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	03/13/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, review of clinical record and policy review, the facility failed to protect the rights of twelve of twelve residents sampled (#1, #3, #5, #7, #9, #2, #4, #6, #8, #10, #13, and #16) to be free from physical abuse from each other. The deficient practice could result in continued resident to resident abuse. Findings include: Regarding Resident #4 on Resident #6 abuse: Resident #6 was admitted on [DATE], with diagnoses of dementia, mood disorder, anxiety disorder, and psychotic disorder. The care plan initiated on October 8, 2025, revealed the resident had behaviors of yelling, wandering, delusional thinking, and a history of making false allegations against residents and staff. Interventions included redirection, administering medications, and assistance developing appropriate methods of coping and interacting. The quarterly Minimum Data Set (MDS) dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) of 04, indicating severe cognitive impairment. The Behavior Charting dated February 20, 2026, indicated the resident was yelling, screaming, cursing, and had an abrasive tone. A nurse's note dated February 20, 2026, revealed that Resident #6 approached the nurse's station crying and reported she was hit by Resident #4 in the nose. The note stated the residents were placed on 15-minute safety checks and closely monitored. -Resident #4 was admitted on [DATE], with diagnoses that included personality disorder, anxiety disorder, adjustment disorder, and depression. The care plan initiated on August 12, 2025, revealed the resident had behaviors consisting of placing herself on the floor, refusing care and medications, making false accusations, fabricating stories, and going into other resident's rooms and breaking their personal items. Interventions included allowing the resident time, encouragement to verbalize concerns, administering medications, education, explanation of why behavior is inappropriate, and checking for safety and comfort. Review of the quarterly MDS dated [DATE], revealed the resident had a BIMS score of 13, indicating (continued on next page)

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	the resident was cognitively intact. A nurses note dated February 20, 2026, revealed the resident stated she was tired of resident #6 opening her door. The facility incident report received on March 12, 2026, revealed that Resident #6 entered into Resident #4's room un-invited and Resident #4 punched Resident #6 in the nose. The facility report also revealed that staff separated the residents and Resident #6 was redirected out of Resident #4's room and placed on 15-minute supervisory checks. An interview was conducted on March 11. 2026, at 3:18 PM with Licensed Practical Nurse (LPN, Staff #182). She stated Resident #4 likes to stay in her room or sit just outside her door so she can enjoy the sunshine. The resident does not like anyone getting too close to her and prefers to be left alone. Resident #6 enjoys walking around and has a behavior of going into other resident rooms. She stated on February 19, 2026, Resident #6 was very agitated, pacing, cursing, and argumentative and Resident #4 was sitting outside of her room. The LPN said both residents appeared to be irritated with each other. Resident #6 began crying and yelling that Resident #4 hit her in the face. She stated both residents were separated and there had not been any more incidents. She stated the staff have implemented having an aide sit in the common area with the residents, where they can observe everyone and deescalate any situations quickly. Staff #182 stated all behaviors should be documented in the care plan; however, the nursing staff do not have access to the care plan to update. The LPN stated the MDS nurse updates the care plan. An interview was conducted on March 11, 2026, at 3:45 PM with Certified Nursing Assistant (CNA, Staff #178). She stated if a resident to resident altercation occurs she will intervene and stop the conflict, ensure the safety of both residents, assess for injuries, obtain vitals, report the incident and keep the residents separated. She stated communication regarding resident to resident altercations are communicated to staff through means of report and documentation in the clinical record. She stated staff receive training for abuse quarterly which is usually completed via computer course or an in-service, however the facility does not have a designated staff member to conduct continued education. She stated she is confident the residents are safe with the training staff receive. Regarding Resident #8 on Resident #10: Resident #10 was readmitted to the facility on [DATE], with diagnoses of parkinsonism and Alzheimer's Disease. The care plan initiated on December 13, 2025, revealed the resident had a psychosocial well-being problem related to a resident to resident altercation. Interventions included 72-hour observation, consultation with pastoral care, social services, and psychiatric services, and allow the resident to vent/share feelings. The comprehensive MDS dated [DATE], revealed the resident had a BIMS score of 07, indicating severe cognitive impairment. An Alert Nursing Note dated February 12, 2026, revealed the resident was moved away from his roommate (#8) because resident #10 stated he hit me. A skin assessment revealed Resident #10 had a purple/blue bruise under his left eye. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #8 was admitted on [DATE], with diagnoses of parkinsonism, major depressive disorder, psychotic disorder, and anxiety disorder. The care plan initiated on November 13, 2025, revealed the resident had behaviors of putting himself on the floor trying to hide from people, including hiding in the closet or under his bed, refusing care and telling his family no one is offering him anything. Interventions included administering medications, providing positive interaction, explaining why behavior is inappropriate, intervening to protect the rights and safety of others, divert attention, and removing the resident from the situation. A Behavior Inter-Disciplinary Team (IDT) Review Care Plan dated February 13, 2026 included when Resident #8 showed signs of agitation, anxiety, or restlessness, approach should be completed in a calm and soothing manner, guidance to a quiet safe space, encourage slow deep breathing or offer a calming activity. The comprehensive MDS dated [DATE], revealed the resident had a BIMS score of 03, indicating severe cognitive impairment. An IDT note dated February 13, 2026, revealed Resident #8 accused Resident #10 of stealing millions of dollars from him and punched Resident #10 in the eye. The facility investigation report received on February 17, 2026, completed by the Administrator, stated a comprehensive investigation was completed using resident interviews and staff interviews and was found that the incident did not happen, however after further review it was determined to be an accident. An interview was conducted on March 12, 2026, at 11:30 AM with LPN (staff #58). She stated Resident #8 has many behaviors and delusions/hallucinations, however, the resident was easily redirected. She stated when the resident becomes agitated escalation occurs quickly. A behavior often exhibited was accusing someone of stealing his four million dollars. An interview with DON (Staff # 167) on March 12, 2026 at 12:51 p.m., revealed that the facility is a behavioral facility and you never know what the behaviors will be or when they manifest. The DON revealed that when she started working here 5 weeks ago there were a lot of resident to resident altercations and when a resident hits another resident that is abuse which is required to be reported. The DON identified one area that staff needed to work on was identifying when residents get into the personal space of other residents and be proactive before the abuse happens. An interview was conducted on March 12, 2026, at 2:55 PM with CNA (Staff #209). He stated staff frequently attempted to keep Resident #8 busy in the dayroom with activities. The CNA said when the Resident