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 02/04/2026

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 and resident interviews, and facility policy, the facility failed to protect the rights of one Resident (#6) out of the three sampled residents to be free from abuse by staff. The deficient practice could result in other residents being abused.Findings include--Regarding Resident (#6)Resident #6 was admitted to the facility on [DATE], with diagnoses that included depression, schizophrenia, quadriplegic, and hypertension. A care plan revised on August 9, 2025, revealed that the Resident #6 was at risk for not meeting emotional, intellectual, physical, and social needs related to Schizophrenia. The interventions revealed that all staff to converse with resident while providing care.Orders dated August 26, 2025, revealed an order for fluoxetine HCl oral tablet 20 mg, one time a day for depression.A quarterly MDS (minimum data set) dated November 12, 2025, revealed that the resident was a BIMS (brief interview for mental status) score of 10 which indicated moderately impaired cognition.A behavior charting assessment dated [DATE], revealed that Resident #6 was very upset and started to get physically and verbally aggressive with staff.Review of the clinical record revealed no evidence of a skin assessment after the altercation between staff and resident on January 26, 2026.Orders dated January 30, 2026, revealed an order for diazepam oral tablet 5 mg (milligram), given 1 tablet by mouth, every 12 hours as needed for anxiety.A progress note, dated August 6, 2025 to February 3, 2026, did not reveal any documentation of risk pertaining to the incident nor did it reveal any issues that would put Resident #6 at risk for staff to resident altercation.A facility document titled, suspected abuse investigation report, dated January 26, 2026, the Director of Nursing (DON, staff #168), per document, revealed that Resident #6 was trying to run into staff and other residents with his electric wheelchair on January 26, 2026, in the common area/day room. Certified nursing assistant (CNA staff #34) got in front of Resident #6's wheelchair. Resident #6 then kicked the CNA (staff #34). The CNA then placed the Resident's #6 into the recliner but also the CNA was yelling loudly. The CNA was suspended and educated related to not using a loud voice towards residents and safe transferring of residents. The investigation conclusion revealed that the CNA was complaining loudly and the loud voice was not appropriate in a behavior setting. However, the suspected abuse that occurred on January 26, 2026, was not reported to the State Agency (SA).The CNA (staff #34) employment record titled, counseling/disciplinary notice, dated January 26, 2026, revealed that the CNA (staff #34) witnessed Resident #6 had gotten to the nurse's station in electronic wheelchair and threw over the medication cart spilling everything on the floor. Resident #6 used his electronic wheelchair as a weapon and headed towards other residents. While the CNA had the right to transfer Resident #6 from electric wheelchair for safety, Resident #6 then kicked the CNA which made CNA (staff #34) upset and he verbalized in a loud way. The CNA was suspended until he completed education from the director of nursing (DON, staff #168) on resident transfers and behavioral response.An interview was conducted on February 4, 2026, at 11:06 a.m., with a CNA (staff # (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

