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	05/01/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - 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 10 of 11 residents sampled (#1, #2, #3, #4, #6, #7, #8, #9, #10, and #11) to be free from physical and verbal abuse between residents. The deficient practice could result in resident injury, psychological, or behavioral harm as well as continued resident to resident abuse.Findings include:Regarding Resident #1 and Resident #2:-Resident # 1, the alleged victim, was admitted [DATE], with diagnoses that included unspecified dementia, mood disorder due to known physiological condition with manic features, and alcohol dependence. The care plan initiated on October 8, 2025 revealed the resident had behaviors of yelling, exit seeking, wandering and delusional thinking, a history of going into other resident's rooms and wandering about the unit. Interventions included redirection and to avoid reacting to Resident if she engages in yelling or any signs of verbal aggression. A behavioral care plan dated April 2, 2026 revealed that Resident #1's known behaviors are mood swings, yelling, refusing care, anxiety, and worry. The Behavioral care plan also revealed that her triggers are missing family when she thinks she is alone on the unit. Interventions included approaching resident with patience and reassurance, using a calm voice and gentle tones, avoid confrontation or insisting on compliance when resident refuses care, and acknowledge resident's feelings.A Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) of 3, indicating that the resident had severe cognitive impairment. A nurse's note dated April 13, 2026, revealed that a Certified Nursing Assistant (CNA) notified the Nurse that Resident #1's face was grabbed at the lip by Resident #2 when Resident # 1 was getting up to move away. The note revealed the residents were placed on 15-minute safety checks and closely monitored. A skin assessment dated [DATE] revealed no new wounds since last documented skin check.-Resident # 2, the alleged perpetrator, was admitted on [DATE], with diagnosis that included personality disorder, anxiety disorder, adjustment disorder, and depression.The care plan revised on August 13, 2025, revealed the resident had behaviors consisting of placing herself on the floor, refusing care and medications, making false accusations, fabricating stories, going into other resident's rooms and breaking personal item. 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 the resident was cognitively intact. The quarterly MDS also revealed behaviors including rejection of care and other behavioral symptoms not directed towards others.A behavioral care plan dated February 13, 2026, revealed current behaviors as verbal aggression, nicotine impulsivity, and refusing cares. Further review of the behavioral care plan revealed triggers of being easily agitated with staff. Interventions included staff setting firm boundaries, providing a written schedule for smoke times, and educating the resident about taking medications as a scheduled for full, positive effect.A behavior note dated March 15, 2026, revealed that the resident became upset because staff have to continuously check her blood sugar. The behavior note documented the resident threw her whole meal out of her room causing the plates to break.A nurse's note dated April 13, 2026 revealed (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035217	A. Building B. Wing	05/01/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that a CNA reported to the nurse that Resident #2 grabbed Resident #1's face by her mouth while Resident # 1 was trying to move away from her. The nurses note documented that Resident #2 stated 'Yeah I grabbed her by the face. I don't like her!' A Psychiatry follow up note dated April 14, 2026 revealed that Resident # 2 provided a coherent account of the event. The psychiatry note revealed that Resident #2 claimed Resident #1 called her a 'filthy name' and Resident #2 reacted by grabbing Resident #1 because Resident #2 felt threatened when Resident #1 stood up. The facility investigation report, undated, documented an eyewitness statement from Certified Nursing Assistant (CNA/Staff # 81) dated April 13, 2026, revealed that Staff # 81 witnessed a verbal altercation between Resident # 1 and Resident # 2 over a pitcher of water. The statement documented that Resident # 1 angrily got up yelling obscenities at Resident #2, as Resident # 1 was getting up Resident # 2 grabbed Resident #1 by her mouth. The statement revealed that Staff #81 got in between both Residents before Resident # 1 retaliated. The facility investigation documented that the facility substantiated the allegation and found that Resident # 2 gets highly agitated when asked questions and if someone gets close to her. The facility investigation also revealed that Resident # 2 is verbally aggressive, which normally results in physical altercations.An interview with CNA (Staff # 67) was conducted on May 1, 2026 at 9:43 a.m. who stated that Resident #1 is very confused and forgetful but can easily be redirected while Resident #2 keeps to herself. Staff # 67 stated that Resident # 2 gets mad easily especially when Resident # 2 does not get her way. Staff #67 stated that Resident #2 gets possessive with belongings and food and