A progress note dated August 21, 2023 and 12:08 p.m. revealed that an investigation was initiated and all parties were notified. An interdisciplinary team (IDT) progress note dated September 15, 2023 at 1:57 p.m. revealed that the resident had a room and unit change following the second resident-to-resident altercation. An interview was conducted on August 7, 2025 at 12:48 p.m. with the Administrator and abuse coordinator, Staff #9, who stated that an altercation involving residents attempting to drag other residents to the ground with skin discoloration noted and a shirt sleeve being ripped off would be considered a resident-to-resident abuse and would need to be reported. A request was made for the facility to provide a copy of the investigation, and the facility verified that they were unable to provide any investigation documents beyond 12 months. -Regarding Resident #111 and Resident #130 Resident #111 was admitted on [DATE] with diagnoses that included schizoaffective disorder (bipolar type), schizoaffective disorder, bipolar disorder, Asperger's syndrome, anxiety disorder, autistic disorder, and hypertension. A care plan focus initiated on March 8, 2023 revealed a behavior problem as evidenced by physical aggression and history of peer altercations. An admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated January 23, 2024 at 9:06 p.m. revealed that an incident report with the police department was filed. A progress note dated January 24, 2024 at 5:56 a.m. revealed an incident where resident #111 was upset about the phone not being fully charged, and she attempted to punch the nurse in the face. The note revealed that the staff began attempts to calm the resident down and move other residents who were in the hall back to their rooms when Resident #111 pushed a CNA and kicked Resident #130 in the leg. The note further revealed that the staff grabbed Resident #130 to keep him from falling and assisted him back to his room. Resident #130 was admitted on [DATE] with diagnoses that included dementia, Alzheimer's disease, schizophrenia, depression, hypertension, generalized anxiety disorder, impulsiveness, major depressive disorder, paranoid schizophrenia, bipolar disorder, insomnia, hyperlipidemia, and polydipsia. A care plan focus initiated on July 7, 2023 revealed a behavior problem related to dementia and schizoaffective disorder as evidenced by a peer altercation. The care plan further revealed interventions initiated on January 25, 2024 that the resident was immediately separated from his peer, staff was educated, replaced the unit phone, and the provider was contacted to provide behavior education. A quarterly Minimum Date Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. A progress note dated January 24, 2024 at 3:12 a.m. revealed that Resident #130 was standing by the nursing station waiting for his medication when Resident #111 was observed going up to him and kicking him in the back of his legs. The note further revealed that the CNA grabbed Resident #130 to prevent him from falling, and the resident declined to press charges. Review of a facility investigation dated January 30, 2024 submitted to the Arizona Department of Health Services (AZDHS) revealed that at 9 p.m. on January 23, 2024 Resident #111 was upset regarding the usage of the phone on the behavioral unit because she felt that two bars of charge was not sufficient for her phone call. The investigation revealed that the 1:1 CNA made the decision to take Resident #111 off of the residents’ unit to another unit to use the phone, and upon arrival at the other unit, Resident #111 continued to escalate which resulted in her kicking Resident #130 who was standing at the desk. The investigation further revealed that Resident #130 did not sustain an injury from the incident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The investigation revealed an interview was conducted with a Licensed Practical Nurse (LPN/Staff#139) on January 23, 2024 who stated that she was giving a report to the on-coming nurse when Resident #111 came to the desk to ask why she could not use the phone. The LPN revealed that she asked the resident to go back to her unit, the resident became upset at her, the resident attempted to open the gate to the nurses station and hit the nurse, and ultimately she kicked Resident #130 who was standing nearby. The investigation also revealed an interview that was conducted with a LPN, Staff #368, who stated that Resident #130 was upset because she wanted to make a phone call, the resident refused to leave the unit when asked to, and she unsuccessfully attempted to hit the day shift nurse. The LPN further revealed that resident #111 kicked Resident #130, and he did not sustain an injury to the leg. The investigation revealed an interview that was conducted on January 23, 2024 with a CNA, Staff #89, who stated that Resident #111 was upset about the phone not having enough bars. The CNA revealed that staff took the phone and sat it on the counter, and the resident began yelling at the nurse. The CNA interview further revealed that Resident #111 kicked Resident #130 on the leg. A request was made for the facility to provide a copy of the investigation, and the facility verified that they were unable to provide any investigation documents beyond 12 months. An interview was conducted on August 7, 2025 at 12:48 p.m. with the Administrator and abuse coordinator, Staff#9, who stated that an altercation involving a