

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 09/23/2025
NAME OF PROVIDER OR SUPPLIER Rehab at Scottsdale Village Square		STREET ADDRESS, CITY, STATE, ZIP CODE 2620 North 68th Street Scottsdale, AZ 85257	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff and resident interviews, and facility policy, the facility failed to protect the rights of two out of the four sample residents to be free from abuse by another resident. The deficient practice could result in other residents being abused. Regarding a resident-to-resident altercation that involved Resident # 50 and Resident #55. -Regarding Resident #50Resident # 50 was admitted to the facility on [DATE], with diagnoses of Bipolar Disorder, Alzheimer's Disease, and Anxiety. Orders dated May 24, 2025, revealed an order for Chlorpromazine HCL Oral Tablet 25 MG given for behaviors relating to Bipolar Disorders. Orders dated July 31, 2025, revealed an order for sertraline HCL oral Tablet 50 mg given for depression. A quarterly MDS (Minimum Data Set) assessment dated [DATE], revealed resident #50 had a BIMS (Brief Interview for Mental Status) score of 03, which indicated severe cognitive impairment. A Progress note dated September 13, 2025, 14:40 hrs. revealed that Resident #50 was in a verbal altercation with another resident. Further review of the progress note revealed a recommendation was made by provider for resident #50 to be placed on a one-on-one. A care plan revised on September 13, 2025, revealed Resident # 50 is at risk for psychosocial well-being problems related to Resident-to-Resident altercations. A Change in Condition Evaluation dated September 13, 2025, revealed that Resident #50 became upset by another resident's actions, which escalated to a physical altercation. The Change in Condition Evaluation further revealed that provider recommended the resident be placed on a one-on-one. -Regarding Resident #55Resident # 55 was re-admitted to the facility on [DATE], with diagnoses of Bipolar, Anxiety, and Depressive Disorder. An annual MDS assessment dated [DATE], revealed Resident # 55 had a BIMS score of 05, which indicated severe cognitive impairment. A Care Plan Revised on August 06, 2025, revealed a focus plan for Resident #55, who has the potential to be verbally aggressive, yelling or cursing at others, relating to dementia. A Progress note dated September 13, 2025, at 14:38 hrs., revealed that Resident #55 was the aggressor in a physical and verbal altercation with another resident. Further review of the progress note revealed that resident # 55 sustained scratches to the right outer eye. This progress note also revealed that the provider recommended that resident # 55 be placed on one-on-one. A skin assessment dated [DATE], revealed a 3 cm laceration to the outer right eye. An interview was conducted on September 23, 2025, at 12:52 PM with a Certified Nursing Assistant (CNA/Staff #35), who stated that a few days ago, there was a staff meeting regarding abuse involving residents #50 to #55. Staff #35 stated that in this meeting, it was discussed that residents #50 and #55 got into a physical altercation, and it was reported. She also stated that in the staff meeting, it went over: how to handle abuse, reporting abuse, and types of abuse. (CNA/Staff # 35) further stated that the different types of abuse are: physical, emotional, and verbal. She also stated that physical abuse is hitting, verbal abuse is when someone says something mean, for example: you're dumb, and emotional abuse is making a resident feel bad, for example, commenting about appearance and making rude comments. She further stated that Resident #50 would be ok one sec, and the next moment would be angry or start fights. (CNA/Staff #35) also stated that Resident #55's mood can switch instantly. She also stated that resident # 50 was upset at resident #55 for (continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>being in the recliner. She further stated that the recliner is in the day room and it belongs to no one. She then stated that Resident # 55 was on the recliner and Resident #50 was standing on the side of the recliner. She then stated that resident #50 told resident #55 to get up, then resident # 55 replied with no, he was sitting there. (CNA/Staff #35) stated that resident # 50 went and grabbed both arms of resident #55. She further stated that Resident # 55 became upset, got up from the recliner, and pushed Resident # 50. (CNA/Staff #35) stated that both residents were hitting each other, and Resident #50 pulled Resident #55's hair. She then stated that she stepped in to separate the resident, and at that moment, another CNA and Nurse stepped in to help. She also stated that they were trying to keep residents separate from each other. An interview was conducted on September 23, 2025, at 2:19 PM with a Licensed Practical Nurse (LPN/Staff #67), who stated that she had received abuse and neglect training. She also stated that their abuse training included the types of abuse: Verbal, resident-to-resident, and physical. She further stated that verbal abuse is calling residents' names, physical abuse is anything aggressive, and any touching that causes bruising. An interview was conducted on September 23, 2025, at 4:13 PM with the Director of Nursing (DON/Staff # 105) and an administrator (Staff #501) present. (Staff # 501) stated that the different types of abuse are: physical, sexual, and neglect. He states that physical abuse would be hitting. He also stated that Resident # 50 and Resident #55 were in a prior incident between the two Residents. (Staff #501) stated that one of the incidents was regarding the recliner, and the other incident was when resident #55 saw resident #50 and threw water on him. He further stated that after that incident, resident #50 was moved to another unit. (Staff #105) stated that just the other day, they had a staff meeting about abuse, neglect, and misappropriation. She also stated that during that meeting, they had talked about resident-to-resident. (DON/Staff #105) stated that she doesn't think that there is an impact on residents regarding resident-to-resident altercation. A policy revised in April 2021 titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program revealed that residents have the right to be free from abuse, neglect.</p>		