becomes agitated he will start to curse and sometimes just sitting with him 1:1 can deescalate him. An interview was conducted on March 12, 2026, at 3:41 PM with CNA (Staff #57). She stated on February 12, 2026, between 3:00 and 4:00 PM, she was in the dayroom when she heard Resident #10 yell help. She saw Resident #8 standing over Resident #10, who was in bed, with his feet up toward Resident #8. The CNA stated she assisted Resident #8 back to bed and asked Resident #10 what happened. Resident #10 stated Resident #8 accused him of stealing four million dollars and then hit him in the eye. The CNA stated she saw purple and blue discoloration under his left eye. The CNA stated she reported the incident to the nurse and then removed Resident #8 from the room. She then (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	got vitals on Resident #10. The CNA stated Resident #10 becomes agitated and escalates quickly. One of his behaviors included accusing residents of stealing his four million dollars. She stated this is the first time she had observed Resident #8 hitting another resident. She said Resident #8's current behavior was stealing food and drinking his roommate's beverages. Staff will intervene and redirect often. Regarding Resident #13 on Resident #16: Resident #16 was admitted on [DATE], with diagnoses of bipolar, anxiety disorder, major depressive disorder, and post-traumatic stress disorder (PTSD). The comprehensive MDS dated [DATE], revealed the resident had a BIMS score of 04 indicating severe cognitive impairment. A nursing note dated March 7, 2026, documented the resident's right wrist was grabbed and squeezed hard by another resident. The care plan dated March 8, 2026, revealed the resident had a psychosocial well-being problem related to a resident to resident altercation. Interventions included 72-hour observation, consultation with pastoral care, social services, and psychiatric services, monitor and document resident's response to problems, and when conflict arises, remove resident to calm, safe environment and allow them to vent/share feelings. Resident #13 was admitted on [DATE], with diagnoses of dementia, and major depressive disorder. The care plan initiated on October 28, 2025, revealed the resident had potential to be physically aggressive related to dementia. Interventions included 1:1 as indicated, administer medications as ordered, assess and address contributing sensory deficits, and monitoring, documenting, and reporting signs or symptoms of the resident posing a danger to himself or others. The quarterly MDS dated [DATE], revealed a BIMS score of 06, indicating severe cognitive impairment. The nurse's note dated March 7, 2026, revealed the resident grabbed another resident and they were both separated and removed from the situation. An interview was conducted on March 12, 2026, at 3:18 PM with Registered Nurse (RN, Staff #103). She stated Resident #16 was drawn to automatic doors. He appeared to be fascinated by them and was usually standing close to them which required redirection. The RN stated Resident #13's behavior is trying to be helpful. If he saw another resident trying to do something they should not be doing he intervened. She stated that is why Resident #13 grabbed Resident #16's wrist to try to pull him away from the automatic doors. She stated she receives in-services and computer-based classes for abuse training. She said the residents are safe due to the extensive abuse training received. Regarding Resident # 1 and Resident # 3: Resident # 3 was admitted on [DATE], with diagnoses that included senile degeneration of brain, alcohol cirrhosis, anxiety disorder, major depressive disorder, and unspecified dementia. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Resident's care plan initiated on June 6, 2025, revealed that the Resident is a fall risk with multiple falls due to gat balance problems. Further review of the care plan revealed an intervention that included anticipating and meet the resident's needs. The Resident's care plan initiated on June 6. 2025, revealed that Resident #3 has the potential to be verbally aggressive due to dementia and poor impulse control. The Interventions included analyzing key times, places and circumstances, triggers, and what de-escalates behavior and document. Further review of interventions revealed that when Resident #3 becomes agitated, intervene before agitation escalates and Guide away from source of distress. A Change of Condition Minimum Data Set (MDS) assessment dated [DATE], revealed a BIMS score of 6 indicating severe cognitive impairment. Further review of the MDS revealed that the Resident was taking Antipsychotic, Antidepressant medications. A nurses note dated February 7, 2026, revealed that Resident # 3 had punched a CNA while providing care. The nurses note also revealed that the Resident had been physically abusive and growling and making threatening faces and putting his hands up to fight anyone who would walk by him regardless if it was a patient or another resident. An incident note dated February 11, 2026, revealed that Licensed Practical Nurse (LPN/Staff # 182), witnessed Resident # 1 kicking Resident # 3, three times on the left thigh before Staff # 182 could reach Resident # 3 and redirect both residents. A care plan initiated February, 11, 2026, revealed that Resident # 3 had a psychosocial well-being problem related to a resident to resident altercation. Interventions included monitor and document resident's unusual response to problems and 72-hour observations. An Interdisciplinary Team (IDT) meeting note dated February 12, 2026, revealed that Resident #3 was kicked by Resident # 1, The IDT note also revealed that both residents were separated, placed on 15 minute checks for 72 hours. IDT interventions included monitoring and documenting resident's unusual response to problems and if conflict arises remove residents to a calm safe environment. Resident # 1 was admitted on [DATE], with diagnoses schizoaffective disorder, bipolar type, unspecified dementia with agitation, and other psychoactive substance abuse. A resolved care plan focus initiated on August 8, 2024 revealed that Resident # 1 was at risk for psychosocial emotional distress related to a resident-to-resident altercation. Interventions included monitoring for psychosocial emotional distress for 72 hours. Further review of the care plan revealed that this focus was resolved on January 31, 2025 and removed from the active care plan. A behavior note dated August 8, 2024 revealed that Resident # 1 was observed assaulting another resident after being told to shut up by the resident. The behavioral note also revealed that while the nurse was trying to break up the fight Resident #1 turned his anger on the nurse, threatening to hit the nurse. A care plan initiated on October 27, 2025 revealed problems related to dementia, schizoaffective bipolar disorder exhibiting verbal aggression, being demanding and psychotic thinking. Interventions include attempt to determine cause if aggression and promptly address needs. Further review of the active care plan revealed no history of physical aggression. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An annual MDS assessment dated [DATE] revealed a BIMS score of 6, indicating severe cognitive impairment. Further review of MDS assessment revealed no behaviors indicated. An incident note dated February 11, 2026, revealed that Licensed Practical Nurse (LPN/Staff # 182), witnessed Resident # 1 kicking Resident # 3, three times on the left thigh before Staff # 182 could reach Resident # 3 and redirect both residents. A care plan initiated February, 11, 2026, revealed that Resident # 1 had a psychosocial well-being problem related to a resident to resident altercation. Interventions included monitor and document resident's unusual response to problems and 72-hour observations. A Social Services note dated February 13, 2026, revealed that a care plan meeting was held on February 11, 2026 revealed that the resident to resident was discussed including interventions of a room change and follow up with psychiatry services. The facility investigation report received February 13, 2026, revealed that Resident # 1 made contact with Resident # 3 during an altercation. The facility report also revealed that staff reacted after the incident started but did not indicate what preemptive interventions were utilized despite the history of physical behaviors for both residents. An Interview with LPN (Staff # 182) on March 11, 2026, at 2:59 p.m., revealed that while she was working on the computer at the nurses' station she looked up and saw Resident # 1 kick Resident # 3 several times in the thigh. Staff # 182 also revealed that other aides arrived and they separated the residents to other sides of the building. Staff # 182 revealed that is was her first day on that floor and stated the advice she was given about Resident # 1's behaviors was not to get on his bad side. An interview with Certified Nursing Assistant (CNA/Staff # 79) on March 12, 2026 at 2:11 p.m., revealed that Resident # 3 was walking by Resident # 1 and witnessed Resident # 1 kick Resident # 3. Staff # 79 also revealed that Resident # 1 gets upset when he does not get his cigarettes or a Coke when he wants one. Staff # 79 stated he will get verbally abusive and physically lash out when he gets frustrated. Staff # 79 also stated that he has seen Resident # 1 get frustrated when residents or staff walk Infront of the television. He revealed that Resident # 3 had been wandering a lot and probably got Infront of the television causing Resident # 1 to kick him. An interview with Director of Nursing (DON/Staff # 167) on March 12, 2026 at 12:51 p.m., revealed that the facility is a behavioral facility and behaviors are unpredictable. The DON revealed that when she started working at the facility 5 weeks ago there were a lot of resident-to-resident altercations and when a resident hits another resident that is abuse which is required to be reported. Regarding Resident # 5 and Resident # 7: Resident # 7 was admitted on [DATE], with diagnoses that included post traumatic stress disorder, major depressive disorder, and mood affective disorder. A care plan focus initiated on July 22, 2025, revealed that Resident # 7 had impaired cognitive function or impaired thought process related to Alzheimer's disease. Interventions included cueing, reorienting, and supervising as needed. Further review of the active care plan did not reveal any concern of physical aggression. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An Incident Note on August 3, 2025, revealed that Resident # 7 was involved in a resident-to-resident altercation and hit another resident in the face. An Incident Note on December 24, 2025, revealed that Resident # 7 was involved in a resident-to-resident altercation with physical aggression. Resident # 7 was observed leaning over other resident hitting him repeatedly. A nurses note dated February 14, 2026, revealed that at 7:20 p.m. CNA (Staff # 178) who was assigned to Resident # 7 reported to the nurse that Resident # 7 had a personal altercation outside. When Resident # 7 came into the dining room he had a witnessed fall. An incident note dated February 14, 2026, revealed that Resident # 5 hit Resident # 7 in the stomach while the other resident was wandering in the dining room. Regarding Resident # 5 Resident # 5, the perpetrator, was admitted on [DATE], with diagnoses that included vascular dementia, cognitive communication deficit, anxiety disorder, and violent behavior. A care plan focus initiated on October 13, 2025, revealed that Resident # 5 displayed behaviors at prior placement, of refusal of medications and activities. The care plan also revealed that Resident # 5 urinated in inappropriate places and exhibited intrusive wandering. Interventions included intervening as necessary to protect the rights and safety of others and approach or speak in a calm manner. A Behavior Note dated December 20, 2025, revealed Resident # 5 started arguing with another resident and they started swinging at each other. A Behavioral Care Plan dated January 10, 2026, revealed Resident # 5's current behaviors are anxiety and screaming/agitation with a known trigger of feeling anxious. Further review of the behavioral care plan revealed no past behaviors of physical aggression even though Resident # 5 was involved in a resident-to-resident altercation 20 days prior. A nurses note dated February 14, 2026, revealed that CNA (Staff # 178) reported that Resident # 5 was involved in a resident-to-resident altercation punching Resident # 7 in the stomach. A facility investigation received February 19, 2026, revealed that the facility determined the incident had occurred. An interview conducted with CNA (Staff # 178) on March 11, 2026 at 3:29 p.m., revealed that Resident # 5 was very agitated that day and he was ranting about something he saw outside. Staff # 178 stated that Resident # 7 inserted himself into the conversation and wanted to help. Resident # 7 started helping Staff # 178 push Resident # 5's wheelchair. Staff # 178 revealed that Resident # 5 does not like anyone touching him including staff and when Resident # 5 realized Resident # 7 had placed his hands on Resident # 5's wheelchair, Resident # 5 stood up and punched Resident # 7 in the stomach. An interview conducted on March 12, 2026 at 2:22 p.m. with Registered Nurse (RN/Staff # 160) revealed that Resident #5's biggest trigger for agitation is taking a shower and being touched. Staff # 160 revealed that they usually leave him alone and try to approach him again. Staff # 160 revealed (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that from time to time Resident # 7 likes to help and push other residents around in a wheelchair even though there are residents that do not like being touched or other residents in their space. An interview with DON (Staff # 167) on March 12, 2026 at 12:51 p.m., revealed that the facility is a behavioral facility and you never know what the behaviors will be or when they will manifest. The DON revealed that when she started working here 5 weeks ago there were a lot of resident-to-resident altercations and when a resident hits another resident that is abuse which is required to be reported. The DON identified one area that staff needed to work on was identifying when residents get into the personal space of other residents and be proactive before the abuse happens. Regarding Resident # 9 and Resident # 2: Resident # 2 was admitted on [DATE], with diagnoses that included cerebrovascular disease, and anxiety disorder. An admission MDS dated [DATE], revealed a BIMS score of 8, indicating moderate cognitive impairment. A nurses note dated February 19, 2026, revealed Resident # 2 was sitting in the day room and told staff that he was hit in the head by his roommate Resident # 9. The nurses revealed that Resident # 9 hit Resident # 2 on left side of the head because Resident # 9 wanted Resident # 2's blanket. Resident # 9 took Resident # 2's blanket and Resident # 9 went back to bed. A social services note dated February 19, 2026 revealed that Resident # 2 was moved to a different room. Resident # 9 was admitted on [DATE], with diagnoses that included Alzheimer's disease, dementia with agitation, personality change, major depressive disorder, and anxiety disorder. A behavior note dated July 15, 2024, revealed that Resident #9 was stealing other resident's food off the counter and becoming combative during redirection back to room after finishing breakfast. A behavior note dated July 23, 2024, revealed that Resident # 9 was taking other residents food after finishing his. A behavior note dated November 23, 2024, revealed that during lunch Resident # 9 reached over and took another resident's cake. A behavioral treatment plan dated December 19, 2025, revealed Resident # 9's current behaviors are sexually inappropriate and isolative behavior with known triggers of female staff assisting in cares. Further review of the behavioral treatment plan revealed past behaviors including elopement and exposing himself. There was no indication that Resident # 9 had a history of taking other Resident's food. A care plan focus initiated on December 24, 2025, revealed that Resident # 9 had a behavior problem related to sexual inappropriateness, history of delusions, elopement risk, and self-isolation. Further review of the care plan revealed interventions which included cares in pairs, and following a behavior plan. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A quarterly MDS assessment dated [DATE], revealed a BIMS score of 7, indicating severe cognitive impairment. The MDS assessment also revealed that Resident # 9 also experienced other behaviors for 1 to 3 days which include sexual acts. A nurses note dated February 19, 2026, revealed Resident # 9's roommate, Resident # 2, claimed he was struck by Resident # 9 on the side of the head and Resident # 9 took Resident # 2's blanket. The nurses note revealed that Resident # 9 admitted to hitting Resident # 2 in the head because he wanted Resident # 2's blanket. A facility investigation report received, February 24, 2026, revealed that the facility confirmed the incident happened based on resident interviews and review of the recorded incident which indicated that the incident occurred. During an interview with Resident # 2 on March 11, 2026 at 10:34 a.m., Resident # 2 said that he did not like his roommate, calling him an ass. Resident # 2 stated that Resident # 9 hit him in the head. Resident # 2 took his hat off and pointed to the left side of his head. Resident # 2 revealed that his room was moved away from him but wanted to leave the facility. An observation with Resident # 9 on March 11, 2026 at 10:46 p.m. revealed the resident lying in his bed with a blanket wrapped around him covering his head. Resident # 9 did not speak; his response was to nod his head. A review of the room revealed no other resident currently occupying the other bed. An interview with CNA (Staff # 79) on March 12, 2026 at 2:11 p.m. revealed that he had never known Resident # 9 to be physically aggressive or to take belongings from other residents. Staff # 79 revealed that Resident # 9 can be handsy with female staff and that's one of the reasons why he primarily works on that unit. Staff # 79 revealed that he did not see the incident with Resident # 2 but heard from Resident # 2 that Resident # 9 hit Resident # 2 and took his blanket because Resident # 9 was cold. An interview with RN (Staff # 103) on March 12, 2026 at 3:18 p.m., revealed that one of Resident # 9's behaviors was to be sexually inappropriate. The RN stated that care staff always does cares in pairs. Staff # 103 said that Resident # 9 grabs female staff and is inappropriate with them. Staff # 103 further stated that Resident # 9 was not known as physical and can be redirectable. An interview with CNA (Staff # 107) on March 13, 2026 at 10:12 a.m., revealed that Resident # 9 is an easy-going guy who likes to stay in his bedroom. Staff # 107 revealed that if Resident # 9 wants something he is going to try and take it. Staff # 107 stated that they try to redirect him before he takes something that does not belong to him. Staff #107 said most residents in their rooms are checked on hourly unless they are on 15 min checks. An interview with Director of Nursing (DON/Staff # 167) on March 12, 2026 at 12:51 p.m., revealed that the facility is a behavioral facility and you never know what the behaviors will be or when they will manifest. The DON stated that when she started working here 5 weeks ago there were a lot of resident-to-resident altercations and when a resident hits another resident that is abuse which is required to be reported. An interview with Administrator (Staff # 60) on March 13, 2026 at 11:34 a.m., revealed that he conducted the investigation and determined that it was a cold night and Resident # 9 was cold and (continued on next page)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	decided he wanted Resident # 2's blanket. Staff # 60 stated that it was determined that the incident occurred because Resident # 2 was consistent in his recollection of the incident and his BIMs score was high enough to believe him. A policy and procedure titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, Revised April 2021, revealed that residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. The policy also revealed that it includes physical abuse.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, clinical record and policy review, the facility failed to update comprehensive care plans related to individualized resident triggers so residents may attain the highest practical physical, mental, and psychosocial well-being for twelve of twelve residents sampled (#1, #3, #5, #7, #9, #2, #4, #6, #8, #10, #13, and #16) to be free from abuse from each other. The deficient practice could result in a plan of care that did not meet the resident's needs and lead to continued resident to resident abuse. Findings include: Regarding Resident #6 and resident #4: Resident #6, the victim, was admitted on [DATE], with diagnosis of dementia, mood disorder, anxiety disorder, and psychotic disorder. The care plan initiated on October 8, 2025, revealed the resident had behaviors of yelling, wandering, delusional thinking, and a history of making false allegations against residents and staff. Interventions included redirection, administering medications, and assistance developing appropriate methods of coping and interacting. The quarterly Minimum Data Set (MDS) dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) of 04, indicating severe cognitive impairment. The Behavior Charting dated February 20, 2026, indicated the resident was yelling, screaming, cursing, and had an abrasive tone. Staff knowledge of behaviors and interventions are not reflected in the resident care plan. A nurse's note dated February 20, 2026, revealed that Resident #6 approached the nurse's station crying and reported she was hit by Resident #4 in the nose. The note stated the residents were placed on 15-minute safety checks and closely monitored. Resident #4, the perpetrator, was admitted on [DATE], with diagnoses that included personality disorder, anxiety disorder, adjustment disorder, and depression. The care plan initiated on August 12, 2025, revealed the resident had behaviors consisting of placing herself on the floor, refusing care and medications, making false accusations, fabricating stories, and going into other resident's rooms and breaking their personal items. Interventions included allowing the resident time, encouragement to verbalize concerns, administering medications, education, explanation of why behavior is inappropriate, and checking for safety and comfort. The quarterly MDS dated [DATE], revealed the resident had a BIMS score of 13, indicating the resident was cognitively intact. A nurses note dated February 20, 2026, revealed the resident stated she was tired of resident #6 opening her door. The facility incident report received on March 12, 2026, revealed that Resident #6 entered into (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #4's room un-invited and Resident #4 punched Resident #6 in the nose. The facility report also revealed that staff separated the residents and Resident #6 was redirected out of Resident #4's room and placed on 15-minute supervisory checks. An interview was conducted on March 11. 