gets mad if other residents touch them. Staff # 67 stated that after the incident between Resident # 1 and Resident # 2, the staff has to keep eyes on Resident # 1 when she is out in the courtyard to try and prevent her from getting close to Resident # 2. Staff # 67 stated that they do get training almost monthly on abuse training.An interview with CNA (Staff # 115) was conducted on May 1, 2026 at 9:45 a.m. Staff # 115 stated that Resident # 2 exhibits behaviors when other residents or staff make her mad. Staff # 115 revealed that Staff # 1 wanders around a lot especially into other resident's rooms. Staff # 115 stated that Resident # 1 likes to go into Resident # 2's room because there used to be another Resident who lived in that room who was sick and Resident # 1 would check on that resident when she wandered the courtyard. CNA # 115 revealed that since this last incident between Resident #1 and Resident #2 the staff now have to keep eyes on Resident #1 to prevent her wandering to Resident #2's room. Staff #115 stated that they usually get information regarding resident's care plan and changes of care during shift change. Staff # 115 also stated that they have access to the care plans in a binder that the CNA's can now access.An interview with Director of Nursing (DON/Staff # 199) on May 1, 2026 at 10:10 a.m. who stated that during her investigation she found out that Resident # 1 and Resident # 2 had an argument and as Resident #1 was trying to get up to leave, Resident # 2 grabbed Resident # 1 by the face. Staff # 199 stated that this is the second altercation between these two residents and she they added the 1:1 for Resident # 1 when in the courtyard to help prevent further altercations. Staff # 199 stated that her expectation is staff be proactive and identify potential aggression before it happens. Staff # 199 stated that the risk for not being proactive is that residents abuse other residents.Regarding Resident #3 and Resident #4: -Resident #3, the alleged victim, was admitted on [DATE], with diagnoses Schizophrenia, bipolar disorder, borderline personality disorder, and suicidal ideations.The behavior care plan dated March 13, 2026 revealed current behaviors which included mood swings, abusive tone, intrusive behaviors and manipulative medication seeking. Interventions included approaching resident with warm patience and reassurance, acknowledging her need for attention or interaction while kindly redirecting her to an appropriate activity, and responding to resident consistently, professionally, and with clear boundaries when resident manipulatively seeks medication.The quarterly MDS assessment dated [DATE] revealed the resident had a BIMS score of 15, indicating the Resident was cognitively intact. The quarterly MDS also revealed mood of feeling down, depressed, and sometimes isolated. The quarterly MDS revealed behaviors other behavioral symptoms not directed towards others.A nurse's note dated April 13, 2026 revealed that Resident # 3 was yelling and screaming for CNA # 27. (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	05/01/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The note also revealed that the staff in the 500 unit were alerted by her screams and sent CNA # 76 to the 600 wing to investigate. The nurse's note revealed that CNA # 76 entered and saw Resident # 3 in her wheelchair at the entrance of her room while Resident # 4 was striking Resident # 3 on the left side of her face. The nurse's note revealed that Resident # 3 stated to CNA # 76 that Resident # 4 entered her room and began hitting her on the left side of the face and ear while Resident #3 was trying to block the hits. A skin assessment dated [DATE] revealed no new skin issues observed.The care plan revised on April 14, 2026, revealed that Resident #3 had behavioral problems related to false allegations and attempts to ?split' staff. Interventions included anticipating and meeting the resident's needs, monitoring behavior episodes and attempt to determine underlying cause, and administering medications. -Resident # 4, the alleged perpetrator, was admitted on [DATE], with diagnoses that included Huntington's disease, schizoaffective disorder, and personal history of traumatic brain disorder. The care plan initiated on March 23, 2026, revealed that Resident # 4 had a potential to be physically aggressive related to poor impulse control and a history of aggressive behaviors toward others. Interventions included intervening when resident becomes agitated, asses and anticipate resident's needs, and administration of medication.The admission MDS assessment dated [DATE], revealed a BIMS score of 7, indicating that the resident had severe cognitive impairment. The admission MDS also revealed behaviors other behavioral symptoms not directed towards others. The behavioral care plan dated March 27, 2026, revealed current behaviors such as impulsive, poor safety awareness and unsafe transfers, physical aggression which include combative striking out at staff. Interventions included maintaining a structural routine, provide close supervision and anticipated needs, and approach resident calmly and give him space pausing care if aggression gets worse.A nurse's note dated April 13, 2026, revealed that CNA # 76 reported that Resident # 4 was in another Resident's room and was hitting Resident #3.A Psychiatry note dated April 14, 2026 revealed that Resident #4 was seen following the altercation with Resident #3. The note revealed that Resident #4 was put on 1:1 supervision for safety. The note also revealed that Resident #4's behavior was consistent with known history of significant aggression and inability to comprehend or reason through social interactions. The facility investigation, undated, documented that their investigation found that it was the first altercation for Resident #4 but would place him on a 1:1 to prevent future altercations with this resident. The facility did not substantiate allegation of abuse due to Resident #4's cognition. An interview was conducted on April 30, 2026 at 2:27 p.m. with Staff # 76 who stated that she was in another unit when she heard Resident #3 yelling through the walls. Staff # 76 stated she waited a minute because it is not uncommon for Resident # 3 to yell but since it continued, she was sent over to the 600 unit to see what was going on. Staff # 76 stated that when she got into the 600 hall Staff # 27 was not in the unit but giving a smoke break to another resident. Staff # 76 stated that when she entered Resident # 3's room, Resident # 3 was yelling at Resident # 4 while blocking her face and Resident # 4 was swinging at her, while she was trying to remove Resident # 4 from the situation. Staff # 27 arrived and helped deescalate the situation while Staff#76 got Resident # 4 to his room. An interview was conducted on May 1, 2026 at 9:10 a.m. with Licensed Practical Nurse (LPN/Staff # 161) who stated that Resident # 3's behaviors included being verbally manipulative, and narcissistic. Staff # 161 stated that Resident # 4 is very physical with his aggression and anything can trigger him. Staff # 161 stated that Resident # 4 had been physical with staff since his admission and that anything can trigger the aggression. Staff # 161 stated that the sitter that had been assigned to him had helped keep him under control, but since she has to cover both 500 and 600 wings, she can't be in both places at once. An interview with Director of Nursing (DON/Staff # 199) on May 1, 2026 at 10:10 a.m. who stated that their investigation determined that Resident # 4 was witnessed by staff in Resident # 3's room swinging at Resident # 3. Staff # 199 stated that due to history of Resident # 4's aggression they have placed him on a 1:1 to help avoid further altercations with other residents. Staff # 199 stated that her expectation is staff be proactive and identify potential aggression before it happens. Staff # 199 stated that the risk for not being proactive is that residents (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	05/01/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	abuse other residents. Regarding Resident # 6 and Resident # 7:-Resident # 6, the alleged victim, was admitted on [DATE] with diagnoses of bipolar disorder, anxiety disorder, major depressive disorder, and post-traumatic stress disorder. The admission MDS dated [DATE], revealed the resident had a BIMS score of 4, indicating that the resident had severe cognitive impairment. The admission MDS revealed mood of feeling down and depressed and sometimes isolated. The admission MDS also revealed behaviors including rejection of evaluation of care and other behavioral symptoms not directed towards others.The Behavioral care plan dated April 15, 2026 revealed current behaviors such as adjusting to skilled nursing facility and blocking entrances to doorways. The behavioral care plan did not indicate any known triggers. Interventions included providing consistent reassurance, orient resident to his surroundings, and providing an alternative place resident can stand as to not block doorways.A nursing note dated April 18, 2026 revealed that Resident # 6 was hit on his left calf by Resident # 7. The nursing note further revealed that the residents were separated and Resident # 6 was assessed for any injuries. The nurses not revealed no injuries were discovered.A skin assessment dated [DATE] revealed two old skin tears to bilateral forearms which were present prior to the incident. The skin assessment revealed no new skin wounds.A care plan dated April 19, 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 # 7, the alleged perpetrator, was admitted on [DATE] with diagnoses that included quadriplegia, major depressive disorder, and Schizophrenia.A behavioral care plan dated February 4, 2026, revealed the resident's current behavior is adjusting to the skilled nursing facility. The behavioral care plan also revealed his triggers as anxiety. Interventions include staff approaching resident with patience, empathy, and consistency.The quarterly MDS dated [DATE], revealed a BIMS score of 10, indicating that the resident had moderate cognitive impairment. The quarterly MDS revealed mood of feeling down and depressed and sometimes isolated. Further review of the quarterly MDS documented no behaviors.A nursing note dated March 6, 2026, documented that Resident # 7 was extremely upset about not having cigarettes and was told by staff that they were getting them today. The nursing note revealed that Resident # 7 started acting out by ramming his side table and door with his wheelchair knocking everything over. The nursing note also documented that he threw his cell phone and ran