resident who kicks another resident in the back of the leg out of frustration with staff would be considered abuse and would need to be reported. -Regarding Resident #36 and Resident #75 Resident #36 was admitted on [DATE] with diagnoses that included Alzheimer's disease, Parkinson's disease with dyskinesia, bipolar disorder, and generalized anxiety disorder. A behavioral care plan initiated on April 29, 2025 revealed that Resident #36 had behaviors of physical and verbal aggression. A Quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 03, which indicated severe cognitive impairment. The MDS also revealed that the resident exhibited behaviors not directed towards others 1-3 days. A change in condition assessment initiated on July 12, 2025 revealed a physical and verbal resident-to-resident altercation that occurred for several minutes before staff was able to separate them. The assessment further revealed that the resident reported he was experiencing new pain following the altercation, with complaints of achiness to the right front shoulder, occasional moans and groans, facial grimacing, and distressed pacing. The assessment also revealed that the resident was experiencing increased agitation throughout the day before the incident occurred, and during the altercation the resident was punching, grabbing, clawing, and pinching. A progress note dated July 12, 2025 at 8:10 p.m. revealed that the resident was nudged by another resident to get out of their way, and a physical and verbal altercation between the two residents began. The note further revealed there was punching, clawing, grabbing, pinching, cursing, and yelling between the two residents for several minutes before staff was able to separate them, and the resident reported front right shoulder pain. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A care plan focus revised on July 14, 2025 revealed that the resident was at risk for psychosocial well-being problems related to a resident-to-resident altercation he was involved in. Resident #75 was admitted on [DATE] with diagnoses that included dementia with agitation, bipolar disorder, mood affective disorder, major depressive disorder, anxiety disorder, depression, hypertension, and insomnia. A behavioral care plan initiated on May 6, 2025 revealed that Resident #75 had behaviors of severe agitation, cursing, striking out and threats. A Quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 05, which indicated severe cognitive impairment. The MDS also revealed that the resident exhibited behaviors not directed towards others 4-6 days. A change in condition assessment initiated on July 12, 2025 revealed a physical and verbal resident-to-resident altercation that occurred for several minutes. The assessment further revealed that the resident was experiencing agitation, aggression, yelling, and delusions towards staff before the altercation occurred, and the resident reported he was experiencing worsened lower back pain following the altercation. A progress note dated July 12, 2025 at 5:00 p.m. revealed that the resident was nudged by another resident to get out of their way, and a physical and verbal altercation between the two residents began. The note further revealed there was punching, clawing, grabbing, pinching, cursing, and yelling between the two residents for several minutes before staff was able to separate them, and the resident reported that the back of his head was sore, and his lower back pain was worse. The note revealed that an as needed (PRN) order for hydroxyzine was ordered. A care plan focus revised on July 14, 2025 revealed that the resident was at risk for psychosocial well-being problems related to a resident-to-resident altercation he was involved in. Review of a facility investigation dated July 12, 2025 revealed that Resident #36 pulled Resident #75 by the arm out of a recliner because he thought that Resident #75 was sitting in his seat. The investigation revealed an interview that was conducted with a Certified Nursing Assistant (CNA/Staff#70) who said that Resident #75 was sitting in a recliner when Resident #36 expressed that he wanted to sit in the recliner. The CNA revealed that Resident #75 told him no, and then Resident #36 grabbed his hands and pulled him up from the recliner which is when Resident #75 stood up and pushed Resident #36 into the wall. The CNA revealed that both of the residents began throwing punches and the staff attempted to separate them with difficulty due to the altercation taking place against the wall. The investigation also revealed an interview conducted with another CNA, Staff #78, who revealed that Resident #36 got upset because Resident #75 was in the recliner, which led to Resident #36 trying to get him out of the recliner and ultimately pushing Resident #36 against the door. The CNA revealed that she tried to separate them when Resident #36 started hitting Resident #75 and pulling his hair while Resident #75 hit Resident #36 back. (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 August 6, 2025 at 8:30 a.m. with a CNA, Staff #78, who stated that she witnessed the incident between Resident #36 and Resident #75. The CNA stated that Resident #75 was sitting in the recliner that Resident #36 usually sat in when Resident #36 made Resident #75 stand up by pulling him up before Resident #75 pushed Resident #36. The CNA further stated that staff attempted to separate the residents but they were unable to for several minutes. The CNA also stated that Resident #36 pulled Resident #75’s hair, and the two residents did have prior altercations with one another. An interview was conducted on August 6, 2025 at 9:11 a.m. with a Registered Nurse (RN/Staff#159) who stated that she witnessed the altercation between Resident #36 and Resident #75. The RN stated that she ran into the dayroom because the CNA’s were screaming for help, and when she got to the room she witnessed Resident #36 grabbing Resident #75 by the back of the head in a “hair hold” while the residents were punching each other. The RN stated that they punched her and the other staff who were present on accident as well, and they could not get Resident #36 to let go of Resident #75, but they eventually were able to pry Resident #36 off of him. The RN stated that she knew the two residents had issues prior to the altercation because she had to intervene in a couple of altercations before this one. The RN stated that the fight started because Resident #75 pushed Resident #36 after he was told he was sitting in Resident #36’s chair. An interview was conducted on August 7, 2025 at 11:38 a.m. with the Director of Nursing (DON/Staff#163) who stated that it was reported to him that Resident #75 was sitting in Resident #36’s usual chair in the dayroom when Resident #36 asked for his seat back. The DON stated that when Resident #36 said no, Resident #36 took him by the hands and pulled him out of the chair. The DON stated that the altercation did occur, but the facility did not allow for the abuse to take place. An interview was conducted on August 7, 2025 at 12:48 p.m. with the Administrator and abuse coordinator, Staff #9, who stated that an altercation involving residents dragging other residents out of their seats, punching, clawing, grabbing, pinching, cursing, and yelling was absolutely resident-to-resident abuse and would need to be reported. -Regarding Resident #7 and Resident #31 Resident #7 was admitted on [DATE] with diagnoses that included anxiety, major depressive disorder mood affective disorder, and dementia A Quarterly Minimum Date Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 08, which indicated moderate cognitive impairment. A progress note dated August 3, 2025 at 2:09 p.m. revealed that the resident called the police on Resident #31 for hovering over another resident in the dining room because he perceived that Resident #31 was being aggressive. The note revealed that the police arrived at the facility and explained to the resident that there was nothing to be worried about. A care plan focus initiated on August 4, 2025 revealed a psychosocial well-being problem potential related to a resident to resident altercation. A skin assessment completed on August 4, 2025 revealed a red and purple discolored bruise to the right eye and a skin scrape on the left thumb. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A change in condition assessment dated [DATE] at 3:39 p.m. revealed a resident-to-resident altercation that occurred on August 3, 2025 in the afternoon. A progress note dated August 4, 2025 at 4:02 p.m. revealed that the resident was involved in a resident-to-resident altercation and received a hit to his face by another resident. The note revealed that the resident was noted to have a black eye, and he stated that the other resident hit him on his face. A progress note dated August 4, 2025 at 4:52 p.m. revealed that the resident was noted with increased confusion and no physical aggression during the shift with discoloration still noted around his right eye. Resident #31 was admitted on [DATE] with diagnoses that included type 2 diabetes, chronic atrial fibrillation, angina pectoris, hyperlipidemia, hypertension, major depressive disorder, vascular dementia, schizoaffective disorder, panic disorder, insomnia, and obsessive-compulsive disorder. An admission Minimum Date Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 05, which indicated severe cognitive impairment. The MDS also revealed that the resident had exhibited other behavior symptoms not directed towards others for 1-3 days. A late-entry progress note dated August 3, 2025 at 4:11 p.m. revealed that the resident was involved in a resident-to-resident altercation with another resident and he hit

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews, and policy review, the facilityfailed to ensure that the abuse policy was adhered to following an incident of resident-to-resident abuse for two residents (#111 and #24). The deficient practice could result in continued resident-to-resident abuse. -Regarding Resident #111 Resident #111 was admitted on [DATE] with diagnoses that included schizoaffective disorder (bipolar type), schizoaffective disorder, bipolar disorder, Asperger's syndrome, anxiety disorder, autistic disorder, and hypertension. A care plan focus initiated on March 8, 2023 revealed a behavior problem as evidenced by physical aggression and a history of peer altercations. A Quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. A progress note dated August 20, 2023 at 11:07 p.m. revealed that Resident #111 grabbed Resident #24's left arm, attempting to drag him to the floor, and 3 staff members attempted to separate the two residents with difficulty. The note revealed that the resident grabbed a chair and attempted to throw it, but was stopped by staff. The note further revealed that the nurse told the resident she cannot abuse other residents, and the resident stated