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	05/19/2026

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, review of clinical record and policy review, the facility failed to protect the rights of 2 of 6 residents sampled (#2, #3) 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 #2: -Resident # 2, the alleged victim, was admitted [DATE] with diagnoses that included paraplegia, schizoaffective disorder, and major depressive disorder. Review of physician orders dated May 4, 2026 revealed behavioral tracking to monitor behaviors including threatening others, screaming, yelling, cursing, name calling, sexually inappropriate comments, racial slurs, and abrasive tone. A nurses note dated May 6, 2026 documented that Resident #2 received physical aggression by another resident. The note revealed that nursing staff observed Resident #2 and Resident #3 having a verbal altercation. The nurses noted revealed that Resident #2 claimed he was punched in the chest by Resident #3. The note documented that he claimed there was a little 'sting' from the punch but denied any serious pain. Regarding Resident #3: -Resident # 3, the alleged perpetrator, was admitted [DATE] with diagnoses that included adjustment disorder, major depressive disorder, mood disorder, and anxiety disorder. A comprehensive care plan dated March 24, 2025 revealed that during discharge planning at times Resident #3 expresses that he does not need to be placed in a secured facility and denies history of behaviors. Further review of the care plan revealed that Resident #3 has a long history of documented behaviors and placement in behavioral facilities. A behavioral care plan dated April 15, 2026 documented that Resident #3's triggers included assistance from staff and cigarettes. The behavioral care plan revealed the current behaviors for Resident #3 as medication seeking behavior, obtaining contraband, cheeking medications, refusal of care and treatments, and agitation if does not get to smoke. Interventions include staff responding with calm understanding, acknowledging frustrations and avoid arguing about rules; instead redirect and support coping strategies. A quarterly MDS assessment dated [DATE] revealed a BIMS score of 15 indicating he is cognitively intact. The MDS assessment revealed that Resident # 3 has a history of rejecting cares. A Nurses Note dated May 6, 2026 reveal that Resident #3 initiated physical aggression towards resident #2. The nurses note documented that Resident #3 was observed having a verbal altercation with Resident #2 by nursing staff. The nurse's note revealed that Resident #3 stated there were no problems and residents were separated with 15 minute checks.6 A Social Services note dated May 6, 2026 revealed that Resident #3 was moved from room [ROOM NUMBER]A to room [ROOM NUMBER]. An IDT Note dated May 6, 2026, documented that Resident #3 claimed he did not touch Resident #2 and no injuries were noted. The IDT note documented that Resident #3 was moved off from Arbor unit and changed to a more secured unit as an intervention. A nursing note dated May 7, 2026 revealed that Resident #3 was having verbal behaviors toward floor nurse requesting pain medications prior to scheduled administration time. The nurse note also revealed that upon being informed medications would be administered only as a ordered, the resident became verbally agitated and argumentative with nursing staff. A facility investigation report, undated, revealed a witness statement dated May 6, 2026 from (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 - Few	Certified Nursing Assistant (CNA, Staff #25) who documented that Staff # 25 was working on the unit around 9:20 p.m. when she saw Resident #3 and Resident #2 arguing with each other and cursing at each other. The witness revealed that Resident #3 was the one who started the verbal altercation using the 'N' word at Resident #2. The facility report did not provide any conclusions to their investigation, however they did provide interventions including Resident #3 being moved to a different unit to prevent further altercations. An interview was conducted with Resident #2 on May 18, 2026 at 3:13 p.m. who stated that Resident #3 was his roommate and during the day while they were in the room together, before smoke break, Resident #3 hits Resident #2 in the chest for not giving Resident #3 money. Resident #2 stated that Resident #3 kept calling me 'nigger' and 'punk'. Resident #3 stated that the physical punch did not hurt him but he was hurt and angry by the racial slurs. An interview was conducted with Resident #3 on May 18, 2026 at 3:31 p.m. who stated that he never had any problems with any residents. Resident #3 stated he has never fought or swore at any other residents while here at the facility. An interview was conducted with Assistant Director of Nursing (ADON/Staff # 155) who stated that a verbal altercation was witnessed by staff between Resident #2 and Resident #3. Staff #155 stated that she heard Resident #2 tell a nurse that Resident #3 had hit him in the chest and if Resident #3 is not moved Resident #2 will break Resident #3's neck. Staff #155 stated that Resident #3 was known for verbally antagonizing and saying degrading things to staff and residents. Staff #155 stated it was determined to move Resident #3 to the 600 hall where he could be monitored more closely. Staff #155 stated abuse can be physical and verbal and verbal abuse can be anything that is demeaning, derogatory, or threatening to another person. Staff #155 stated racial slurs at another resident would be considered abuse. An interview was conducted with Director of Nursing (DON/Staff #159) on May 19, 2026 at 11:28 p.m. stated that Resident #2 was in the same room as Resident #3 and they were not able to determine if the punch was thrown or who started what but placed interventions on Resident #3 by moving him into the 600 because we had the room in there. The DON stated that racial slurs and putting someone down is considered verbal abuse and the concern would be verbal usually leads to physical harm. 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 and verbal abuse.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review, the facility failed to ensure wound was monitored and treated for 1 of 3 residents sampled for wound care (Resident #1). The deficient practice resulted in the development of maggots in the wound bed. Findings include: Resident #1 was admitted on [DATE], with diagnoses that included unspecified dementia, type 2 diabetes mellitus, essential hypertension, peripheral vascular disease, and diabetic neuropathy. A comprehensive care plan dated February 12, 2025, revealed that Resident #1 has peripheral vascular disease (PVD) related to diabetes mellitus. Interventions included monitoring, documenting, and reporting as needed any signs or symptoms of skin problems related to PVD including redness, edema, blistering, cuts, and other skin lesions. Further review of the interventions for the diabetes mellitus documented to monitoring, documenting, reporting as needed any signs or symptoms of infection to any open areas, including redness, pain, heat, swelling, or pus formation. A physician's order dated January 15, 2026 revealed that staff were to monitor a corn on right foot pinky toe and to report any signs or symptoms of infection to MD. Review of the annual Minimum Data Set (MDS) dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) of 3, indicating that the resident had sever cognitive impairment. The MDS assessment revealed no indication of wounds including foot problems such as infection of the foot, diabetic foot ulcers, and other open lesions on the foot. The CNA (certified nurse assistant) skin inspection reports dated April 24 and 28, 2026 included skin was good. The documentation did not include any skin issues. The nursing note dated April 29, 2026 included resident will be monitored for skin irritation, redness, or adverse reaction. Review of skin assessment dated [DATE] documented no new skin issues and feet were dry. A physician order dated May 3, 2026 included for a wound consult and treatment with skilled wound care surgical group until wounds are resolved. An alert note dated May 5, 2026, documented a new physician order to cleanse and apply xeroform and secure with dry sterile dressing. A alert note dated May 5, 2026, documented by Licensed Practical Nurse (LPN/Staff #143) revealed that a CNA notified the LPN (Staff #143) of an old saturated dressing on the right foot; and that, the bandage was removed and noted an open area with serosanguinous drainage to the right outer foot. The nurse documented that it was painful to the touch and the skin surrounding the wound was peeling. The note also documented that the dressing was changed and power of attorney, doctor, Assistant Director of Nursing were notified. However, there was no documentation found in the clinical record that the resident had physician orders for or was receiving treatment to the right foot wound prior to or on May 5, 2026. The IDT (interdisciplinary team) note dated May 5, 2025 included a plan to continue with wound treatments and wound team consult. A skin assessment dated [DATE] revealed a new skin finding to the right outer foot. The skin assessment documented that the right outer foot was noted with an old saturated dressing, indicating the wound was not new. A nurses noted dated May 6, 2026, by LPN/Staff #141, who documented that during cares a CNA notified the writer that the wound dressing to right foot was saturated form the drainage. The nurse documented that upon removing the dressing from the right foot, 5-10 white active larvae were observed in the wound bed. The nurses note revealed that larvae were removed via irrigation with normal saline, wound bed was cleansed and area around wound was cleaned. A physician orders dated May 6, 2026 included the following:Cleanse the right foot