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	10/20/2025

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 clinical record review, staff interviews, review of facility documentation and policies, the facility failed to protect the rights of four residents (#1, #2, #10, and #20) to be free from abuse from each other. The deficient practice could result in further abuse of residents and appropriate action not taken.Findings include:Regarding incident involving Resident #20 and Resident #2:-Regarding Resident #20 (alleged perpetrator):Resident #20 was initially admitted at the facility on August 20, 2021, with diagnoses of dementia, chronic obstructive pulmonary disease (COPD), and generalized anxiety disorder.A review of the annual Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 6.0, severely impaired, and no behavioral symptoms exhibited.A review of the care plan dated August 19, 2025, revealed the resident has a cognitive deficit related to dementia with behavioral disturbance. The intervention included for the staff to attempt to keep her away from close proximity to one particular resident at all times.Review of the Nurse Note progress note dated September 29, 2025, at 2:55 PM revealed that Resident #20, identified as Resident A in the progress note, was observed self-transferring in a wheelchair in the day room. Another resident, identified as Resident B, attempted to grab the handle of the wheelchair. Resident #20 turned and struck the other resident with a closed fist. The other resident proceeded to strike Resident #20 with a closed fist. The nurse separated the residents, redirecting Resident #20. A head-to-toe assessment was completed, and no injuries. Resident #20 was placed on every 15-minute check until reevaluated by psych.Another care plan, revised on September 30, 2025, revealed the resident is at risk for a psychosocial well-being problem related to a resident-to-resident altercation.-Regarding Resident #2:Resident #2 was initially admitted at the facility on December 22, 2022, with diagnoses of senile degeneration of the brain, Type 2 Diabetes Mellitus, and dementia.Review of the care plan dated June 23, 2025, revealed the resident has a cognitive deficit related to dementia and Parkinson's disease.Review of the Significant Change in Status MDS dated [DATE], revealed a BIMS score of 6.0, severely impaired, and behavioral symptoms not directed to others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) occurred.A review of the eINTERACT SBAR Summary for Providers progress note dated September 29, 2025, at 2:10 PM revealed, a change in condition situation, per nursing observations, evaluation, and recommendations: Resident #2 was observed in the dayroom grabbing the handle of another resident, identified as the aggressor, wheelchair. Resident #2 turned and struck the other resident with a closed fist. The other resident proceeded to strike Resident #2 with a closed fist. The nurse separated both residents. A head-to-toe assessment was completed for both residents, and there were no injuries.Review of another care plan dated September 30, 2025, revealed that the resident was at risk for a psychosocial well-being problem related to a resident-to-resident altercation. The intervention included removing residents to a calm, safe environment and allowing them to vent/share feelings.Per the facility's investigation report, after a comprehensive internal investigation was completed, per the report, it was found that Resident #20 (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was highly agitated and disoriented for the past several days. She did not like anyone to touch her and her belongings, and when Resident #2 touched her, Resident #20 responded by slapping at Resident #2.Regarding incident involving Resident #10 and Resident #1:-Regarding Resident #10 (alleged perpetrator):Resident #10 was initially admitted at the facility on September 17, 2024, with diagnoses of Alzheimer's disease, Dementia, and Type 2 Diabetes Mellitus.A review of the annual MDS assessment dated [DATE], revealed a BIMS score of 9.0, moderately impaired, and no behavioral symptoms exhibited.An eINTERACT SBAR Summary for Providers progress note dated October 10, 2025, at 12:15 PM revealed a change of condition for behavioral symptoms. Per the progress note's nursing observations, evaluation, and recommendation, a verbal and physical altercation between the roommate and Resident #10 was the aggressor. Resident #10 slapped, pushed his roommate, and fell on the floor. The residents were separated and monitored. The administrator, director of nursing, the providers, and the family were notified.A review of the care plan dated October 10, 2025, and revised on October 13, 2025, revealed the resident has a potential psychosocial well-being problem related to a resident-to-resident.