2026, at 3:18 PM with Licensed Practical Nurse (LPN, Staff #182). She stated Resident #4 likes to stay in her room or sit just outside her door so she can enjoy the sunshine. The resident does not like anyone getting too close to her and prefers to be left alone. Resident #6 enjoys walking around and has a behavior of going into other resident rooms. She stated on February 19, 2026, Resident #6 was very agitated, pacing, cursing, and argumentative and Resident #4 was sitting outside of her room. The LPN said both residents appeared to be irritated with each other. Resident #6 began crying and yelling that Resident #4 hit her in the face. She stated both residents were separated and there have not been any more incidents. She stated the staff have implemented having an aide sit in the common area with the residents, where they can observe everyone and deescalate any situations quickly. Staff #182 stated all behaviors should be documented in the care plan; however, the nursing staff do not have access to the care plan to update. The LPN stated the MDS nurse updates the care plan. Staff knowledge of behaviors and interventions are not reflected in the resident care plan. Regarding Resident #10 and resident #8: Resident #10, the victim, was readmitted on [DATE], with diagnosis of parkinsonism and Alzheimer's Disease. The care plan initiated on December 13, 2025, revealed the resident had a psychosocial well-being problem related to a resident to resident altercation. Interventions included 72-hour observation, consultation with pastoral care, social services, and psychiatric services, and allow the resident to vent/share feelings. The comprehensive MDS dated [DATE], revealed the resident had a BIMS score of 07, indicating severe cognitive impairment. An Alert Nursing Note dated February 12, 2026, revealed the resident was moved away from his roommate (#8) because he stated he hit me. A skin assessment revealed Resident #10 had a purple/blue bruise under his left eye. There is no updated care plan. Resident #8, the perpetrator, was admitted on [DATE], with diagnosis of parkinsonism, major depressive disorder, psychotic disorder, and anxiety disorder. The care plan initiated on November 13, 2025, revealed the resident had behaviors of putting himself on the floor trying to hide from people, including hiding in the closet or under his bed, refusing care and telling his family no one is offering him anything. Interventions included administering medications, providing positive interaction, explaining why behavior is inappropriate, intervening to protect the rights and safety of others, divert attention, and removing the resident from the situation. A Behavior Inter-Disciplinary Team (IDT) Review Care Plan dated February 13, 2026 included when Resident #8 showed signs of agitation, anxiety, or restlessness, approach should be completed in a calm and soothing manner, guidance to a quiet safe space, encourage slow deep breathing or offer a calming activity. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The comprehensive MDS dated [DATE], revealed the resident had a BIMS score of 03, indicating severe cognitive impairment. An IDT note dated February 13, 2026, revealed Resident #8 accused Resident #10 of stealing millions of dollars from him and punched Resident #10 in the eye. The facility investigation report received on February 17, 2026, completed by the Administrator, stated a comprehensive investigation was completed using resident interviews and staff interviews and was found that the incident did not happen, however after further review was determined to be an accident. An interview was conducted on March 12, 2026, at 11:30 AM with LPN (staff #58). She stated Resident #8 has many behaviors and delusions/hallucinations, however, the resident was easily redirected. She stated when the resident becomes agitated escalation occurs quickly. A behavior often exhibited was accusing someone of stealing his four million dollars. The LPN stated twice a month abuse training is conducted by the Director of Nursing (DON), the Administrator, and one of the Unit Managers. She said completed computer-based courses on abuse and protocols for abuse are posted at the nurse's station. An interview with DON (Staff # 167) on March 12, 2026 at 12:51 p.m., revealed that the facility is a behavioral facility and you never know what the behaviors will be or when they manifest. The DON revealed that when she started working here 5 weeks ago there were a lot of resident to resident altercations and when a resident hits another resident that is abuse which is required to be reported. The DON identified one area that staff needed to work on was identifying when residents get into the personal space of other residents and be proactive before the abuse happens. An interview was conducted on March 12, 2026, at 2:55 PM with CNA (Staff #209). He stated staff frequently attempted to keep Resident #8 busy in the dayroom with activities. The CNA said when the Resident becomes agitated he will start to curse and sometimes just sitting with him 1:1 can deescalate him. An interview was conducted on March 12, 2026, at 3:41 PM with CNA (Staff #57). She stated on February 12, 2026, between 3:00 and 4:00 PM, she was in the dayroom when she heard Resident #10 yell help. She saw Resident #8 standing over Resident #10, who was in bed, with his feet up toward Resident #8. The CNA stated she assisted Resident #8 back to bed and asked Resident #10 what happened. Resident #10 stated Resident #8 accused him of stealing four million dollars and then hit him in the eye. The CNA stated she saw purple and blue discoloration under his left eye. The CNA stated she reported the incident to the nurse and then removed Resident #8 from the room. She then got vitals on Resident #10. The CNA stated Resident #10 becomes agitated and escalates quickly. One of his behaviors included accusing residents of stealing his four million dollars. She stated this is the first time she had observed Resident #8 hitting another resident. She said Resident #8's current behavior was stealing food and drinking his roommate's beverages. Staff will intervene and redirect often. Staff knowledge of behaviors and interventions are not reflected in the resident care plan. Regarding Resident #16 and resident #13: Resident #16, the victim, was admitted on [DATE], with diagnoses of bipolar, anxiety disorder, major depressive disorder, and post-traumatic stress disorder (PTSD). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the comprehensive MDS dated [DATE], revealed the resident had a BIMS score of 04 indicating severe cognitive impairment. Review of a nursing note dated March 7, 2026, documented the resident's right wrist was grabbed and squeezed hard by another resident. Review of the care plan dated March 8, 2026, revealed the resident had a psychosocial well-being problem related to a resident to resident altercation. Interventions included 72-hour observation, consultation with pastoral care, social services, and psychiatric services, monitor and document resident's response to problems, and when conflict arises, remove resident to calm, safe environment and allow them to vent/share feelings. Resident #13, the perpetrator, was admitted on [DATE], with diagnosis of dementia, and major depressive disorder. Review of the care plan initiated on October 28, 2025, revealed the resident had potential to be physically aggressive related to dementia. Interventions included 1:1 as indicated, administer medications as ordered, assess and address contributing sensory deficits, and monitoring, documenting, and reporting signs or symptoms of the resident posing a danger to himself or others. Review of the quarterly MDS dated [DATE]. 2026, revealed a BIMS score of 06, indicating severe cognitive impairment. Review of nurse's note dated March 7, 2026, revealed the resident grabbed another resident and they were both separated and removed from the situation. An interview was conducted on March 12, 2026, at 3:18 PM with Registered Nurse (RN, Staff #103). She stated Resident #16 was drawn to automatic doors. He appeared to be fascinated by them and was usually standing close to them which required redirection. The RN stated Resident #13's behavior is trying to be helpful. If he saw another resident trying to do something they should not be doing he intervened. She stated that is why Resident #13 grabbed Resident #16's wrist to try to pull him away from the automatic doors. She stated she receives in-services and computer-based classes for abuse training. She said the residents are safe due to the extensive abuse training received. Staff knowledge of behaviors and interventions are not reflected in the resident care plan. Regarding Resident #3 and resident #1: Resident # 3, the alleged victim, was admitted on [DATE], with diagnoses that included senile degeneration of brain, alcohol cirrhosis, anxiety disorder, major depressive disorder, and unspecified dementia. A nurses note dated February 7, 2026, revealed that Resident # 3 had punched a CNA while providing care. The nurses note also revealed that the Resident had been physically abusive and growling and making threatening faces and putting his hands up to fight anyone who would walk by him regardless if it was a patient or another resident. An incident note dated February 11, 2026, revealed that Licensed Practical Nurse (LPN/Staff # 182), witnessed Resident # 1 kicking Resident # 3, three times on the left thigh before Staff # 182 could reach Resident # 3 and redirect both residents. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A care plan focus initiated February, 11, 2026, revealed that Resident # 7 had a psychosocial well-being problem related to a resident to resident altercation. Interventions included 72 hour observations, consultation with pastoral care, social services, and psych services, monitor and document resident's unusual response to problems and when conflict arises, remove residents to calm safe environment. Resident # 1, the alleged perpetrator, was admitted on [DATE], with diagnoses schizoaffective disorder, bipolar type, unspecified dementia with agitation, and other psychoactive substance. A resolved care plan focus initiated on August 8, 2024 revealed that Resident # 1 was at risk for psychosocial emotional distress related to a resident-to-resident altercation. Interventions included monitoring for psychosocial emotional distress for 72 hours. Further review of the care plan revealed that this focus was resolved on January 31, 2025 and removed from the active care plan. A behavior note dated August 8, 2024 revealed that Resident # 1 was observed assaulting another resident after being told to shut up by that resident. The behavioral note also revealed that while the nurse was trying to break up the fight Resident #1 turned his anger on the nurse, threatening to hit the nurse. A care plan initiated on October 27, 2025 revealed problems related to dementia, schizoaffective bipolar disorder exhibiting verbal aggression, being demanding and psychotic thinking. Interventions include attempt to determine cause if aggression and promptly address needs. Further review of the active care plan revealed no history of physical aggression. An annual MDS assessment dated [DATE] revealed a BIMS score of 6, indicating severe cognitive impairment. Further review of MDS assessment revealed no behaviors indicated. An incident note dated February 11, 2026, revealed that Licensed Practical Nurse (LPN/Staff # 182), witnessed Resident # 1 kicking Resident # 3, three times on the left thigh before Staff # 182 could reach Resident # 3 and redirect both residents. A care plan focus initiated February, 11, 2026, revealed that Resident # 1 had a psychosocial well-being problem related to a resident to resident altercation. Interventions included 72-hour observations, consultation with pastoral care, social services, and psych services, monitor and document resident's unusual response to problems and when conflict arises, remove residents to calm safe environment. It was noted that Resident # 1's care plan focus was identical to Resident # 3's care plan focus and interventions. Regarding Resident #7 and resident #5: Resident # 7, the alleged victim, was admitted on [DATE], with diagnoses that included post traumatic stress disorder, major depressive disorder, and mood affective disorder. A care plan focus initiated on July 22, 2025, revealed that Resident # 7 had impaired cognitive function or impaired thought process related to Alzheimer's disease. Interventions include cueing, and reorienting and supervising as needed. Further review of the active care plan did not reveal any concern of physical aggression. Review of Incident Note on August 3, 2025, revealed that Resident # 7 was involved in a (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident-to-resident altercation and hit another resident in the face. Review of Incident Note on December 24, 2025, revealed that Resident # 7 was involved in a resident-to-resident altercation with physical aggression. Resident # 7 was observed leaning over the other resident hitting him repeatedly. A nurses note dated February 14, 2026, revealed that at 7:20 p.m. CNA (Staff # 178) was assigned to Resident # 7 had reported to the nurse that Resident # 7 had a personal altercation outside. When Resident # 7 came into the dining room he had a witnessed fall. An incident note dated February 14, 2026, revealed that Resident # 5 hit Resident # 7 in the stomach while the other resident was wandering in the dining room. A care plan focus initiated February, 16, 2026, revealed that Resident # 7 had a psychosocial well-being problem related to a resident to resident altercation. Interventions included 72-hour observations, consultation with pastoral care, social services, and psych services, monitor and document resident's unusual response to problems and when conflict arises, remove residents to calm safe environment. Resident # 5, the alleged perpetrator, was admitted on [DATE], with diagnoses that included vascular dementia, cognitive communication deficit, anxiety disorder, and violent behavior. A Behavior Note dated December 20, 2025, revealed Resident # 5 started arguing with another resident and started swinging at each other. Review of a Behavioral Care Plan dated January 10, 2026, revealed Resident # 5's current behaviors are anxiety and screaming/agitation with a known trigger of feeling anxious. Further review of the behavioral care plan reveals past behaviors of physical aggression even though Resident # 5 was involved in a resident-to-resident altercation 20 days prior. A nurses note dated February 14, 2026, revealed that CNA (Staff # 178) reported that Resident # 5 was involved in a resident-to-resident altercation punching Resident # 7 in the stomach. A care plan focus initiated February, 16, 2026, revealed that Resident # 5 had a psychosocial well-being problem related to a resident to resident altercation. Interventions included 72-hour observations, consult with pastoral care, social services, and psych services, monitor and document resident's unusual response to problems and when conflict arises, remove residents to calm safe environment. Regarding Resident #2 and resident #9: Resident # 2, the victim, was admitted on [DATE], with diagnosis that included cerebrovascular disease, and anxiety disorder. A nurses note dated February 19, 2026, revealed Resident # 2 was sitting in the day room and told staff that he was hit in the head by his roommate Resident # 9. The nurses revealed that Resident # 9 hit Resident # 2 on left side of the head because Resident # 9 wanted Resident # 2's blanket. Resident # 9 took Resident # 2's blanket and Resident # 9 went back to bed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A care plan focus initiated February, 19, 2026, revealed that Resident # 2 had a psychosocial well-being problem related to a resident to resident altercation. Interventions included 72-hour observations, consultation with pastoral care, social services, and psych services, monitor and document resident's unusual response to problems and when conflict arises, remove residents to calm safe environment. Resident # 9, the alleged perpetrator, was admitted on [DATE], with diagnoses that included Alzheimer's disease, dementia with agitation, personality change, major depressive disorder, and anxiety disorder. A behavior note dated July 15, 2024, revealed that Resident #9 was stealing other residents' food off the counter and becoming combative during redirection back to room after finishing breakfast. A behavior note dated July 23, 2024, revealed that Resident # 9 was taking other residents food after finishing his. A behavior note dated November 23, 2024, revealed that during lunch Resident # 9 reached over and took another resident's cake. A behavioral treatment plan dated December 19, 2025, revealed Resident # 9's current behaviors are sexually inappropriate and isolative behavior with known triggers of female staff assisting in cares. Further review of the behavioral treatment plan revealed past behaviors including elopement and exposing himself. There was no indication that Resident # 9 had a history of taking other Resident's food. A nurses note dated February 19, 2026, revealed Resident # 9's roommate, Resident # 2 claimed he was struck by Resident # 9 on the side of the head and took Resident # 2's blanket. The nurses note revealed that Resident # 9 admitted to hitting Resident # 2 in the head because he wanted his blanket. A care plan focus initiated February, 19, 2026, revealed that Resident # 2 had a psychosocial well-being problem related to a resident to resident altercation. Interventions included 72-hour observations, consultation with pastoral care, social services, and psych services, and remove residents to calm safe environment. Further review of the affected residents' care plans revealed that all residents involved in a resident-to-resident altercation received the same care plan focus and the same interventions no matter if they were the victim or the perpetrator. Further review of the care plans revealed that previous history of resident-to-resident aggression was not on the active care plan. An interview was conducted with LPN (Staff # 182) on March 11, 2026 at 2:59 p.m. She revealed that most of her information on residents' behaviors was received during shift change or during shift reports. Staff # 182 revealed that she does not have access or does not know how to access the care plan and cannot make changes to the care plan. An interview was conducted with CNA (Staff # 178) on March 11, 2026 at 3:29 p.m. who revealed that if there is a resident-to-resident altercation she would communicate to her nurse and document in the charting system. Staff # 178 stated that she cannot update care plans as she does not have access to care plans but the nurses have access to the care plans. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with Corporate Resource RN (Staff # 220) on March 12, 2026 at 1:27 p.m. revealed that after a resident-to-resident altercation they separate the residents and provide redirection. If the residents involved are roommates, we separate the two parties typically moving the aggressor to a single room. Staff # 220 also revealed the MDS nurse is responsible for updating the care plan when there is a resident-to-resident altercation. An interview was conducted with MDS LPN (Staff # 165) on March 13, 2026 at 8:52 a.m. who revealed that he is responsible for updating the care plans after a resident-to-resident altercation once he is made aware of the incident. Staff #165 revealed that all residents involved in resident-to-resident altercations get the same interventions including 72-hour observation, consulting with social services and removing the resident. He said the care plans are vague and are general and not specific to the resident. Staff # 165 also revealed that if someone needed more information regarding the resident-to-resident altercation they can get it from Risk Management, however Staff # 165 revealed not everyone has access to Risk Management. Another interview was conducted with Corporate Resource (Staff # 220) on March 13, 2026 at 12:37 p.m. revealed that it is her expectation that resident care plans are customized to the resident and anyone in the building can update the care plan to get an accurate account of the resident. A Policy titled, Care Plans, Comprehensive Person-Centered, revised March 2022, revealed that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The policy also revealed that care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant decision making. When possible, interventions address the underlying sources of the problem areas, not just symptoms or triggers.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, clinical record and policy review, the facility failed to update behavioral health care plans related to individualized resident triggers so residents may attain the highest practical physical, mental, and psychosocial well-being for two residents (#8 and #9). The deficient practice could result in a plan of care that did not meet the resident's needs. Findings include: Resident #8, the perpetrator, was admitted on [DATE], with diagnosis of parkinsonism, major depressive disorder, psychotic disorder, and anxiety disorder. Review of the care plan initiated on November 13, 2025, revealed the resident had behaviors of putting himself on the floor trying to hide from people, including hiding in the closet or under his bed, refusing care and telling his family no one is offering him anything. Interventions included administering medications, providing positive interaction, explaining why behavior is inappropriate, intervening to protect the rights and safety of others, divert attention, and removing the resident from the situation. A Behavior Inter-Disciplinary Team (IDT) Review Care Plan dated February 13, 2026 included when Resident #8 showed signs of agitation, anxiety, or restlessness, approach should be completed in a calm and soothing manner, guidance to a quiet safe space, encourage slow deep breathing or offer a calming activity. Review of the comprehensive MDS dated [DATE], revealed the resident had a BIMS score of 03, indicating severe cognitive impairment. An IDT note dated February 13, 2026, revealed Resident #8 accused Resident #10 of stealing millions of dollars from him and punched Resident #10 in the eye. The facility investigation report received on February 17, 2026, completed by the Administrator, documented that a comprehensive investigation was completed using resident interviews and staff interviews and it was determined that the incident did not happen, however after further review the incident was determined to be an accident. An interview was conducted on March 12, 2026, at 11:30 AM with LPN (staff #58). She stated Resident #8 has many behaviors and delusions/hallucinations, however, the resident was easily redirected. She stated when the resident becomes agitated escalation occurs quickly. She said a behavior often exhibited was accusing someone of stealing his four million dollars. The LPN stated twice a month abuse training is conducted by the Director of Nursing (DON), the Administrator, and one of the Unit Managers. She said completed computer-based courses on abuse and protocols for abuse are posted at the nurse's station. An interview with DON (Staff # 167) on March 12, 2026 at 12:51 p.m., revealed that the facility is a behavioral facility and you never know what the behaviors will be or when they manifest. The DON revealed that when she started working here 5 weeks ago there were a lot of resident to resident altercations and when a resident hits another resident that is abuse which is required to be reported. The DON identified one area that staff needed to work on was identifying when residents get into the (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	personal space of other residents and be proactive before the abuse happens. An interview was conducted on March 12, 2026, at 2:55 PM with CNA (Staff #209). He stated staff frequently attempted to keep Resident #8 busy in the dayroom with activities. The CNA said when the Resident becomes agitated he will start to curse and sometimes just sitting with him 1:1 can deescalate him. An interview was conducted on March 12, 2026, at 3:41 PM with CNA (Staff #57). She stated on February 12, 2026, between 3:00 and 4:00 PM, she was in the dayroom when she heard Resident #10 yell help. She saw Resident #8 standing over Resident #10, who was in bed, with his feet up toward Resident #8. The CNA stated she assisted Resident #8 back to bed and asked Resident #10 what happened. Resident #10 stated Resident #8 accused him of stealing four million dollars and then hit him in the eye. The CNA stated she saw purple and blue discoloration under his left eye. The CNA stated she reported the incident to the nurse and then removed Resident #8 from the room. She then got vitals on Resident #10. The CNA stated Resident #10 becomes agitated and escalates quickly. One of his behaviors included accusing residents of stealing his four million dollars. She stated this is the first time she had observed Resident #8 hitting another resident. She said Resident #8's current behavior was stealing food and drinking his roommate's beverages. Staff will intervene and redirect often. Regarding Resident #9 Resident # 9 was admitted on [DATE], with diagnoses that included Alzheimer's disease, dementia with agitation, personality change, major depressive disorder, and anxiety disorder. A behavior note dated July 15, 2024, revealed that Resident #9 was stealing other residents' food off the counter becoming combative during redirection back to room after finishing breakfast. A behavior note dated July 17, 2024, revealed that Resident # 9 continues to eat other residents' food from the counter while staff try unsuccessfully to redirect him. A behavior note dated July 23, 2024, revealed that Resident # 9 was taking other residents food after finishing his. A behavior note dated November 23, 2024, revealed that during lunch Resident # 9 reached over and took another resident's cake. A behavioral treatment plan dated December 19, 2025, revealed Resident # 9's current behaviors are sexually inappropriate and isolative behavior with known triggers of female staff assisting in cares. Further review of the behavioral treatment plan revealed past behaviors including elopement and exposing himself. There was no indication that Resident # 9 had a history of taking other Resident's food. A care plan focus initiated on December 24, 2025, revealed that Resident # 9 had a behavior problem related to sexual inappropriateness, history of delusions, elopement risk, and self-isolation. Further review of the care plan revealed interventions which included cares in pairs, and following behavior plan. Review of the current care plan does not indicate a history of taking resident food or belongings. A quarterly MDS assessment dated [DATE], revealed a BIMS score of 7, indicating severe cognitive (continued on next page)

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	03/13/2026

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	impairment. The MDS assessment also revealed that Resident # 9 also experienced other behaviors for 1 to 3 days which include sexual acts. An interview with CNA (Staff # 79) on March 12, 2026 at 2:11 p.m. revealed that he had never known Resident # 9 to be physically aggressive or to take belongings from other residents. Staff # 79 revealed that Resident # 9 can be handsy with female staff and that's one of the reasons why he primarily works on that unit. Staff # 79 revealed that he did not see the incident with Resident # 2 but heard from Resident # 2 that Resident # 9 hit Resident # 2 and took his blanket because Resident # 9 was cold. An interview with RN (Staff # 103) on March 12, 2026 at 3:18 p.m., revealed that one of Resident # 9's behaviors was to be sexually inappropriate. The RN stated that care staff always does cares in pairs. Staff # 103 said that Resident # 9 grabs female staff and is inappropriate with them. Staff # 103 further stated that Resident # 9 was not known as physical and can be redirectable. An interview with a CNA (Staff # 107) on March 13, 2026 at 10:12 a.m., revealed that Resident # 9 is an easy-going guy who likes to stay in his bedroom. Staff # 107 revealed that if Resident # 9 wants something he is going to try and take it. Staff # 107 stated that they try and redirect before he takes something that does not belong to him. Staff #107 revealed most residents if they are in their room are checked on hourly unless they are on 15 min checks. A policy titled Dementia-Clinical Protocol revised November 2018, revealed that for treatment and management of dementia the IDT will identify and document the resident's condition and level of support needed during care planning and review changes as they arise. The policy also revealed that the physician will help define potential benefits and risks of medical interventions based on individual risk factors, current conditions, history and details of current symptoms.

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on staff interviews, facility documentation, and policy review, the facility failed to track, trend, and analyze the cause of resident-to-resident abuse and implement a measurable preventative action plan. The deficient practice could result in continued resident-to-resident abuse.Findings include:Review of a quality assessment and assurance committee (QAA) meeting dated December 11. 2025, revealed that the meeting review period was for November 2025. Review of the meeting minutes revealed that the number of reportable incidents for November was blank. Further review of the meeting minutes revealed there were 1 pending report for November, however, trends listed for November 2025 revealed 1 incident in Kiva and 3 incidents in Vista East. Review of the Clinical systems review conducted by the Director of Nursing does not specifically review resident to resident Abuse. Further review of meeting minutes revealed ongoing action plans which include, avoiding resident to resident by educating on behaviors, memory care, and how to prevent resident-to-resident by keeping the residents arms distance from one another.Review of QAA meeting dated February 24, 2026, revealed that the meeting review period was for December 2025 and January 2026. Review of the meeting minutes revealed that the number of reportable incidents for December 2025 were 6 while the number for reportable incidents for January 2026 were 2 for a total of 8 incidents. There were no listed pending reports, however documentation of the trends across units revealed 2 incidents in Kiva, 2 in Vista East, and 3 in [NAME] totaling 7 incidents. Further review of meeting minutes revealed the same action plan avoiding resident to resident with the same plan to educate on behaviors, memory care, and how to prevent resident by keeping residents arms distance from one another. Review of the resolved action plans was left blank and there is no measurable progress on the action plan of avoiding resident-to-resident abuse. An interview with the Director of Nursing (DON/Staff # 167) revealed that she audits the resident-to-resident altercations examining such things as what time of day, who is working and what kind of medications the resident is taking. She stated that her main focus is educating staff on abuse including how to be cognizant of residents invading other residents' space. The DON also revealed that the facility does not know what triggers the resident's and that is why they involve psych services especially after a resident-to-resident altercation. An interview with the Administrator (Staff # 60) on March 13, 2026 at 11:34 a.m. revealed that during QAA meetings they discuss falls, staffing issues, and go over quality measures. The Administrator revealed that resident-on-resident altercations are kept track under reportable events along with anything that is self-reported to the state agency. The administrator stated that they talk about the incidents but the only tracking of trends that they do is with regards to where the incident took place. The administrator revealed that he does not go far enough in tracking the trends of resident-to-resident abuse. The Administrator also revealed that the DON Staff # 167 is working on analyzing the data and coming up with a plan for the resident-to-resident abuse. A policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised April 2021, revealed that the resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support objective such as establishing and implementing a quality assurance and performance improvement (QAPI) review and analysis of reports, allegations or findings of abuse, neglect mistreatment or misappropriation of property. A policy titled Abuse, Neglect, Exploitation and Misappropriation, QAPI Review of, revised September 2022, revealed that all occurrences of abuse, neglect, and mistreatment, injuries of unknown source, and theft or misappropriation of resident property are reviewed by the QAPI committee. The policy further revealed that the QAPI committee reviews any allegations of abuse during their regularly scheduled meetings. If an allegation confirms that abuse has occurred the QAPI committee is responsible for integrating the findings into a performance improvement initiative. The performance improvement projects related to abuse are considered a priority and are supported by the administration and governing body.