

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 11/06/2025
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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of records, and review of facility policy and procedure, the facility failed to protect the rights of three of seven sampled residents (#10, #8, and #20) to be free from abuse by other residents (#22, 16, and 6). The deficient practice could lead to ongoing abuse, leading to harm of other residents.-Findings include:Regarding Resident #10Resident #10 (alleged victim) was admitted to the facility on [DATE], with diagnoses including Alzheimer's disease, major depressive disorder, anxiety disorder, encounter for palliative care, benign prostatic hyperplasia with lower urinary tract symptoms, and senile degeneration of brain.A review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident was severely cognitively impaired. The MDS further revealed that resident #10 had exhibited no verbal or physical behavioral symptoms directed towards others during the assessment period. Review of resident #10's care plan that was initiated September 23, 2025, revealed a risk for psychosocial well-being related to a resident-to-resident altercation. Interventions included increased communication and monitoring of his usual response to problems.Resident #22 (alleged perpetrator) was admitted to the facility on [DATE] with diagnoses including unspecified moderate dementia-with agitation, anxiety disorder, anemia, chronic obstructive pulmonary disease, generalized muscle weakness, hypothyroidism, acute respiratory failure with hypoxia, metabolic encephalopathy, and unsteadiness on feet.Review of resident #22's quarterly MDS dated [DATE] revealed a BIMS score of 8, which indicated moderate cognitive impairment. The MDS further stated that resident #22 exhibited no verbal or physical behavioral symptoms directed towards others. A care plan that was initiated September 23, 2025 that revealed that resident #22 was at risk for a psychosocial wellbeing problem related to a resident-to-resident altercation. Interventions included 72-hour observation, consult with pastoral, social services, and psych services, and monitor/document resident #22's unusual response to problems. -Regarding October 20, 2025 incidentOn October 20, 2025, at 12:24 p.m. an incident progress note was entered into the clinical record for resident #10. It stated that at approximately 12:24 p.m. resident #10 was observed having being struck in the abdomen by another resident. Per the note, resident #10 was at baseline very confused and only muttered something about a radio. Both residents were immediately separated for safety. Resident #10 was assessed head to toe with no redness or bruising noted. Resident #10 denied any pain.Review of resident #10's skin assessment, dated October 20, 2025, revealed that resident #10's skin was clean dry and intact. No skin issues or injuries were noted.Review of a psych follow up progress note dated October 21, 2025, documented that per the assessment, resident #10's deemed that his safety risk was low and a safety plan was not required.On October 20, 2025, at 12:43 p.m. an incident progress note was entered into the clinical record for resident #22. It stated that at approximately 12:24 p.m. resident #22 was observed punching another resident in the abdomen. Resident #22 kept saying he's a f'cking rat. Both residents were separated for safety.Review of a psych follow up progress note dated October 21, 2025, revealed that resident #22 had been seen by Behavior Nurse Practitioner (NP/staff #174). The note documented that the NP had adjusted the orders for medications and resident #22 was monitored and remained under observation.Review of the facility's undated 5-day investigation report regarding the altercation which occurred on October 20, 2025 revealed that resident #10 entered the day room at approximately 12:30 p.m. and was observed greeting other residents around the room. Per the report, resident #10 approached resident #22, resident #22 said something to resident #10 and then resident #22 punched resident #10 in the stomach. The report documented that neither resident had physical injuries noted. Further review of the 5-day investigation report revealed a written staff witness statement by a Registered Nurse (RN/staff #130). The statement indicated that staff #130 was giving another resident medication in the shower room and upon exiting observed the resident-to-resident altercation. Attempts to contact the RN (staff #130) for a telephonic interview were made on November 6, 2025 at 11:29 a.m., 12:42 p.m., and 3:24 p.m. No return call was received. -Regarding resident #10 and resident #22 on October 21, 2025 incidentReview of a clinical records for residents #10 revealed an incident progress note at on October 21, 2025, at 4:43 p.m. The notes stated that resident #22 had been observed verbally assaulting resident #10 in the dayroom. Resident #10 was sitting at the table, and not provoking resident #22. Resident #22, moved his wheelchair near resident #10 and resident #22 punched resident #10 in the upper body. Resident #10 was transported outside to diffuse and separate the residents and no physical injuries were noted to</p>		