over it with his wheelchair yelling 'I hate this place'. The nurses note revealed that he continued to ram his wheelchair into a gate and breaking it. A care plan initiated on April 12, 2026, revealed that Resident # 7 had behavior problems of restlessness related to anxiety. Interventions included intervening as necessary to protect the rights and safety of others, diverting attention, and removing resident from situations and take to alternate locations. A nursing note dated April 18, 2026 at 9:44 a.m., revealed that Registered Nurse (RN/ Staff # 177) was alerted that Resident # 7 went over to Resident # 6 with his motorized wheelchair and intentionally hit Resident # 6 in the right calf. The nursing note documented that the residents were separated.A nursing note dated April 18, 2026 at 10:30 a.m. stated that Resident # 7 came to Staff # 177 upset that he was not alerted to the smoking session at 10:00 a.m. The nursing note further revealed that Resident # 7 began screaming at another resident at the nurses station. The nurses note documented that Staff # 177 separated Resident # 7 from the situation outside where Resident # 7 continued to be verbally abusive to Staff # 177.A nursing note dated April 18, 2026 at 3:52 p.m. revealed that Resident # 7 was throwing all his belongings on the floor breaking his nebulizer machine. The facility investigation, undated, documented that the altercation did occur. Resident # 7 was placed on 15-minute supervisory checks until resident could be seen by Behavioral Health.An interview was conducted with RN (Staff #177) on April 30, 2026 at 1:54 p.m. who stated that the day prior to the incident Resident #7 had a hard day because he was getting mail with contraband such as vapes with Tetrahydrocannabinol (THC) in them without a doctor's order so it was confiscated which aggravated (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	05/01/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident # 7. Staff # 177 stated the next day, April 18, 2026, he was still upset and focusing on the removed contraband. Staff # 144 stated that Resident # 6 was outside wandering when he saw a food tray being delivered and grabbed it thinking it was his, but it was for Resident # 7. Staff # 177 stated that Resident # 7 got further upset and ?went after' Resident # 6 with his wheelchair hitting him in the right calf. Staff # 177 said Resident # 7 was upset throughout the day throwing his belongings on the floor and ramming his wheelchair into doors and gates. Staff # 177 stated that finally Resident # 7's medical doctor came in to talk to him address the contraband and he started to calm down.An interview was conducted with CNA (Staff # 79) on April 30, 2026 at 2:01 p.m. who stated that he was in front of Resident # 7's door along with 2 other CNAs when he sees Resident # 7 move his electric wheelchair ramming it into Resident # 6's leg. Staff # 79 stated they had to separate them because Resident # 7 kept pushing his wheelchair into Resident #6. Staff # 79 stated that Resident # 6 likes to wander into residents' rooms and needed redirection. Staff # 79 stated that Resident # 7 was upset because Resident # 6 had his food tray by mistake.An interview with Director of Nursing (DON/Staff # 199) on May 1, 2026 at 10:10 a.m. who stated that it was determined through the investigation that Resident # 7 ran his motorized wheelchair into Resident # 6 because Resident # 7 thought Resident # 6 was stealing his food tray. Staff # 199 stated that she has had conversations with Resident # 7 regarding his behavior and Therapy has evaluated his ability to drive a wheelchair. Staff # 199 stated that her expectation is staff be proactive and identify potential aggression before it happens. Staff # 199 stated that the risk for not being proactive is that residents abuse other residents.Regarding Resident # 8 and Resident # 9:-Resident #8, the alleged victim, was admitted on [DATE] with diagnoses that included dementia, major depressive disorder, personal history of other mental and behavioral disorders. The care plan dated March 2, 2026 revealed the resident had the potential to be physically aggressive related to dementia with a history of hitting staff. Interventions included anticipating resident's needs, intervening before agitation escalates, and administration of medication. The admission MDS assessment dated [DATE] revealed the resident had a BIMS score of 14, indicating the resident was cognitively intact. The admission MDS also revealed other behavioral symptoms not directed towards others.The behavioral care plan dated March 7, 2026 revealed the resident's current behaviors as anxiety, agitation, and cursing at staff. The behavioral care plan also revealed no known triggers. Interventions include by responding with a calm steady tone and avoid reacting emotionally.The care plan dated March 12, 2026 revealed the resident had a potential to be verbally aggressive related to dementia. Interventions included anticipating resident's needs, intervening before agitation escalates, and administration of medication. A nurse's note dated April 20, 2026 documented that Licensed Practical Nurse (LPN/Staff #146) was notified that Resident # 9 physically engaged Resident # 8 by placing arms around Resident # 8's neck initiating a chokehold while Resident # 9 positioned himself behind Resident # 8. The nurses note further revealed that residents were separated and assessments were completed on the residents.A skin assessment dated [DATE] revealed that skin was intact an no new wounds were observed since previous assessment.-Resident #9, the alleged perpetrator, was admitted on [DATE] with diagnoses that included dementia with agitation, bipolar disorder, unspecified mood disorder, and major depressive disorder.The care plan dated August 6, 2025, revealed that Resident # 9 had the potential to be verbally aggressive yelling or cursing at others related to dementia. Interventions included assessing resident's coping skills, intervening before agitation escalates and guiding the resident away from source of distress. A quarterly MDS assessment dated [DATE], revealed a BIMS score of 6 indicating that the resident had severe cognitive impairment. The quarterly MDS also revealed other behavioral symptoms not directed towards others.A behavioral care plan effective February 12, 2026 revealed that Resident #9's current behaviors included refusing and combative with cares, severe agitation, cursing, striking out and threats to others. Interventions included, to approach resident calmly and respectfully using a soft reassuring tone when he is combative, and when resident becomes agitated by striking out, staff are to ensure safety by maintaining a safe distance and removing other residents (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	05/01/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for the area if needed.The care plan dated April 2, 2026 revealed that Resident # 9 had the potential to be physically aggressive related to dementia. The care plan also documented that Resident #9 hit another resident with a tray table on April 2, 2026. Interventions included providing physical and verbal cues to alleviate anxiety, and intervening before the resident's agitation escalates. A nursing note dated April 21, 2026 revealed that Staff #146 was notified that Resident # 9 was engaged in an activity with building blocks at the communal table area. Resident # 9 left the table and upon his return Resident # 9 observed Resident # 8 occupying the same table and the arrangement of the blocks had been disrupted by Resident # 8. The nurses note further documented that Resident # 9 walked behind Resident # 8 and proceeded to physically engage Resident # 8 by placing his arms around Resident # 8's neck, initiating a choke hold. The facility investigation, undated, documented that the resident to resident altercation did occur.An interview was conducted with CNA (Staff # 85) on April 30, 2026 at 2:11 p.m. who stated that Resident # 9 was at the table playing with blocks and stacking them. Staff # 85 stated that Resident # 9 got up and walked away while Resident # 8 came in the room and sat down across from the blocks. Staff # 85 stated that Resident # 9 told Resident # 8 not to touch his block but Resident # 8 took his arm and knocked the blocks all over. Staff # 85 stated that Resident # 9 got upset and walked behind Resident # 8 and put him in a headlock. Staff #85 stated that she had to bribe Resident # 9 with ice cream in order for him to let go of Resident # 8 and follow her. An interview was conducted with CNA (Staff #88) on April 20, 2026 at 2:19 p.m. who stated that Resident # 9 was playing with his blocks when he got up and walked away from the table distracted. Staff # 88 stated that Resident # 8 came in sat down and knocked all the blocks across the table which angered Staff # 9. Staff # 88 stated that Resident # 9 came up behind Resident # 8 and grabbed Resident # 8's neck with his arms. Staff # 88 stated they had to offer Resident # 9 snacks in order to let him go and out of the room. An interview with LPN (Staff # 146) on May 1, 2026 at 8:30 a.m. who stated that it was reported to her that Resident # 9 was building blocks on the table and got up to talk with another resident and Resident # 8 sat down by the blocks. Staff # 146 stated that Resident # 8 knocked the blocks down and Resident # 9 approached Resident # 8 from behind and put Resident # 8 in a headlock. Staff # 146 stated that she did an assessment on Staff # 8 after they were separated and found no injuries.An interview with Director of Nursing (DON/Staff # 199) on May 1, 2026 at 10:10 a.m. who stated that the incident between Resident # 8 and Resident # 9 should have never happened. Staff # 199 stated that the staff were all over in the day room and saw the incident building to the moment Resident # 8 knocked the blocks over and allowed Resident # 9 to get close enough to Resident # 8 did not meet her expectations. The DON stated that the concern for not anticipating is that residents could abuse other residents. Regarding Resident #10 and Resident # 11:-Resident # 10, the alleged victim, was admitted [DATE] with diagnoses that included dementia with agitation, major depressive disorder, and post-traumatic stress disorder. The behavioral care plan dated February 16, 2026 revealed current behaviors of anxiety and agitation. The behavioral care plan further revealed triggers which included feeling confused. The annual MDS assessment dated [DATE], revealed a BIMS score of 11, indicating that the resident had moderate cognitive impairment. The annual MDS revealed no behaviors for the resident.An alert note dated April 24, 2026 documented that Staff # 146 was at the nursing station when Resident # 10 was seen exiting his room towards the hallway, Staff # 146 noticed that Resident # 10 was getting too close to Resident # 11. The alert note revealed that Resident # 11 got agitated when another Resident yelled 'call 911' repeatedly. The note documented that Resident # 11 was observed holding Resident # 10 by the throat and slammed Resident # 10 against the wall.A skin assessment dated [DATE] revealed a new skin tear on Resident #10's left upper arm. -Resident # 11, the alleged perpetrator, was admitted [DATE] with diagnoses that included senile degeneration of the brain, early onset Alzheimer's disease, and alcohol abuse. The discharge MDS assessment dated [DATE], revealed that resident # 11 had a BIMS score of 3, indicating that the resident had severe cognitive impairment. The discharge MDS also revealed other behavioral symptoms not directed towards others.An alert note dated April 24, 2026, revealed (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	05/01/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that Resident # 11 was mostly wandering during the overnight shift. At approximately 4:40 a.m. Resident # 11 tried to charge at a nurse and grab the nurse's arm. The alert note documented that Resident # 11 seemed angry for no reason trying to fight staff and wandering. note documented that Resident # 11 seemed angry for no reason trying to fight staff and wandering. An alert note dated April 24, 2026, revealed that attempts were made to contact Resident's hospice nurse to see what could be done with Resident # 11's aggression. The alert note documented that Resident # 11 had tried to hit two nurses and a CNA. An alert note dated April 24, 2026 at 12:50 p.m. revealed that Staff # 146 was sitting at the nursing station when Resident # 11 was walking with CNA # 131 in the hallway. The alert note documented that Resident # 10 was seen exiting from his room toward the hallway when another Resident started yelling 'call 911' over and over again. The nursing note revealed that Staff # 11 got agitated and angry and Staff # 146 observed Resident # 11 holding Resident # 10's throat and slammed Resident # 10 against the wall. The facility investigation, undated, documented that the altercation did occur.An interview was conducted on April 30, 2026 at 2:37 p.m. with CNA (Staff # 131) who stated that when she started her shift Resident # 11 was brand new to her and that Staff # 131 was told by the previous shift that Resident #11 was aggressive and strong. Staff # 131 stated that she started walking with him as he wandered up and down the hall as it seemed to ease some of his aggression. Staff # 131 stated that as she was coming off her lunch break to go back and walk with Resident #11 when she runs into Resident # 10 who asked where the exits were. Staff # 131 stated that she noticed how close Resident # 11 and Resident # 10 were getting while another resident was sitting on a bench. Staff # 131 stated that while she was redirecting Staff # 10 away from Staff # 11 the resident sitting on the bench stands up and yells 'call 911' several times. Staff # 131 stated that she noticed Resident #11 get angry and upset at which point she tried to push Resident #10 away from Resident # 11 but Staff # 131 was the only one there at the moment and Resident # 11 grabbed Resident # 10 by the neck and started choking him. Staff #131 stated other staff came to help and separate the residents. Staff # 131 ended up taking Resident # 10 away into his room closing the door. An interview was conducted on May 1, 2026 at 8:21 p.m. with CNA (Staff # 84) who stated that she was in the day room doing an activity when she heard a resident yelling call 911. Staff # 81 stated she left the day room and saw Resident # 11 choking Resident # 10 and the staff helped separate the residents.An interview was conducted on May 1, 2026 at 8:30 a.m. with Staff # 146 who stated that she was at the nurses' station doing documentation while Staff # 131 was walking Resident # 11 back and forth in the hall way. Staff # 146 stated that she noticed Resident # 10 come out of his room and speak with Staff # 131. Staff # 146 stated that she noticed how close Resident # 10 was to Resident # 11 and that another Resident was sitting on a bench talking which was making Resident # 11 upset. Staff # 146 stated that she told Staff # 131 to move Resident # 10 but as she was trying to do that, the resident sitting on the bench stood up and yelled 'call 911' several times. Staff # 146 stated that this made Resident # 11 extremely mad. She stated that he started cussing and moved quickly towards Resident # 10, grabbing Resident # 10 by the neck. Staff # 146 stated that all staff got up and separated the Residents and that they called the police, who eventually took him out of the facility. During an interview with Director of Nursing (DON/Staff # 199) on May 1, 2026 at 10:10 a.m., staff #199 stated that Resident # 11 was a hospice respite stay, because his wife needed a break. Staff # 199 stated that Resident # 11 was agitated from the start and staff had a difficult time administering medications. Staff # 199 stated that Resident # 11 had started choking Resident # 10 and slamming him against the wall. The DON revealed the Crisis team was called and Resident # 11 was removed from the facility. Staff # 199 stated that her expectation is staff be proactive and identify potential aggression before it hap

