STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035217	A. BUILDING _____ B. WING _____	01/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SCOTTSDALE VILLAGE SQUARE	2620 NORTH 68TH STREET SCOTTSDALE, AZ 85257

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on clinical record reviews, facility documentation, staff interviews and policy review, the facility failed to ensure that one resident (#23) was free from physical abuse by resident (#87), and that two residents (#54 and #84) were free from physical abuse. The deficient practice could result in further incidents of resident to resident abuse. Findings Include: -Resident #23 was admitted to the facility on (MONTH) 22, (YEAR), with [DIAGNOSES REDACTED]. Review of the clinical record revealed that resident #23 resided on the high acuity Behavioral Unit. A behavioral care plan included the resident had physical and verbal behaviors with staff. A goal included for a decrease in symptoms. Interventions included determining the cause of the behaviors, redirection, and encourage the resident to attend activities. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had no cognitive impairment. The MDS included the resident required limited assistance with ADL's (activities of daily living). -Resident #87 was admitted to the facility on (MONTH) 26, (YEAR), with [DIAGNOSES REDACTED]. Review of the clinical record revealed resident #87 resided on the high acuity Behavioral Unit. A behavioral care plan included the resident had a history of [REDACTED]. A goal included for a decrease in symptoms. Interventions included determining the cause of the behaviors, redirection, and encourage the resident to attend activities.Review of a quarterly MDS assessment dated (MONTH) 14, 2019 revealed a BIMS score of 9, which indicated the resident had moderate cognitive impairment. The MDS included that the resident required supervision with most ADL's. Review of the facility's Investigative report revealed that on the afternoon of (MONTH) 8, 2019, resident #87 was walking past resident #23 in the day room, and stopped to yell at resident #23. Resident #87 then hit resident #23 on the right arm with a hairbrush. Resident #87 then attempted to hit resident #23 a second time, but the strike was blocked by resident #23's raised right arm. The residents were separated, and escorted back to their rooms. Both residents quickly calmed down. Resident #87 was found to have two very small lacerations to her right hand with scant blood. Resident #23 was not injured.An interview was conducted on 1/3/2020 at 1:21 p.m. with a certified nursing assistant (CNA/staff #92). Staff #92 stated that she witnessed the incident that happened on (MONTH) 9, 2019. She stated that she heard resident #87 yell something at resident #23, and soon both residents were yelling at each other. Staff #92 stated that she saw resident #87 hit resident #23 on her right arm with a hairbrush. She said that resident #87 attempted to hit resident #23 a second time, but her arm was blocked by resident #23. An interview was conducted with a Licensed Practical Nurse (staff #224) on 1/3/2020 at 1:27 p.m. Staff #224 stated that she witnessed the altercation between resident #87 and #23. She added that resident #87 yelled at resident #23 and hit her on her right arm with a hairbrush. She said that resident #87 did swing the hairbrush a second time at resident #23, but #23 was able to block the hairbrush. Staff #224 said she did find two small scratches on resident #87's right hand and that she assumes the scratches were caused by the blocking motion of resident #23. -Resident #84 was admitted on (MONTH) 4, 2019 with [DIAGNOSES REDACTED]. A behavior care plan related to [MEDICAL CONDITION] disorder was initiated on (MONTH) 5, 2019. A goal was to have fewer symptoms. Interventions were to redirect behaviors, follow behavior plan and psychiatric follow up as ordered. The admission MDS assessment dated (MONTH) 11, 2019 revealed the resident scored 11 on the Brief Interview for Mental Status, indicating the resident had moderate cognitive impairment. The resident's behaviors included delusions and verbal behavioral symptoms for 1-3 days out of 7. The MDS indicated the resident was currently considered by the state level II Preadmission Screening and Resident Review (PASRR) to have serious mental illness (SMI). A nursing progress note dated (MONTH) 8, 2019 at 8:00 a.m. revealed that at approximately 7:30 a.m., resident #84 and resident #54 had been arguing in the dining room during breakfast. Resident #54 was taken to her room. At approximately 7:50 a.m., resident #54 came out of her room and was self-propelling herself towards the day room as resident #84 came out of the day room. Resident #84 started yelling when she saw resident #54. Once she was close enough, resident #84 began to posture at resident #54. The note