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	04/17/2026

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 clinical record review, staff interviews, review of facility documentation and policies, the facility failed to protect the rights of 3 residents (#3, #4, #7) to be free from physical abuse by other residents (#2, #5, #6). The deficient practice could result in further abuse of residents and appropriate action not taken.Findings Include:Regarding Resident #3 and Resident #2 incident:Resident #3 was admitted on to the facility on 2/20/2025 with diagnoses that included Dementia and Major Depressive Disorder.The Resident's care plan dated 5/21/2025, revealed that the resident had an impaired cognitive function or impaired thought processes related to Dementia.The Resident's Behavioral Care Plan progress notes with an effective of 2/17/2026, revealed that the Resident's current behavior included an adjustment to living in a skilled nursing facility. The interventions included for the staff to provide supportive and compassionate care to help ease the transition; establish a consistent daily routine to provide structure and reduce uncertainty; and introduce him gradually to staff, peers, and activities focusing on building familiarity and comfort at his pace.The Resident's Alert Note in the progress notes dated 3/29/2026, at 8:50 AM, revealed that Resident #2 with a closed fist hit Resident #3's right shoulder. It was documented that a Certified Nursing Assistant (CNA) saw Resident #2 punch Resident #3 and that Resident #3 denied pain. Resident #3 was assessed and there were no red marks and bruising. Resident #3's doctor was notified and there were no new orders received. The Resident's Power of Attorney (POA), the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) were notified.The revised care plan dated 3/30/2026 included a psychosocial well-being problem related to resident to resident altercation. The interventions included to follow the behavioral care plan; cue, reorient and supervise as needed; and when conflict arises, remove the resident to a calm safe environment and allow to vent and share his feelings.Another review of the Resident's Alert Note in the progress notes dated 3/30/2026, at 5:11 AM, revealed that Resident #3 was on an alert charting following the incident with Resident #2. Resident #3's skin assessment, per document, had no redness, bruising, swelling, or open areas. Resident #3 complained of soreness on his right shoulder and rated the pain 2 out of 10.A Psych Follow Up progress note dated 3/31/2026, was reviewed. Resident #3 was seen for psychiatric follow-up after an altercation in which Resident #2 struck Resident #3's right shoulder with a closed fist. Per document, the staff witnessed the contact and immediately intervened. It was documented that Resident #3 denied pain, and there were no redness, bruising, or visible injury noted. Further, per documentation, Resident #3 reported that he was sitting in the day room when Resident #2 approached him from the corner of his eye and Resident #2 struck his arm without prior interaction or verbal exchange. Resident #3 only had mild soreness to the right shoulder. Resident #3's well being remained consistent with baseline following the incident.-Resident #2 was admitted to the facility on [DATE], with a primary diagnosis of Schizoaffective Disorder.A review of the Resident's Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15.0, indicating that the resident's cognition was intact. The Resident did not exhibit behavioral symptoms. The Resident's active diagnosis included Schizophrenia. The MDS further revealed that the Resident was taking (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	Antianxiety and Antipsychotic medications on a routine basis.A Behavioral Care Plan progress note, effective 3/11/2026, was reviewed. The Resident's current behaviors included a verbal and physical aggression (posturing, threats) and exit- seeking. The interventions included that the Resident may display verbal or physical aggression when he feels frustrated, overwhelmed, or perceives a loss of control, and that these behaviors may be his way of expressing distress or attempting to regain a sense of power. It was documented that the staff should remain calm, maintain a safe distance, avoid arguing or escalating the interaction, use steady, respectful tone, offer space for the Resident to de-escalate while redirecting the Resident to a quieter area if possible. Once the Resident begins to settle, offer the Resident simple choices and supportive guidance while maintaining clear boundaries and prioritizing safety.The Alert Note in the progress note dated 3/29/2026, at 2:11 AM, revealed that Resident #2 asked to smoke every 10 minutes or so and kept trying to negotiate good behavior for a cigarette. The staff nurse informed Resident #2 that he can not have a cigarette but he may go back to his room and behave. Per document, Resident #2 was told many times that he may not have a cigarette until 8:00 AM during the designated smoking time. Resident #2 started threatening the staff. It was documented that Resident #2 called 911. Resident #2 chased and went after the staff while on the phone with the 911 dispatcher. The police came and were able to calm Resident #2, and informed Resident #2 that smoking time is at 8:00 AM.Another review of the Alert Note in the progress note dated 3/29/2026, at 9:25 AM, revealed that at the start of the AM shift, Resident #2 was agitated with anxiety, getting up, walking around, and making inappropriate gestures to female staffs, along with showing verbal aggression then escalated to physical. Resident #2 was not happy that he was not allowed to smoke as he wanted, due to set times for smoke breaks. Resident #2 saw a housekeeper coming and Resident #2 grabbed the housekeeper's hand with the keys and yanked it out of her arm. The housekeeper staff reported an injury to her right shoulder. After the housekeeper staff incident with Resident #2, Resident #2 became aggressive and punched a male CNA's abdomen. Resident #2 became verbally aggressive when he was asked to sit down. The ADON, DON, and the administrator were notified of Resident #2's physical aggressive behavior. The staff called 911 at 8:01 AM. Further, per document, during the time that the police officers were in the facility campus, Resident #2 randomly hit Resident #3's right shoulder in passing prior to being approached by the police officer. Upon being approached by the officers, Resident #2 reached for the police officer's hand gun.A review of the Resident's comprehensive care plan which was revised on 3/30/2026, revealed that the Resident had the potential to be verbally aggressive related to mental, emotional illness, poor impulse control, and will threaten staff when he did not get what he wants. The care plan revealed that on 3/29/2026, Resident #2 punched another resident in the arm. The interventions included immediate separation, the staff to follow the Behavioral Care Plan for any possible triggers. The plan also included for the Resident to be relocated to another facility.The Interdisciplinary Team (IDT) progress note dated 3/30/2026, revealed, per document, that Resident #2 hit Resident #3's shoulder. Resident #3 and Resident #2 were separated. The administrator, DON, and the police were notified. The police took Resident #2 to a hospital and, Resident #2 would be transferred to another facility once he was released from the hospital. The document revealed that the facility was unable to meet the needs of Resident #2.A review of the facility's 5-day report investigation revealed an undated report. The report included statements from the staff members. On the left upper top corner of the statement document, Incident #1 was written. Per the document, it revealed that early morning on 3/29/2026, Resident #2 had been up all night, was very agitated, was not listening, was very adamant about having a cig, and was asking several times. The CNA (Staff #10) informed Resident #2 that it was not time yet. Resident #2 was told to step out. Then, Resident #2 walked very slowly, then turned around and struck the CNA (Staff #10) in the stomach. The CNA (Staff #10) reported the incident to the nurse. In the middle part of the statement document, Incident #2 was written. Per the document, it revealed that after the police was called, the CNA (Staff #10) went to the gate and spoke with the police to give his statement. After giving his statement to the police, the CNA (Staff #10) returned in (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the day room and saw that Resident #2 struck Resident #3's right shoulder. The CNA (Staff #10) separated Resident #2 and Resident #3, and then the CNA (Staff #10) informed the nurse. The police came and took Resident #2 out of the facility. In addition, the 5 -day report investigation revealed that the IDT team determined that it might be in the best interest of the facility not to re-admit Resident #2 back to the facility as the facility was unable to meet his needs.Regarding Resident #6 and Resident #7 incident:-Resident #6 was admitted to the facility on [DATE], with diagnoses that included dementia, Bipolar Disorder, Major depressive Disorder, and Anxiety Disorder.The Resident's care plan initiated on 8/6/2025, revealed that the Resident was at risk for not meeting emotional, intellectual, physical, and social needs related to Dementia. The interventions included that all staff were to converse with the Resident while providing care; introduce the Resident to other residents with similar background, interests; and encourage and facilitate the interaction.A review of the Resident's Quarterly MDS assessment dated [DATE], revealed a BIMS score of 6.0, indicating that the Resident's cognition was severely impaired. The assessment revealed that physical behavioral symptoms directed towards others and verbal behavioral symptoms directed towards others were not exhibited, but other behavioral symptoms not directed towards others had occurred. Further, the assessment revealed that the Resident was receiving Antipsychotic and Antidepressant medications.The Resident's Behavioral Care Plan progress note with an effective date of 2/12/2026, revealed a current behavior that included refusing and combative with care, severe agitation, cursing, striking out, and threats. The interventions included when Resident #6 becomes combative or refuses care, approach him calmly and respectfully; avoid rushing or overwhelming him by explaining each step clearly; and allow extra time for processing to help Resident #6 feel a sense of control. Further, per Behavioral Care Plan, if Resident #6 becomes agitated, pause and attempt care later when he is calmer; redirect his attention to a preferred topic or activity; and use familiar routines to ease anxiety; and when Resident #6 becomes severely agitated such as striking out, cursing, or making threats, ensure safety by maintaining a safe distance and removing other residents from the area if needed.An Alert Note progress note dated 4/2/2026, revealed that Resident #6 hit Resident #7 with a tray table. Resident #6 and Resident #7 were immediately separated and the tray table was removed from Resident #6. Resident #6 was assessed and no injury found.An IDT Note progress note dated 4/3/2026, revealed that Resident #6 was the aggressor towards Resident #7.Further review of the Resident's