that she did not care and that Resident #24 should not have been in the hallway. A progress note dated August 21, 2023 at 12:08 p.m. revealed that an investigation was initiated and all parties were notified. A progress note dated August 22, 2023 at 12:35 p.m. revealed that the facility spoke with the resident's family due to concerns with behaviors, resident-to-resident altercations, and to seek alternation placement if the resident continued to exhibit the behaviors. -Regarding Resident #24 Resident #24 was admitted on [DATE] with diagnoses that included schizoaffective disorder (bipolar type), psychotic disorder with delusions, systemic lupus erythematosus, major depressive disorder, vascular dementia, extrapyramidal and movement disorder, generalized anxiety disorder, and major depressive disorder. A Quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. A progress note dated August 20, 2023 at 11:58 p.m. revealed that Resident #111 grabbed Resident #24's left arm to try and drag him to the floor, and he did not fight back or fall to the floor. The note revealed that upon assessment, Resident #24's left arm had slight discoloration noted and the sleeve to his shirt was ripped off. The progress note also revealed that the doctor, power of attorney, and behavioral manager were notified. A progress note dated August 21, 2023 and 12:08 p.m. revealed that an investigation was initiated and all parties were notified. An interdisciplinary team (IDT) progress note dated September 15, 2023 at 1:57 p.m. revealed that the resident had a room and unit change following the resident-to-resident altercation. An interview was conducted on August 7, 2025 at 12:48 p.m. with the Administrator and abuse coordinator (Administrator/Staff#9) who stated that an altercation involving residents attempting to drag other residents to the ground with skin discoloration noted and a shirt sleeve being ripped off would be considered a resident-to-resident abuse and would need to be reported. A request was made for the facility to provide a copy of the investigation, and the facility verified that they were unable to provide any investigation documents beyond 12 months. Review of a policy revised in September of 2022 titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revealed that if resident abuse was suspected, the suspicion must be reported immediately to the administrator and other officials according to state law. The policy also revealed that immediately is defined as within two hours of an allegation involving abuse. 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. The policy also revealed that the facility would develop and implement policies and protocols to prevent and identify abuse of residents, and they would investigate and report any allegations within the timeframe required by federal requirements. 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.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews, and policy review, the facilityfailed to ensure that an incident involving abuse between two residents (#111 and #24)was reported in a timely manner. The deficient practice could result in continued resident to resident abuse. -Regarding Resident #111 Resident #111 was admitted on [DATE] with diagnoses that included schizoaffective disorder (bipolar type), schizoaffective disorder, bipolar disorder, Asperger's syndrome, anxiety disorder, autistic disorder, and hypertension. A care plan focus initiated on March 8, 2023 revealed a behavior problem as evidenced by physical aggression and a history of peer altercations. A Quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. A progress note dated August 20, 2023 at 11:07 p.m. revealed that the nurse was attempting to administer Resident #111's medication when she told the nurse to give Resident #24 his medications first because she wanted to continue to walk the hallways. The note further revealed that the nurse explained that she could continue to walk after receiving her medications, which resulted in Resident #111 yelling at the nurse and pointing her finger close to her face before turning around and charging at Resident #24. The note revealed that Resident #111 grabbed Resident #24's left arm, attempting to drag him to the floor, and 3 staff members attempted to separate the two residents with difficulty. The note revealed that the resident grabbed a chair and attempted to throw it, but was stopped by staff. The note further revealed that the nurse told the resident she cannot abuse other residents, and the resident stated that she did not care and that Resident #24 should not have been in the hallway. A progress note dated August 21, 2023 at 12:08 p.m. revealed that an investigation was initiated and all parties were notified. A progress note dated August 22, 2023 at 12:35 p.m. revealed that the facility spoke with the resident's family due to concerns with behaviors, resident-to-resident altercations, and to seek alternation placement if the resident continued to exhibit the behaviors. -Regarding Resident #24 Resident #24 was admitted on [DATE] with diagnoses that included schizoaffective disorder (bipolar type), psychotic disorder with delusions, systemic lupus erythematosus, major depressive disorder, vascular dementia, extrapyramidal and movement disorder, generalized anxiety disorder, and major depressive disorder. A Quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. A progress note dated August 20, 2023 at 11:58 p.m. revealed that Resident #24 was pacing in the hallway when the nurse was trying to give another resident her medication. The note further revealed that the other resident refused her medication and turned toward Resident #24 and grabbed his left arm to drag him to the floor, and he did not fight back or fall to the floor. The note revealed that staff attempted to separate the residents with difficulty because she would not let go of his arm, but eventually they successfully separated the residents. The note revealed that upon assessment, Resident #24's left arm had slight discoloration noted and the sleeve to his shirt was ripped off. The progress note also revealed that the doctor, power of attorney, and behavior\al manager were notified. A progress note dated August 21, 2023 and 12:08 p.m. revealed that an investigation was initiated and all parties were notified. An interdisciplinary team (IDT) progress note dated September 15, 2023 at 1:57 p.m. revealed that the resident had a room and unit change following the resident-to-resident altercation. An interview was conducted on August 7, 2025 at 12:48 p.m. with the Administrator and abuse coordinator (Administrator/Staff#9) who stated that an altercation involving residents attempting to drag other residents to the ground with skin discoloration noted and a shirt sleeve being ripped off would be considered a resident-to-resident abuse and would need to be reported. A request was made for the facility to provide a copy of the investigation, and the facility verified that they were unable to provide any investigation documents beyond 12 months. Review of a policy revised in September of 2022 titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revealed that if resident abuse was suspected, the suspicion must be reported immediately to the administrator and other officials according to state law. The policy also revealed that immediately is defined as within two hours of an allegation involving abuse. 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. The policy also revealed that the facility would investigate and report any allegations within the timeframe required by federal requirements.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **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 documentation was completed accurately for six residents (Residents #11, 43, 113, 114, 25 and 115) regarding abuse and resident assessment. This deficient practice could lead to incomplete documentation in residents' medical records.Findings include: -Regarding Resident #11: Resident #11 was admitted to the facility on [DATE], with diagnoses that included Alzheimer’s disease, vascular dementia, end-stage renal disease, dependence on renal dialysis, hypotension, depression and anxiety. On July 29, 2025, upon entrance to the facility, Resident #11 was identified as a resident who received dialysis treatment. During an initial pool interview with Resident #11 on July 29, 2025, at 12:18 PM, he stated that he goes to dialysis on Mondays, Wednesdays and Fridays. He stated that the staff do not check on him when he returns from dialysis. A nursing care plan, revised September 8, 2023, listed an intervention to complete a dialysis worksheet before and after dialysis treatment. A review of the resident’s medical record revealed no evidence of staff completing assessments before or after the resident went to dialysis. An interview was conducted with a Registered Nurse (RN/staff #148) on July 31, 2025, at 9:55 AM. The RN stated that the dialysis center checks Resident 11’s vital signs and weight following dialysis. The RN stated that when the resident returns to the facility, staff ensure he is accounted for, but do not perform an actual assessment. Staff #148 stated they do not assess the resident’s fistula site and do not document a progress note or assessment note in the medical record. An interview was conducted with the Director of Nursing (DON/staff #163), on July 31, 2025 at 12:47 PM. The DON stated the facility does not have a formal assessment tool they use for residents going to, or returning from, dialysis. The DON stated that staff check Resident 11’s vital signs and monitor his fistula site upon his return. However, the DON was unable to locate documentation showing that the condition of the fistula site was assessed before or after dialysis treatments in Resident #11’s medical record. The DON stated that the assessment information should be documented in the medical record. -Regarding Resident #43: Resident #43 was admitted to the facility on [DATE], with diagnoses that included bipolar disorder, schizoaffective disorder, dementia, depression, anxiety and chronic pain syndrome. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On December 9, 2023, the SA received a report from the facility regarding a physical altercation that Resident #43 was involved in with another resident. A review of Resident #43’s medical record did not reveal any documentation of a physical altercation on December 9, 2023. An interview was conducted with the DON (staff #163) on August 6, 2025, at 9:05 AM. The DON could not locate any documentation in Resident #43’s medical record regarding the physical altercation that occurred on December 9, 2023. -Regarding Resident #113: Resident #113 was admitted to the facility on [DATE], with diagnoses that included dementia, Parkinson’s disease, anxiety, depression and insomnia. On February 9, 2024, the SA received a report from the facility regarding a physical altercation that Resident #113 was involved in with another resident. A review of Resident #113’s medical record did not reveal any documentation of a physical altercation on February 9, 2024. An interview was conducted with the DON (staff #163) on August 6, 2025, at 9:05 AM. The DON could not locate any documentation in Resident #113’s medical record regarding the physical altercation that occurred on February 9, 2024. -Regarding Resident #114: Resident #114 was admitted to the facility on [DATE], with diagnoses that included depression, dementia, cerebral infarction and a sleep disorder. On February 9, 2024, the SA received a report from the facility regarding a physical altercation that Resident #114 was involved in with another resident. A review of Resident #114’s medical record did not reveal any documentation of a physical altercation on February 9, 2024. An interview was conducted with the DON (staff #163) on August 6, 2025, at 9:05 AM. The DON could not locate any documentation in Resident #114’s medical record regarding the physical altercation that occurred on February 9, 2024. -Regarding Resident #115: Resident #115 was admitted to the facility on [DATE], with diagnoses that included dementia, hypertension and insomnia. On December 9, 2023, the SA received a report from the facility regarding a physical altercation that Resident #115 was involved in with another resident. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #115’s medical record did not reveal any documentation of a physical altercation on December 9, 2023. An interview was conducted with the DON (staff #163) on August 6, 2025, at 9:05 AM. The DON could not locate any documentation in Resident #115’s medical record regarding the physical altercation that occurred on December 9, 2023. -Regarding Resident #25 Resident #25 was admitted on [DATE] with diagnoses that included dementia, type 2 diabetes, generalized anxiety disorder, major depressive disorder, Parkinson's disease, insomnia, hypertension, gastro-esophageal reflux disease, macular degeneration, and allergic rhinitis. A Quarterly Minimum Date Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 08, which indicated moderate cognitive impairment. Review of a facility investigation dated March 18, 2024 revealed that a self-report was reported to the Arizona Department of Health Services on March 12, 2024 at 10:30 a.m. regarding an allegation of misappropriation of resident personal property. The investigation revealed that the resident made a statement that someone took her ring off of her in the night, but she did not remember who it was. The investigation further revealed that the resident stated it was a female who took it, she last saw the ring at dinner, and she wanted the police to be called. The investigation revealed that staff searched the room and were interviewed, and one Certified Nursing Assistant (CNA/Staff#49) stated that she saw the ring on the resident while giving her a shower, and again while changing the resident. Review of the inventory sheet for Resident #25 revealed that there was no evidence that the residents’ ring was documented on the inventory sheet in the “Items Lost, Damaged, Replaced, or Removed” section of the inventory sheet. There was no evidence that an allegation of misappropriation or a missing ring was documented in the clinical record of Resident #25. An interview was conducted on August 7, 2025 at 11:38 a.m. with the Director of Nursing (DON/Staff#163) who stated that he would expect staff to document allegations of misappropriation in the clinical record as a progress note or behavioral assessment, but that the business office sometimes keeps files regarding financial misappropriation. The DON noted that even if there was documentation by the business office, he would still expect staff to put some information on the incident in the clinical record. The DON pulled up Resident #25’s clinical record to find any documentation of the incident and he stated that there was no evidence of documentation in her clinical record regarding the misappropriation allegation or incident. Review of a policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, was revised in April of 2021 and revealed that residents have the right to be free from abuse, neglect, and misappropriation of resident property and exploitation. The policy also revealed that the facility would need to develop and implement policies and protocols to prevent and identify misappropriation of resident property. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a policy titled, Charting and Documentation, was revised in July of 2017 and revealed that all services provided to the resident, progress towards the care plan and goals, or any changes in the resident's mental, physical, functional, or psychosocial condition should have been documented in the resident’s medical record. The policy further revealed that events, incidents, or accidents involving the resident would need to be documented in the medical record, and it must be objective, complete, and accurate. A policy titled, End-Stage Renal Disease, Care of a Resident with, revised September 2010, states that staff will be educated regarding the type of assessment data that is to be gathered about the resident’s condition. A policy, titled Abuse and Neglect—Clinical Protocol, revised March 2018, states that when alleged abuse occurs, the nurse is to assess the individual and document related findings.