-Regarding Resident #1 (alleged victim):Resident #1 was admitted at the facility on February 6, 2025, with Parkinsonism, Major Depressive Disorder, epilepsy, traumatic brain injury, and anxiety disorder.A review of the MDS assessment dated [DATE], revealed a BIMS score of 10.0, moderately impaired; and per assessment, his mood included feeling down, depressed, or hopeless.A review of the eINTERACT SBAR Summary for Providers progress note dated October 10, 2025, at 12:39 PM revealed a change of condition for trauma; and per nursing observations, evaluation, and recommendations, the resident was in a verbal/physical altercation with another resident. The progress note revealed that Resident #1 ran into his roommate with his wheelchair, then Resident #1 was slapped on the back of his head, pushed out of his wheelchair, and fell onto the floor, hitting the back of his head. A golf ball-sized reddened/swollen bump was noted on the top back of his head. There were no other injuries. The residents were separated. The provider was notified.A review of the physician progress note dated October 11, 2025, revealed that the resident was involved in an altercation yesterday, in which he was pushed. The resident did not recall the incident, who the incident was with, or what happened. Per the progress note, Resident #1 reported pain in the back of the head, but has no evidence of trauma.Per the Skin Only progress note dated October 10, 2025, at 5:16 PM, revealed per skin issue, a traumatic wound was located at the top/back of the head, 10.0 centimeters (cm) in length by 10 cm in width. The resident sustained an injury to the top/back of the head after a fall, reddened, swollen bump was noted. The provider and the resident's family member were notified.During an observation conducted on October 20, 2025, at 11:42 PM, in Resident #1's room, Resident #1 was in his bed, lying down with a blanket covering all the way to his face. A certified nursing assistant (CNA/Staff #40) was in the resident's room. Staff #40 stated that he was in the room for a one-on-one with the resident in the other bed. Staff #40 stated that the Resident #1 was in the same room for 4 months.An interview was conducted on October 20, 2025, at 12:27 PM with a CNA/Staff #45. Staff #45 stated that her abuse training includes reporting to the nurse and providing a statement on what had happened. She stated that abuse is sexual, stealing, hitting, such as hitting someone's head and arm, and touching someone inappropriately. She stated that she will report the abuse because it could harm residents and staff. She stated that if she witnessed two residents having an altercation, she would separate them, take one resident outside, because the residents might get overstimulated. She stated that Resident #10 gets frustrated, demanding cigarettes and coffee, is independent, ambulatory, continent, and Resident #10 came to her unit two days ago. During an observation on October 20, 2025, at 12:38 PM, Resident #10 was standing in his room, and he was talking about his past, and stated that he arrived in his room two or three days ago.An interview was conducted on October 20, 2025, with a Licensed Practical Nurse (LPN/Staff #50). Staff #50 stated that abuse types include physical, exploitation, financial, neglect, and mental. She stated that she reports the abuse to her director of nursing (DON) or the administrator. She stated that physical abuse is punching, hitting, and kicking another person. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She stated that if a resident with dementia or the resident is mentally sick, and kicking another person, she considers it abuse. She will separate the residents to make sure the abuse does not continue. She stated that Resident #10 is pleasant, alert, and oriented, and she does not know the reason why Resident #10 was moved to her unit. She stated that Resident #2 has dementia and can be active. She stated that regarding Resident #20, she is not aware or was not made aware during the report of any altercation between Resident #2 and Resident #20.On October 20, 2025, at 1:21 PM, Resident #2 was observed in her room, lying in her bed, and she did not want to have a conversation.On October 20, 2025, at 1:22 PM, Resident #20 was observed in her room, and she stated that she gets along with the other residents.Another interview was conducted on October 20, 2025, with CNA/Staff #36. Staff #36 stated that abuse is physical, verbal, mental, emotional, and financial. She stated that she gets dementia care training provided by her night supervisor. She stated that physical abuse could be two residents having a physical altercation, like hitting. She stated that verbal abuse includes cursing someone, calling them names, and being verbally aggressive. She said that she works in the locked unit, and if she witnessed an altercation in the behavioral dementia unit, she would separate both residents, place the aggressor on a one-on-one, and if the residents are roommates, she would switch the resident to another room. Staff stated that Resident #1 has been involved in an incident. She stated that Resident #1's roommate was moved out of the room. She stated that Resident #10 pushed Resident #1 from his wheelchair about a week ago. Resident #1 fell on the floor and hit his head, then Resident #10 was moved out to another unit. The residents were separated because they could get hurt. If she witnessed abuse, she would notify the nurse and the administrator.Another interview was conducted on October 20, 2025, with a Registered Nurse (RN/Staff #47). Staff #47 stated that her abuse training included reporting the abuse immediately to the administrator, so the abuse can be investigated. If the abuse is not reported, the abuse can cause injury if repeated, and the resident will live in fear and depression. She stated that abuse is not right and it is a violation of the resident's rights. She stated that abuse can also be physical, sexual, emotional, and financial. She stated that physical abuse involved physical contact, like punching, hitting the head, or arms. She stated that Resident #1 uses his wheelchair; she was not aware of any altercation involving Resident #1, except that his roommate, Resident #10, was