wound with normal Saline or Wound cleanser, pat dry, apply calcium alginate and cover with dry dressing and change daily and PRN (as needed) for dislodged or saturated dressing; and,Cleanse wound with betadine, apply xeroform and DSD (dry sterile dressing) and change daily and PRN every day shift for wound care. The order did not include the location of the wound to which this treatment was to be applied.These orders was transcribed onto the TAR (treatment administration record) for May 2026 and revealed the following:The PRN order for calcium alginate to right foot was not marked as administered as ordered on May 6 and the order was documented as discontinued on May 7, 2026; (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	and,The order for xeroform and DSD was documented as administered and discontinued on May 6. The CNA skin inspection report dated May 8, 2026 revealed wound on the lower front and back of right foot. A wound care surgical note dated May 8, 2026 revealed that the would was located on the small toe, lateral area of right foot with an open area measuring 4.5 cm (centimeters) x 3 cm x 0.1 cm. A CNA skin inspection report with eligible date of May 8 or 18, 2026 included corn wrapped. Review of the TAR (treatment administration record) for May 2026 included that the physician order to monitor corn on the right foot pinky toe was transcribed and was documented as administered from May 1 through 17, 2026. A telephonic interview was conducted on May 18, 2026 at 3:52 p.m. with LPN (Staff #141) who stated that on the night of May 6 he was notified by a CNA that the resident's (#1) bandages were soaked and needed to be changed. Staff #141 stated upon removing the bandages he noted some abnormal findings including larvae in the wound bed and on the bandage. Staff #141 stated that they had been monitoring the corn on the right foot but not sure how the wound on the right foot started or when it started. Staff # 141 stated he cleaned out the wound with saline and rewrapped the wound and notified his manager and doctor. An interview was conducted on May 19, 2026 at 9:41 a.m. with LPN (Staff #143), who stated that when she arrived to work on May 5, 2026 and she was surprised and upset to see a bandage on Resident #1's right lateral foot. Staff #143 stated she was upset seeing the bandage on the right foot because there was no documentation regarding what happened to the foot and what treatment had been done besides just the bandage. Staff #143 stated that she knew the bandage was not there on May 1, 2026 during her shift because she had done a skin assessment and there was no bandage or wound on the right foot. Staff #143 stated that when she removed the bandage she saw the circular wound but not maggots. Staff #143 stated the the concern for not reporting wounds initially is they don't get properly monitored and infection could occur. An interview was conducted on May 19, 2026 with CNA (Staff #99), who stated that she was off of work for a while and when she came back to work about 2-3 weeks ago, she could not remember the exact date, she noticed blood on Resident #1's right lateral foot. Staff #99 reported there was a fair amount of blood and she had notified Registered Nurse (RN/Staff #205) who bandaged the foot. A request for information regarding Staff #205 revealed that staff #205 was terminated on May 2, 2026 for not completing a two week notice. An interview was conducted on May 19, 2026 with Director of Nursing (DON/Staff #159) stated that it is her expectation that any new wounds should be documented into PCC and a skin assessment done along with contacting the DON as well as the physician. The DON stated that Resident #1 had a corn on her right lateral foot in which they were monitoring and at some point it fell off causing the bleeding. She stated once that she was made aware of the wound the wound doctor was notified and Resident #1 was seen by the wound doctor on May 8, 2026. DON reviewed nursing note from Staff #141 and stated that Staff #141 is not a wound nurse and is unable to diagnosis larvae in a wound. The DON stated the concern that a new wound not documented when discovered could lead to improper or delayed treatment and infections. A policy titled, Wound Care revised October 2010, included a purpose to provide guidelines for the care of wounds to promote healing; and, to verify that there is a physician order for wound care. It also revealed that any wound care should be documented in the resident's medical record, with information that includes the type of wound care given, the date and time the wound care was given, the name and title of the individual providing wound care, any changes in the resident condition, all assessment data obtained when inspecting the wound and the signature and title of the person recording the data. The policy revealed that reporting of any changes to wounds must be done in accordance with facility policy and professional standards of practice.