comprehensive care plan revealed an updated care plan dated 4/3/2026. The care plan revealed that Resident #6 was at risk for psychosocial well-being problem related to Resident to Resident altercation and, another revised care plan dated 4/6/2026, revealed that the resident had the potential to be physically aggressive related to Dementia. Resident #6 hit another resident with a tray table on 4/2/2026. The interventions included to follow the updated Behavioral Care Plan; when the Resident becomes agitated, intervene before agitation escalates, guide away from the source of distress, engage calmly in conversation; and when conflict arises to remove the residents to a calm safe environment.A review of the Psych Follow Up progress notes dated 4/7/2026, revealed that Resident #6 was evaluated following a report of aggression toward Resident #7 on the evening of 4/2/2026, during which Resident #6 struck Resident #7 with a tray table. Resident #6 and Resident #7 were immediately separated and there were no injuries identified per nursing documentation.-Resident #7 was readmitted on [DATE], with diagnoses that included Dementia, Type 2 Diabetes Mellitus, and cognitive communication deficit.The Quarterly MDS assessment dated [DATE], revealed that a BIMS was not conducted due to the resident was rarely and never understood. The Resident did not exhibit physical and verbal behavioral symptoms directed towards others, but, other behavioral symptoms not directed towards others such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds, occurred. The Resident's Behavioral Care Plan progress note effective 2/13/2026, revealed a wandering/exit seeking current behavior.A review of the Alert Note in the progress note dated 4/2/2026, at 9:41 PM, revealed that the nurse was notified by staff that Resident (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	March 2026, by a laundry staff member. Staff #43 stated that Resident #4 was at the bottom of the ramp, on his backside, and his wheelchair tipped over. Resident #5 was at the top of the ramp to the day room. Staff #43 stated that he was the nurse for Resident #4 and Resident #5 on the day of the incident, but did not witness the incident between Resident #4 and Resident #5. Staff #43 said that he noticed Resident #4 on the floor and he called another nurse. They separated Resident #4 and Resident #5. Resident #5 went back to his room while Resident #4 was taken to the day room. Resident #4 was assessed and Resident #4 was sent out to the emergency room because he was on aspirin. Resident #4 returned back to the facility that same evening, and Resident #4 did not have injury. An interview was conducted on 4/17/2026, at 11:33 AM with the DON (Staff # 80). The DON stated that her responsibilities included assessing the department to make sure that the staff are following the policies and procedures; auditing to make sure all care required were being completed, and if not followed, she would do an in-service to the staff as to why the polices and procedures are put in place; and assisting nurses. Regarding abuse, the DON stated that abuse could be physical, verbal, and when residents receive inappropriate care. She said that physical abuse such as an altercation between residents include laying a hand and or using an object to hit another resident. She said that a verbal abuse is when a resident is calling a resident bad name. The DON said that her plan was to educate her staff before an abuse happens by being proactive not reactive. Her plan also included tracking and trending abuse, on what unit, and tracking and trending the time and day when an abuse happens. The DON also stated that she had created a behavioral care book with a behavioral care plan, which specifies specific triggers per resident. Regarding the incident involving Resident #6 and Resident #7, the DON stated that the training CNAs reported the incident because they were standing at the doorway while Resident #6 and Resident #7 were yelling at each other, Resident #6 picked up the folded table and swung at Resident #7, and Resident #6 and Resident #7 were immediately separated. The DON stated that the it was the training CNAs first night in the facility, and they were just there to observe. The DON said that there were no CNA staff members in the incident room when the incident between Resident #6 and Resident #7 happened because the CNAs were assisting other residents. The DON said that the nurse was supposed to be looking at the window while preparing the medications. Further, the DON stated that when residents are in the common area, there should always be a staff member observing them. The DON said that the nurse did not provide full attention because she was preparing the medications. The DON said that her expectation was that there should be a CNA staff member at the area at all times to try to eliminate a resident to resident altercation from happening. The DON said that if she had a CNA physically sitting at the area, and 2 residents are arguing, the CNA could have pulled and redirected the residents. The DON stated that the incident between Resident #6 and Resident #7 did not have a CNA who was physically in the common area and there was no CNA supervision. She did not expect the training CNAs to approach the residents and to deescalate because the training CNAs do not have the experience yet, and it would be more of a risk if the training CNAs do not know what to do. Regarding the incident between Resident #2 and Resident #3, the DON stated that the police officer witnessed Resident #2 hit the shoulder of Resident #3. The DON stated that Resident #2 made physical contact with Resident #3. Further, the DON said that Resident #2 was getting