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	09/08/2025

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. (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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(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	**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 two of three sampled residents (#28 and #14). The deficient practice could result in psychosocial or physical harm to residents. -Regarding resident #14 Resident #14 was admitted to the facility on [DATE] with diagnoses that included dementia with agitation, bipolar disorder, hyperlipidemia, type 2 diabetes, mood affective disorder, anxiety disorder, benign prostatic hyperplasia, depression, hypertension, gastro-esophageal reflux disease, and insomnia. An Annual Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 05, which indicated severe cognitive impairment. A behavior progress note dated September 6, 2025 at 12:15 p.m. revealed that the resident was observed to become agitated with another resident over a seating arrangement, which escalated into a verbal and physical altercation. The note revealed that one Certified Nursing Assistant (CNA) tried to break the altercation up and was not strong enough to get them apart, and was injured in the process. The note further revealed that two CNA's and one nurse were able to separate and calm the residents down, and Resident #14 was noted to have a mildly painful skin tear and bruise on his right hand. A care plan focus initiated on September 6, 2025 revealed a psychosocial well-being problem risk related to a resident to resident altercation. A change of condition assessment dated [DATE] revealed that the resident responded to threats from another resident, and began a physical and verbal altercation. The assessment also revealed the resident sustained a right hand contusion and skin tear. -Regarding Resident #28 Resident #28 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, atherosclerotic heart disease, hyperlipidemia, hypothyroidism, Parkinson's disease, bipolar disorder, and generalized anxiety disorder. A Quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 03, which indicated severe cognitive impairment. A care plan focus initiated on September 6, 2025 revealed a psychosocial well-being problem risk related to a resident to resident altercation. A change of condition assessment dated [DATE] revealed that the patient was observed to have become agitated with another patient that escalated into an argument and became physical. The assessment revealed that the resident sustained a contusion on his right hand with no pain, and the physician recommended a 72-hour one on one supervision to keep the resident safe. Review of video footage from September 6, 2025 at 10:39 a.m., revealed that Resident #14 was wiping something off of a recliner seat in the day room next to Resident #28 when Resident #28 appeared to be waving his arm near Resident #14. The video revealed a verbal altercation began and caught the attention of several residents in the dayroom before Resident #14 attempted to sit in the recliner. The video further revealed that as Resident #14 tried to sit down, Resident #28 swung his arm to push Resident #14, who then began swatting his hands while Resident #28 kicked his legs at him. The video revealed that Resident #14 pulled the legs of Resident #28 and attempted to take him out of the chair as the CNA's and nurse rushed into the room to help separate the residents. The video revealed that the altercation lasted approximately one minute, and the dayroom had one CNA and 12 residents. An interview was conducted on September 8, 2025 at 2:02 p.m. with a Registered Nurse (RN/Staff#37) who stated that Residents #14 and #28 had an altercation on September 6, 2025, and that a CNA got hurt in the altercation as well. The RN stated that she was not in the room when the altercation broke out, but she ran to the dayroom when she heard screaming. The RN stated that at the time of the altercation, there was one staff member in the room with several residents in the dayroom, and both residents had an almost identical injury to their right hands. The RN stated that the CNA, Staff #56, told her that Resident #28 was sitting in a recliner second closest to the door when Resident #14 entered the room to sit in his usual spot. The RN stated that both residents talk with their hands and tend to be aggressive and posturing, and that Resident #14 said something toResident #28 about the chair in front of him and made contact with their hands before the kicking started. The RN stated that Resident #28 was sitting in the chair while Resident #14 grabbed his legs and attempted to pull him out of the chair, The RN further stated that by the time she walked into the dayroom, both residents were standing up. The RN stated that she knows the incident occurred because of the injuries the residents had, the huffing and puffing that both residents were doing when she entered the room, both residents spoke to her about the fight afterwards, and there was a camera in the room. An interview was conducted on September 8, 2025 at 3:20 p.m. with a CNA, Staff #56, who stated that she was scratched up in an altercation between two residents over the weekend. The CNA