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	12/23/2025

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 - 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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**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 four of eight sampled residents (#24, 15, 20, and 9) to be free from abuse by other residents (#20, 22, 11, 18). The deficient practice could lead to ongoing abuse, leading to harm to other residents.-Findings include:Regarding Resident #24Resident #24 (alleged victim) was admitted to the facility on [DATE], with diagnoses including Alzheimer's disease, dementia in other diseases classified elsewhere, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, post-traumatic stress disorder, anxiety disorder, and insomnia.A review of the annual Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. The MDS further revealed that Resident #24 had exhibited no verbal or physical behavioral symptoms directed towards others during the assessment period.Review of Resident #24's care plan, which was initiated on October 10, 2025, revealed a risk for psychosocial well-being problem potentially related to a resident-to-resident altercation. Interventions included: when conflicts arise, remove residents to a calm, safe environment, allowing them to vent and share feelings.Resident #20 (alleged perpetrator) was admitted to the facility on [DATE], with diagnoses including dementia, without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, anxiety disorder, post-traumatic stress disorder, vascular dementia, with other behavioral disturbance, and major depressive disorder.A review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 00, which indicated the resident #20 could not complete the assessment. The MDS further revealed that Resident #20 had exhibited no verbal or physical behavioral symptoms directed towards others during the assessment period.Review of Resident #20's care plan that was initiated September 4, 2025, revealed a risk for a behavioral problem, intrusive and combative with care at times. Interventions included an attempt to redirect behaviors. -Regarding the December 5, 2025, incident On December 5, 2025, a nursing progress note was entered into the clinical record for Resident #24. It stated that Resident #24 was observed getting hit in the face with a room door. Resident #24 had an abrasion to the right lower eyebrow. Head-to-toe skin assessment was completed with no other injuries noted.Review of a skin assessment for Resident #24, dated December 5, 2025, revealed that Resident #24 had an abrasion on his right upper eyelid and no other skin injuries or wounds were noted.On December 5, 2025, a nursing progress note was entered into the clinical record for resident #20. It stated that Resident #20 was observed abruptly closing the door to a resident's room on the resident's face, causing injury. Resident #20 was then taken to the day room for checks every 15 minutes. Review of a skin assessment dated [DATE], revealed no areas of concern for resident #20. Review of the facility's undated 5-day investigation report regarding the altercation that occurred on December 5, 2025, revealed that a laundry aid (staff #234) was delivering clothing to resident #24's room and witnessed the altercation. Following the alteration, Resident #20 was placed on 15-minute supervisory checks. The report further stated that resident #24 was seen by the facility's behavior nurse practitioner. Resident #20 could not recall the events, and no changes were ordered to his medications. An interview was conducted by telephone on December 23, 2025, at 2:22 p.m. with staff #234. Staff #234 stated that on December 5, 2025, she was delivering clean clothing to the room of resident #24. As she was hanging clothes in his closet, she heard a verbal argument between Resident #24 and Resident #20. She then observed resident #20 attempting to enter resident #24's room. Resident #24 was attempting to close the door while resident #20 was trying to enter. Staff #234 stated that she called out for help and witnessed Resident #20 forcefully push the door into the face of Resident #24. An interview was conducted with Director of Nursing (DON/staff #31) on December 23, 2025, at 3:23 p.m. Staff #31 stated that the altercation between Resident #20 and Resident #24 on December 5, 2025, in which a resident used a door to strike another resident, would meet the definition of abuse and fail to meet the facility's expectation. Regarding Resident #15Resident #15 (alleged victim) was admitted to the facility on [DATE], with diagnoses including unspecified dementia, with agitation, metabolic encephalopathy, major depressive disorder, generalized anxiety disorder, and a personal history of benign neoplasm of the brain.A review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 2, which indicated the resident had severe cognitive impairment. The MDS further revealed that Resident #15 had exhibited other behavioral symptoms not directed towards others one to three days during the assessment period.Review of resident #15's care plan that was initiated on April 19, 2024, revealed a