more agitated because Resident #2 wanted more smoking time and the staff informed Resident #2 that it was not time to smoke yet. The DON said that she expected her staff to redirect the Resident and to keep the smoking schedule. The DON said that if she was the nurse on duty, she would have taken Resident #2 to have a cigarette to try to calm him down. Regarding Resident #4 and Resident #5 incident, the DON stated that the incident happened outside, the ramp was narrow, one person at a time can only come up and down, and the incident involved one resident was coming up the ramp while the other resident was going down the ramp. The DON said that the CNAs do their rounding outside every 15-minutes. The DON said that she does not want her CNAs just inside the common area. The DON said that she was glad that the housekeeper staff saw what happened between Resident #4 and Resident #5, and that the houseke

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	04/17/2026

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the review of the clinical records, staff interviews, and review of facility's policy and procedure, the facility failed to ensure a PASRR Level 2 (pre-admission screening and resident review) was submitted for one residents (#2) to the appropriate state-designated authority . The deficient practice could result in residents' medically related social and emotional needs not being met.Findings include:Resident #2 was admitted to the facility on [DATE], with a primary diagnosis of Schizoaffective Disorder.Resident #2's Pre-admission Screening and Resident Review (PASRR) Level 1 was completed on 2/26/2026. Per document, the Resident has a serious mental illness, Schizophrenia, and a Level 2 referral for mental illness was necessary.A review of the Resident's Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15.0, indicating that the resident's cognition was intact. The Resident did not exhibit behavioral symptoms. The Resident's active diagnosis included Schizophrenia. The Resident was taking Antianxiety and Antipsychotic medications on a routine basis.A Behavioral Care Plan progress note with an effective of 3/11/2026, was reviewed. The document revealed that the Resident's current behaviors included verbal and physical aggression (posturing, threats) and exit-seeking. The interventions included that the Resident may display verbal or physical aggression when he feels frustrated, overwhelmed, or perceives a loss of control, and that these behaviors may be his way of expressing distress or attempting to regain a sense of power. The staff should remain calm, maintain a safe distance, avoid arguing or escalating the interaction, use steady, respectful tone, offer space for the Resident to de-escalate while redirecting the Resident to a quieter area if possible. Once the Resident begins to settle, offer the Resident simple choices and supportive guidance while maintaining clear boundaries and prioritizing safety.On April 16, 2026, at 3:29 PM, the Administrator (Staff #88) provided a document revealing that the facility did not have Level 2 PASRR for Resident #2.An interview was conducted on 4/17/2026 at 10:11 AM with the Social Service Director (Staff #50) and present during the interview was another Social Service staff member (Staff #55). Regarding PASRR, the Social Service Director stated that when a resident is admitted to their facility and the resident did not come in with a PASRR, she would complete a Level 1 PASRR for the resident. She said that if the resident had a diagnosis of Schizophrenia, she would send a Level 2 referral by submitting the document electronically to Arizona Health Care Cost Containment System (AHCCCS). Regarding Resident #2's PASRR, the Social Service Director stated that Resident #2 was admitted for a long term stay at the facility, and that she completed Resident #2's Level 1 PASRR. She further stated that Resident #2 did not have a Level 2 because she did not submit the document to AHCCCS for a referral. The Social Service Director stated that the reason for submitting a referral for determination for Level 2 for a resident was to make sure that the resident was appropriate for the facility and the environment to meet the resident's needs. The Social Service Director stated that Resident #2 was taken by the police to the hospital for an evaluation because Resident #2 became violent with his behaviors.An interview was conducted on 4/17/2026, at 11:33 AM with the DON (Staff # 80). Regarding PASRR for Resident #2, the DON stated that Resident #2 was admitted with a Schizoaffective Disorder as his main diagnosis. The DON stated that Resident #2 was in a secured unit, and Resident #2 was being followed by their facility psychiatric provider. The DON said that she does not know a lot about PASRR. The DON said that she was informed that Resident #2 did not have a Level 2 PASRR referral submitted to AHCCCS.According to AHCCCS, Preadmission Screening and Resident Review (PASRR) is guided by federal regulations that require all individuals being considered for admission to a Medicaid-certified nursing facility (NF) be screened prior to admission, to determine if the person has, or is suspected of having, a mental illness, intellectual disability, or related condition. The PASRR helps to ensure that individuals are not inappropriately placed in nursing homes for long term care. The PASRR requires that: 1) all applicants to a Medicaid-certified nursing (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility be evaluated for mental illness (MI) and/or intellectual disability (ID);2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings); and3) receive the services they need in those settings including specialized services.