

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 08/22/2025
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)		
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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

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F 0689 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 reviews, staff interviews, facility documentation and policies and procedures, the facility failed to ensure adequate supervision was provided to one resident (#10). The deficient practice resulted in placing resident's safety at risk with a non-authorized person. Findings include: Resident #10 was admitted to the facility on [DATE], with diagnoses that included Unspecified Dementia, Unspecified Severity with Agitation, and Schizoaffective Disorder, Bipolar. Review of a care plan initiated on April 24, 2025 revealed that resident #10 had an Activities of Daily Living (ADL) self-care performing deficit related to Dementia diagnosis. The goal was the resident will maintain current level of function in (Specify) through the review date. The interventions were to encourage the resident to participate to the fullest extent possible with each interaction. (with a target date of 4/24/25). Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed the resident #10 had moderate severe cognitive impairments with daily decision-making skills. Review of medical record revealed that resident #10 had a guardian listed as the responsible party and emergency contact. Others listed on the admission record for contacts were resident's sister, a case worker and resident #10 as self. Review of the medical record on 8/22/2025 did not reveal any paperwork documenting guardianship and did not list any restrictions of visitors for resident #10. Review of the incident report indicated that resident #10 was under Court Ordered Treatment residing in the locked memory care unit. Resident #10 was allowed to leave the premises on 06/09/2025 with the sister without the permission and awareness of the assigned Maricopa County Public Fiduciary. An interview was conducted Admission's (staff #50) on August 22, 2025 at 12:25pm. When asked about the admission process and who responsible for obtaining the necessary paperwork and communicating the information to the staff she stated that typically she does all the admission paperwork. Staff #50 stated once paperwork is received it is uploaded into the electronic charting system. When asked who is responsible for getting the Power of Attorney, Guardianship or Court orders treatment paperwork, staff #50 stated she usually does. When asked where the Court Ordered Treatment and a court appointed guardian paperwork for resident #10 was in the medical record, she stated it was an oversight on her part and this paperwork was not in resident #10's medical record's chart. Staff #50 then stated she had received that paperwork in reference on April 18, 2025 on her phone and forgot to upload to resident #10's medical record chart. An interview was conducted with Licensed Practical Nurse (LPN/Staff #70) on August 22, 2025 at 12:45 pm to discuss contact information on resident's demographic sheet which has who is the responsible party. When asked staff #70 how do you know who to communicate and how do you know who to contact if you need to inform someone regarding the condition of any changes with a resident. Staff #70 stated that the resident face sheet has that and that what they go by. When asked what the process is if a resident wants to leave the facility, is there a process? Staff #70 stated they would look in the resident's chart to see which is the responsible party and make sure there was a Doctors order. Staff #70 also stated there is a time frame for fours to being out of building. When asked staff #70 if there is a restriction list she stated she would check the chart or ask administration. When asked if there are sign in and sign out sheets for residents that are leaving and coming back, staff #70 stated yes that there is a sign in and sheet out sheet. An interview was conducted with Licensed Practical Nurse (LPN/Staff #55) on August 22, 2025 at 3:17 pm to discuss incident that occurred on June 9, 2025. LPN stated that on June 9, 2025 resident's sister was there visiting. She was informed that his sister wanted to take him out to lunch. LPN said she called the Doctor and the Doctor gave the order for resident to go out to lunch with his sister. LPN stated she called the sister before dinner time to check to see if he would be back for dinner. Resident's sister stated that she had dropped the resident off about an hour and a half ago at the front door. LPN stated she called management and stated that management then called police. LPN stated that resident was located but not sure on the time. LPN stated that this was their first time for her that resident went off premises and did not know anything about resident having a guardian or any restrictions regarding the sister taking him out. An interview was conducted with Executive Director (ED/Staff #60) on August 22, 2025 at 2:01pm to discuss incident of resident leaving the facility with an unauthorized person on June 9, 2025 and not returning to the facility, ED stated on June 9, 2025, resident's sister came to visit resident. ED stated that he escorted resident's sister to his room and that resident was visibly excited to see his sister. Order was obtained for resident to leave facility with sister to go to lunch. Per ED, staff did not check resident #10's information sheet and let resident out of the facility with a non-authorized person. Documentation revealed that resident #10 never check back		