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 02/04/2026

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	34) who worked at the facility for about 7 months and assisted residents with activities of daily living (ADLs) including transferring, bathing, dressing, and oral care. Regarding abuse, the CNA stated that there are different types of abuse, including physical, verbal, financial and staff get abuse training once a month. The CNA then stated that he is familiar with resident #6, who is mostly independent and CNA assists the resident with toileting, dressing, and getting ready for meals. The CNA then stated that on January 26, 2026, during dayshift, Resident #6 came to day room naked in the morning, in his electric wheel chair and was upset with a licensed practical nurse (LPN, staff #140) for not getting his medications. While LPN was doing her medication count at medication cart for medication pass close to nurse station at day room, the Resident #6 started to get extremely upset with the LPN and using his electric wheelchair (EWC) as a weapon to go all over the day room, that is when CNA intervened and tried to calm down the resident. Resident #6 became upset, cursed and kicked the CNA, causing bruising to CNA's leg and side. CNA further stated that he tried to control the situation by physically grabbing the resident's leg from his electric wheelchair and sat him on a recliner couch. Resident #6 then put himself to the floor and tried to crawl towards the wheelchair. That is when the CNA called the DON and notified of the incident. CNA was then sent home pending investigation, provided education and training on abuse.An interview was conducted on February 4, 2026, at 2:26 p.m., with the DON (staff #168) who stated that abuse means hurting another person verbally, physically, emotionally, and financially. The DON further stated that all staff receive abuse training during new hire orientation, monthly, and annually. The DON stated when there is an altercation between a resident and a staff member, then both were separated and head to toe assessment were done of resident for any injuries. The DON stated that the incident is then reported to the State Agency (department of health services, AZDHS) within 2 hours (hrs.) and start the investigation if it is deemed abuse. The DON then stated that the abuse investigations will start immediately which included interviewing resident, staff, visitor and other residents. If the alleged perpetrator is a staff member then staff will be immediately sent home pending investigation. The DON recalled the incident between CNA (staff #34) and Resident #6, she stated that the incident happened in the day room on January 26, 2026. She also stated that Resident #6 was in his electric wheelchair and ran into the medication cart, causing the cart to be dumped to the floor containing the laptop, medications, and water pitcher. She further stated that the resident backed up his wheelchair, to hit another resident, that is when CNA (staff#34) intervened and tried to get Resident #6 out of his wheelchair to the recliner couch. The DON stated that during the transfer to the recliner, Resident #6 started kicking the CNA with his leg and the CNA then notified the DON regarding the incident in a loud and angry tone. The DON further stated that the CNA was suspended immediately because he was not supposed to be talking in a loud tone in a behavior unit. The DON then stated that the CNA (staff #34) was also provided in-service training the next day regarding abuse, neglect, and resident rights. The DON further stated that she would not consider the incident as abuse because it was not intentional and the CNA was trying to protect other residents and therefore, the incident was not notified to the SA.An interview was conducted on February 4, 2026, at 3:04 p.m., with an administrator (staff #7) who stated that there are all kinds of abuse including physical, verbal, sexual, and financial. The administrator then stated that the facility process for staff to resident abuse is to identify if the incident was intentional, then separate the resident, making sure resident is safe, notify state agency within 2 hrs., suspend staff pending investigation, and then submitting investigation report to state agency within 5 working day along with staff in-service training regarding abuse, neglect, and resident rights. The administrator further stated that if abuse was not reported to the state agency then the (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents would also be at risk. The administrator then stated that the incident between CNA (staff #34) and Resident #6, was not intentional and therefore the SA was not notified. However, the CNA (staff #34) was suspended on the day of investigation January 26, 2026, was reeducated the next day on resident rights, abuse, and neglect.Review of the facility policy titled Resident Rights, revised in February 2021, revealed that the resident would be treated with respect, kindness, and dignity. The policy further revealed that resident would be free from abuse, neglect, misappropriation of property, and exploitation.Review of the facility policy titled Identification and investigation of Abuse, Neglect, Misappropriation, and injuries of unknown origin, revised on August 1, 2023, revealed that if a staff member is implicated in an abuse/neglect situation, regardless of discipline, the facility will protect the resident, which may include but not limited to, immediately removed from any resident contact, interviewed with their version of the incident documented, suspended pending investigation results. The policy further revealed that document results of the resident assessment, notification of the physician and resident advocate, and any treatment provided.

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	035217	A. Building B. Wing	02/04/2026