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	05/01/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 repeat resident to resident abuse and update individualized resident interventions for three of eleven residents sampled (#1, #2, and #4). 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 #1:Resident # 1, was admitted [DATE], with diagnoses that included dementia, mood disorder due to known physiological condition with manic features, and alcohol dependence. A nurse's note dated February 20, 2026, revealed that Resident #1 approached the nurse's station crying and reported Resident #2 hit her in the nose. The note revealed both residents were placed on 15-minute safety checks and closely monitored. A nurse's note dated April 13, 2026, revealed that a Certified Nursing Assistant (CNA) notified the nursing staff that Resident #2 grabbed Resident #1 by face/lip area during an altercation. The note indicated both residents were placed on15-minute safety checks and closely monitored. The care plan initiated on April 14, 2026, revealed that Resident #1 has psychosocial well-being problem related to a resident-to-resident altercation with interventions that included, 72-hour observation, consulting with pastoral care, social services, psychiatry services, monitoring resident's usual responses, and when conflict arises remove residents to calm safe environments. Further review of the care plan revealed no indication that Resident #1 and Resident # 2 were in a previous altercation on February 20, 2026. The care plan also failed to indicate previous interventions that were in place as a result of the first altercation. Review of an undated facility investigation report revealed interventions that were implemented after the April 13, 2026 incident included a staff member present in the pavilion as long as Resident # 1 or Resident #2 are present at all times. Further review of the care plan revealed no intervention of staff members needing to be in the pavilion when either Resident #1 or Resident #2 are present. -Regarding Resident #2:Resident # 2, was admitted on [DATE], with diagnosis that included personality disorder, anxiety disorder, adjustment disorder, and depression.A nurses note dated February 20, 2026, revealed the resident stated she was tired of resident #1 opening her door which led her to hit Resident #1.A nurses note dated April 13, 2026 revealed that a CNA reported to the nurse that Resident #2 grabbed Resident #1's face by her mouth while Resident # 1 was trying to move away from her. The nurses note documented that Resident #2 stated 'Yeah I grabbed her by the face. I don't like her!' The care plan initiated on April 14, 2026, revealed that Resident #2 has psychosocial well-being problem related to a resident-to-resident altercation with interventions that included, 72-hour observation, consulting with pastoral care, social services, psychiatry services, monitoring resident's usual responses, and when conflict arises remove residents to calm safe environments. Further review of the care plan revealed no indication that Resident #1 and Resident # 2 were in a previous altercation on February 20, 2026. The care plan also failed to indicate previous interventions that were in place as a result of the first altercation. A undated facility investigation report revealed interventions that were implemented after the April 13, 2026 incident which included a staff member present in the pavilion as long as Resident # 1 or Resident #2 are present at all times. Further review of the care plan revealed no intervention of staff members needing to be in the pavilion when either Resident #1 or Resident #2 are present. An interview was conducted with CNA (Staff # 67) on May 1, 2026 at 9:43 a.m. who stated that Resident #1 is very confused and forgetful but can easily be redirected. She stated that Resident #2 keeps to herself. Staff #67 stated that Resident #2 gets possessive with belongings and food and gets mad if other residents touch them. Staff # 67 stated that after the incident between both staff members the staff has to keep eyes on Resident # 1 when she is out in the courtyard to try and prevent her from getting close to Resident # 2. An interview with CNA (Staff # 115) on May 1, 2026 at 9:45 a.m. stated that Resident # 2 exhibits behaviors when other residents or staff make her (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	05/01/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mad. Staff # 115 revealed that Staff # 1 wanders around a lot especially into other resident's rooms. Staff # 115 stated that Resident # 1 likes to go into Resident # 2's room because there used to be another resident who lived in that room who was sick and Resident # 1 would check on that resident when she wandered the courtyard. CNA # 115 revealed that since this last incident between Resident #1 and Resident #2 the staff now have to keep eyes on Resident #1 to prevent her wandering to Resident #2's room. An interview was conducted with the Minimum Data Set Licensed Practical Nurse (MDS LPN/Staff # 152) on May 1, 2026 at 8:47 a.m., who stated the Interdisciplinary Team (IDT) meets following resident-to-resident altercations to determine interventions which are then added to the care plan. Staff # 152 stated that in the IDT meeting it was determined that staff needed to be present in the pavilion when Resident # 1 or Resident # 2 are present. Staff #152 reviewed the current care plan and stated this intervention was not in the care plan and probably should be. Staff # 152 stated the concern for this intervention not being in the care plan is that staff would not know this intervention was in place and the Residents could get in another altercation.An interview was conducted with the Director of Nursing (DON/Staff # 199) on May 1, 2026 at 10:10 a.m. who stated that during her investigation she found out that Resident # 1 and Resident # 2 had an argument and as Resident #1 was trying to get up to leave when Resident # 2 grabbed Resident # 1 by the face. Staff # 199 stated that this is the second altercation between the two residents. She stated they added the 1:1 for Resident # 1 and Resident # 2 when in the courtyard to help prevent further altercations. Staff # 199 stated that this intervention should be in the care plan, but when Staff # 199 reviewed the care plan for this intervention she stated that she could not find it. She stated the concern is, if it is not in the care plan, that staff could be unaware of the intervention and the residents could have another altercation. -Regarding Resident # 4Resident # 4 was admitted on [DATE], with diagnoses that included Huntington's disease, schizoaffective disorder, and personal history of traumatic brain disorder. The care plan initiated on March 23, 2026, revealed that Resident # 4 had a potential to be physically aggressive related to poor impulse control and a history of aggressive behaviors toward others. Interventions included intervening when resident becomes agitated, asses and anticipate resident's needs, and administration of medication.A nurse's note dated April 13, 2026, revealed that the nurse was informed by CNA # 76 that this resident was in Resident #3's room and was hitting Resident #3.The care plan initiated on April 14, 2026, revealed that Resident #4 has a psychosocial well-being problem related to a resident-to-resident altercation with interventions that included, 72-hour observation, consulting with pastoral care, social services, psychiatry services, monitoring resident's usual responses, and when conflict arises remove residents to calm safe environments.A Psychiatry note dated April 14, 2026 revealed that Resident #4 was seen following the altercation with Resident #3. The note revealed that Resident #4 was put on 1:1 supervision for safety. A facility investigation report, undated, revealed interventions that were implemented after the April 13, 2026 incident included placing the Resident on a 1:1 to prevent future altercations.Further review of the care plan revealed no intervention of Resident #4 on being placed on a 1:1.An interview was conducted on May 1, 2026 at 9:10 a.m. with Licensed Practical Nurse (LPN/Staff # 161) who stated that Resident # 3's behaviors included being verbal, manipulative, and narcissistic. Staff # 161 stated that Resident # 4 is very physical with his aggression and anything can trigger him. Staff # 161 stated that Resident # 4 had been physical with staff since his admission and that anything can trigger the aggression. Staff # 161 stated that the sitter that was assigned to him has helped keeping him under control especially since she has to cover both 500 and 600 wings and can't be in both places at once. An interview was conducted with Minimum Data Set Licensed Practical Nurse (MDS LPN/Staff # 152) on May 1, 2026 at 8:47 a.m., who stated that after all resident-to-resident altercations the Interdisciplinary Team would meet to discuss the incident and interventions that need to be put into place. Staff # 152 further stated that once the interventions were decided, they are placed in the care plan. Staff # 152 stated that Resident # 4 had some medication adjustments after the altercation and the IDT team had placed Resident # 4 on a 1:1. Staff # 152 reviewed the care plan and stated that the (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	05/01/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1:1 was not in the care plan interventions. Resident # 152 stated that the concern for not documenting the 1:1 in the care plan, is staff not being aware that a one on one is needed and he could attack another resident. An interview with Director of Nursing (DON/Staff # 199) was conducted on May 1, 2026 at 10:10 a.m. who stated that their investigation determined that Resident # 4 was witnessed by staff in Resident # 3's room swinging at Resident # 3. Staff # 199 stated that due to history of Resident # 4's aggression they had placed him on a 1:1 to help avoid further altercations with other residents. Staff # 199 reviewed the care plan and stated that the intervention of the 1:1 was not in the care plan, She stated that it needed to be in the care plan for documentation purposes and to let staff know what interventions were in place. 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. The policy revealed that the ITD team reviews and updates the care plan: when there has been a significant change in the resident's condition, and when a desired outcome is not met.