moved out of their room.Several phone calls were attempted on October 20, 2025. A call was placed to Staff #38, and a voice message was left.A phone interview was conducted on October 20, 2025, at 2:15 PM with a CNA/Staff #18. Staff #18 stated that her abuse training is through computer and in-service. She stated that abuse can be physical and emotional, and to report the abuse to her supervisor because if it is not reported, it can be considered as neglect. A call was placed to CNA/Staff #32, left a voice mail message.A phone interview was conducted on October 20, 2025, at 2:39 PM with CNA/Staff #49. Staff #49 stated that her responsibility when she witnesses abuse is to report. Staff #49 stated that there was an incident in one of the rooms in her unit. The residents were both going out to smoke, and Staff #49 was going to take the residents to smoke. Staff #49 stated that Resident #1 was in a wheelchair, Resident #1 might have backed his wheelchair, and Resident #10 grabbed Resident #1 by the back of his neck. Staff #49 separated the residents and notified the nurse.A phone interview was conducted on October 20, 2025, at 2:44 PM with Staff #52. Staff #52 stated that she received her abuse training during her orientation, monthly staff meeting, and in-services. She stated that abuse is restraining, confinement, taking things, verbal assault, and physical assault, such as intentional hitting, and residents hitting each other. Staff #52 stated that between Resident #2 and Resident #20 incident, she was on duty that day, and the incident happened in the dayroom about 1:30 PM. She stated that Resident #20 was attempting to self-ambulate, she was pushing her wheelchair with her feet, passed by Resident #2, then Resident #2 grabbed the handle of the wheelchair, then Resident #20 turned around and hit Resident #2, and then Resident #2 hit Resident #20 on her back. Staff #52 stated that she separated both residents and escorted Resident #20 to her room. Staff #52 stated that she spoke with Resident #20, and Resident #20 stated that she was aware that she hit Resident #2, (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	but not aware of the reason why she did it. Staff #52 stated that there was physical contact made, and she considers it an abuse.A phone interview was conducted on October 21, 2025, at 8:57 AM with Staff #38. Staff #38 stated that two weeks ago, there was an incident involving Resident #10 and Resident #1, which she did not witness. The residents were roommates. She stated that a CNA came to her about the incident, describing that Resident #1 was under his bed, the staff picked him up from the floor, and both residents reported what had happened. She stated that Resident #10 smacked Resident #1 on the back of his head and then pushed his wheelchair. Resident #1 became frustrated, so he backed his wheelchair into Resident #10's leg by accident. She stated that the residents were separated. She stated that Resident #1 had muscle spasm and his feet pushed the bottom of the floor, and then his wheelchair went backwards. She stated that Resident #10 told her that Resident #1 backed into him. Staff #38 stated that she took Resident #1 to the dayroom, assessed him, saw a goose egg bump on the back of his head, applied ice, performed neuro checks, and notified the provider, his family, and the administrator to report the incident. Staff #38 stated that Resident #10 has a history of being verbally aggressive, walks independently, and has dementia. She stated that Resident #1 is impaired physically because he cannot swing, has spastic movement, and is weak. Staff #38 stated that her abuse training involved doing it through the online module, having continuing education training (CEU), and a skills lab. She stated that abuse is verbal, physical, and intimidation. She stated examples of physical abuse, such as assaulting, hitting, kicking, and neglect by staff. She considered the incident between Resident #10 and Resident #1 to be physical abuse, with the smack on the head. She also stated that Resident #10 can easily get agitated and has a short fuse, and Resident #1 accidentally backed into Resident #10.An interview was conducted on October 20, 2025, at 3:55 PM with the administrator/Staff #15. The administrator stated that abuse is anything with physical, sexual, misappropriation of property, abandonment, or neglect. Physical abuse is hitting somebody or being forceful, like grabbing, hitting on the head, pushing somebody down, and punching someone. Regarding Resident #1 and Resident #10, the administrator stated that the incident was not witnessed by staff, but the residents concurred that the incident had occurred. The administrator said that Resident #10 hit Resident #1 on the back of his head because Resident #1 was blocking the doorway. Regarding Resident #2 and Resident #20, the administrator stated that both residents were in their wheelchairs. Resident #20 was passing by Resident #2; Resident #2 grabbed the wheelchair, and Resident #20 got upset, so Resident #20 turned back and hit Resident #2's head.Review of the facility's policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised in April 2021, revealed that residents have the right to be free from abuse.Review of the facility's policy titled, Resident Rights, revised in February 2021, revealed that the federal and state laws guarantee certain basic rights to all residents of this facility. The rights include the resident's right to: b. be treated with respect, kindness, and dignity; and c. be free from abuse.