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

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **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 ensure an allegation of abuse was reported timely to required entities for one resident (#6). The deficient practice could lead to ongoing abuse leading to harm of a resident.Findings include--Regarding Resident (#6)Resident #6 was admitted to the facility on [DATE], with diagnoses that included depression, schizophrenia, quadriplegic, depression, and hypertension.A quarterly MDS (minimum data set) dated November 12, 2025, revealed that the resident was a BIMS (brief interview for mental status) score of 10 which indicated moderately impaired cognition.A behavior charting assessment dated [DATE], revealed that Resident #6 was very upset and started to get physically and verbally aggressive with staff.Review of the clinical record revealed no evidence of a skin assessment after the altercation between staff and resident on January 26, 2026.The clinical record revealed no evidence that the incident was reported to the State Agency (SA) within 24 hrs. (hours).A request was made on February 4, 2026, at 3:20 p.m. for document regarding reporting to SSA for abuse allegation between CNA (staff #34) and Resident #6. The facility failed to provide the requested documentation during the survey.A facility document titled, suspected abuse investigation report, dated January 26, 2026, the Director of Nursing (DON, staff #168), per document, revealed that Resident #6 was trying to run into staff and other residents with his electric wheelchair on January 26, 2026, in the common area/day room. Certified nursing assistant (CNA staff #34) got in front of Resident #6's wheelchair. Resident #6 then kicked the CNA (staff #34). The CNA then placed the Resident's #6 into the recliner but also the CNA was yelling loudly. The CNA was suspended and educated related to not using a loud voice towards residents and safe transferring of residents. The investigation conclusion revealed that the CNA was complaining loudly and the loud voice was not appropriate in a behavior setting. However, there was no evidence that the suspected abuse investigation dated January 26, 2026, was reported to the SA.An interview was conducted on February 4, 2026, at 10:52 a.m. with CNA (staff #67) who stated that in cases of alleged abuse, the facility's policy is to first examine the picture for the safety of the resident, then report it to the nurse or abuse coordinator right away.An interview was conducted on February 4, 2026, at 2:26 p.m., with a DON (staff #168) who stated that abuse means hurting another person verbally, physically, emotionally, and financially. The DON further stated that all staff receive abuse training during new hire orientation, monthly, and annually. The DON then stated when there is an altercation between a resident and a staff member, both were separated and head to toe assessment were done on resident for any injuries and reporting to the SA within 2 hrs. The DON then stated that the risk of not reporting abuse allegations to the SA could result in further abuse. The DON further stated that abuse allegation between CNA (staff #34) and the Resident #6 was not reported to the SA because it was not an intentional abuse and CNA was trying to protect the other residents from Resident #6.An interview was conducted on February 4, 2026, at 3:04 p.m., with an administrator (staff #7) who stated that there are all kinds of abuse including physical, verbal, sexual, and financial. The administrator then stated that the facility process for staff to resident abuse is to identify if the incident was intentional, then separate the resident, and making sure the resident is safe, then notify SA within 2 hrs. The administrator further stated that the risk of not reporting abuse to the state agency could result in further risk to the resident. Then regarding the incident between CNA (staff #34) and the Resident #6, the administrator stated that he did not think that the incident was intentional and therefore the state agency was not notified.An interview was conducted on February 4, 2026, at 3:20 p.m. with an administrator (staff #7) who stated that (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility did not have any document regarding reporting to SA for an abuse allegation between CNA (staff #34) and Resident #6.Review of the facility policy titled Identification and investigation of Abuse, Neglect, Misappropriation, and injuries of unknown origin, revised on August 1, 2023, revealed if any form of abuse is alleged (physical, verbal) or serious bodily injury is identified related to any other reportable incident (injury of unknown source or allegation of neglect involving serious bodily injury), the Chief Executive Officer (CEO) will notify the State Agency immediately, but not later than 2 hours after the allegation is made. The policy further revealed that all other allegations involving neglect, exploitation, mistreatment, misappropriation of resident property and injuries of unknown source will be reported to State Agency immediately, but not later than 24 hours from the time the incident/allegation was made to the staff member.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **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 ensure an allegation of abuse investigation report was submitted within 5 working days to the State Survey Agency for one resident (#6). The deficient practice could lead to ongoing abuse leading to harm of a resident.Findings include--Regarding Resident (#6)Resident #6 was admitted to the facility on [DATE], with diagnoses that included depression, schizophrenia, quadriplegic, depression, and hypertension. A quarterly MDS (minimum data set) dated November 12, 2025, revealed that the resident was a BIMS (brief interview for mental status) score of 10 which indicated moderately impaired cognition.A behavior charting assessment dated [DATE], revealed that Resident #6 was very upset and started to get physically and verbally aggressive with staff.A request was made on February 4, 2026, at 3:20 p.m. for facility's 5-day investigation report for abuse allegation between CNA (Staff #34) and Resident #6. The facility failed to provide the requested documentation during the survey.The clinical record revealed no evidence that the incident investigation report was submitted to the State Agency (SA) within 5 working days.A facility document titled, suspected abuse investigation report, dated January 26, 2026, the Director of Nursing (DON, staff #168), per document, revealed that Resident #6 was trying to run into staff and other residents with his electric wheelchair on January 26, 2026, in the common area/day room. Certified nursing assistant (CNA staff #34) got in front of Resident #6's wheelchair. Resident #6 then kicked the CNA (staff #34). The CNA then placed the Resident's #6 into the recliner but also the CNA was yelling loudly. The CNA was suspended and educated related to not using a loud voice towards residents and safe transferring of residents. The investigation conclusion revealed that the CNA was complaining loudly and the loud voice was not appropriate in a behavior setting. However, there was no evidence that the abuse investigation dated January 26, 2026, was submitted to the State Survey Agency within 5 working days.An interview was conducted on February 4, 2026, at 2:26 p.m., with a DON (Staff #168) who stated that abuse means hurting another person verbally, physically, emotionally, and financially. The DON further stated that all staff receive abuse training during new hire orientation, monthly, and annually. The DON then stated when there is an altercation between a resident and a staff member, both were separated and head to toe assessment were done on resident for any injuries and reporting to the SA within 2 hrs. The DON then stated that the abuse investigations will start immediately which included interviewing resident, staff, visitor and other residents. If the alleged perpetrator is a staff member then staff will be immediately sent home pending investigation. The DON also stated that a detailed investigation report will be sent to the SA within 5 working days. The DON further stated that If the abuse incident was not investigated then it could happen again.An interview was conducted on February 4, 2026, at 3:04 p.m., with an administrator (Staff #7) who stated that there are all kinds of abuse including physical, verbal, sexual, and financial. The administrator then stated that the facility process for staff to resident abuse is to identify if the incident was intentional, then separate the resident, and make sure the resident is safe, notify SA within 2 hrs., suspend staff pending investigation, and then submitting the detailed investigation report to the SA within 5 working days along with staff in-service training regarding abuse, neglect, and resident rights. The administrator further stated that If the risk of abuse was intentional and was not investigated then all the residents would be at risk for further abuse.An interview was conducted on February 4, 2026, at 3:20 p.m. with an administrator (Staff #7) who stated that facility did not have any 5-day investigation report for abuse allegation between CNA (Staff #34) and the Resident #6.Review of the facility policy titled Identification and investigation of Abuse, Neglect, Misappropriation, and injuries of (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unknown origin, revised on August 1, 2023, revealed that the investigation must be completed within five working days, unless there are special circumstances causing the investigation to continue beyond 5 working days (holiday, account review of funds).