stated that resident #54 lifted her leg up from a seated position in her wheelchair, and kicked resident #84 in the abdomen. Before staff approached, resident #84 punched resident #54 on the right side of her face with a closed fist. Resident #54 sustained a bruise under her right eye and a scratch to the right side of her face. A physicians' order was received to have both residents eat in their rooms for the rest of the day and to keep them separated for 24 hours. -Resident #54 was admitted on (MONTH) 6, (YEAR) with [DIAGNOSES REDACTED]. A behavioral care plan related to [MEDICAL CONDITION] disorder included a target behavior of physical aggression to peers. Staff approaches included at the first sign of being upset towards a peer they are to be immediately separated, if persists, the resident is to be removed for a minimum of 30 minutes, if the resident acts physically aggressive to anyone, she is to go to her room for a minimum of 2 hours, with all special privileges suspended, if at mealtime, she may return after peers are done to finish her meal and may come out of her room after two hours, once she is visibly calm. A behavior care plan related to [MEDICAL CONDITION] disorder/[MEDICAL CONDITIONS], borderline personality disorder and [MEDICAL CONDITION] disorder included a goal to have fewer symptoms. Interventions included to attempt to redirect behaviors, follow behavior plan and psychiatric follow-up as ordered. The quarterly MDS assessment dated (MONTH) 22, 2019 revealed the resident scored a 15 on the BIMS assessment, indicating she was cognitively intact. The MDS included the resident required set-up and supervision of one person physical assistance for activities of daily life (ADLs). The behaviors included delusions and verbal behaviors directed toward others (1-3 days out of 7). A nursing progress note dated (MONTH) 8, 2019 included the physical altercation between resident #54 and resident #84. An interview was conducted on (MONTH) 6, 2020 at 1:37 p.m., with a restorative nursing assistant/certified nursing assistant (staff #52). She stated that her process for redirecting residents during an altercation would include separating them and giving them both a verbal warning to calm down. After that, she would implement their care plans. She stated that she would tell the nurse immediately after the residents had been separated. She said when residents begin to be aggressive verbally, staff keep an eye on them for the whole day. She said she doesn't know exactly what is written in the residents' behavioral care plans, but she knows they are supposed to be separated. On (MONTH) 6 2020 at 1:43 p.m., an interview was conducted with a Licensed Practical Nurse (LPN/staff #184). She stated her

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	(continued... from page 1) process would be to separate the residents. She stated that normally, they would be separated until they are calm. She stated that either a CNA or nurse would monitor the resident(s) to ensure they were calm before they would be allowed to come back into the general population. As she understands, that is what the residents' behavioral care plans say. She said staff can tell by the resident's demeanor and tone whether or not the residents are calm. She said if the residents are still posturing, then they are probably not calm enough to return. She stated that when both residents are agitated, they make it known and nursing staff should be able to tell. On (MONTH) 6, 2020 at 1:51 p.m., an interview was conducted with the Director of Nursing (DON). She said that her expectation is to immediately separate and distract the residents. She said that some of the residents have behavioral plans that specify exactly what staff are supposed to do. She said the goal would be to diffuse and deter any aggression. She stated that her expectation would be for the residents to be separated for at least 30 minutes, per their behavior plan. Review of a policy titled, Abuse & Neglect revealed the facility is committed to protecting residents from abuse by anyone, including other residents. A policy titled Behavioral Assessment, Intervention and Monitoring stated the interdisciplinary team will evaluate behavioral symptoms in residents to determine the degree of severity, distress, and potential safety risk to the resident, and develop a plan of care accordingly. The care plan will incorporate findings from the comprehensive assessment and be consistent with current standards of practice. The care plan will include, at a minimum, a description of the behavioral symptoms, targeted and individualized interventions for the behavioral and/or psychosocial symptoms, and how the staff will monitor for effectiveness of the interventions. According to a policy titled, Safety and Supervision of Residents, resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment.