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

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.

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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.
F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, interviews and policy review, the facility failed to ensure an allegation of abuse involving two of seven sampled residents (#60 and #72) was immediately reported to the Administrator and reported to the State Agency (SA) within 2 hours after the allegation was made. The deficient practice could result in further abuse incidents not being identified timely and corrective action implemented and reported to the S[NAME] Findings include: -Resident #72 was admitted to the facility on (MONTH) 6, (YEAR) with [DIAGNOSES REDACTED]. -Resident #60 was admitted to the facility on (MONTH) 21, 2019 with [DIAGNOSES REDACTED]. An Interdisciplinary Team (IDT) note dated (MONTH) 11, 2019 included that today at 10:30 a.m., a family member of resident #72 reported to the social services coordinator (staff #40) that resident #72's roommate (resident #60) hit resident #72 on purpose on the head, on the right side temple area on the night of (MONTH) 6, 2019. Resident #72 reported that he and resident #60 were not arguing and did not have a conflict. He reported that he was sitting in his wheelchair, when resident #60 came over and hit him in the head. Resident #72 stated it did not hurt and he asked resident #60 why he did that and resident #60 did not respond. Resident #60 was interviewed and denied hitting or having any altercation with his roommate, resident #72. Review of the facility's investigative report dated (MONTH) 18, 2019 included that a resident to resident incident took place on (MONTH) 6, 2019. The report included that resident #72 reported that his roommate, resident #60, hit him twice on the side of his head in their room, which was unprovoked. The report included that the incident was unwitnessed and there were no physical indications that this occurred. Further, the report revealed resident #60 was interviewed and denied the allegation. Further review of the investigative report revealed an interview with a Licensed Practical Nurse (LPN/staff #27) dated (MONTH) 11, 2019, which included the social service coordinator (staff #40) reported that a family member of resident #72 spoke to him on the phone and he mentioned that on (MONTH) 6, 2019, his roommate, resident #60 punched him in the head, while he was in his room. The report also included an interview dated (MONTH) 11, 2019, with a LPN (staff #231). She reported that resident #72 did tell her that his roommate hit him in the head for no reason. She reported that resident #72 told her that the night shift nurse (LPN/staff #27) was aware. The report also included an interview dated (MONTH) 11, 2019, with the nurse who worked the night shift on (MONTH) 6, 2019, LPN (staff #143). She stated this incident was not reported to her on her shift on (MONTH) 6. In addition, the investigative documentation was completed on (MONTH) 11, 2019, and the State Agency (SA) report was not completed online until 2:32 p.m. In an interview with staff #231 on (MONTH) 6, 2020 at 10:44 a.m., she stated that she was coming on shift in the morning when resident #72 reported to her that resident #60 hit him in the head. She stated that she asked resident #72 if he had reported this to the night shift nurse and he said he had. She stated she did not remember who the night shift nurse was but at the time, she assumed the night shift nurse reported it to the proper people. An interview was conduced on (MONTH) 7, 2020 at 8:40 a.m. with the Director of Nursing (staff #96). She said if there is an allegation of abuse, the first thing to do is to ensure the resident(s) safety and to assess for injury. She stated if it is a resident to resident incident, the residents are separated immediately. She said the allegation should be reported immediately to the charge nurse and/or DON and then it needs to be reported to the SA within 2 hours. She stated with this incident, the social services coordinator (staff #40) reported it to her, and the LPN (staff #231) did not report it because she thought the night nurse (staff #27) had reported it and taken care of everything. Review of facility policy titled, Abuse & Neglect dated (MONTH) (YEAR) included the investigation process begins when the Administrator or the Director of Nursing receives information that abuse or neglect may have taken place. Information may come from a staff member, a resident, visitor, or family member, a resident advocate, another agency, or other sources. Information may be received orally, in writing or via electronic communications .All alleged or suspected violations involving mistreatment, neglect or abuse including injuries of unknown origin, involuntary seclusion and misappropriation of elder property are to be reported immediately to the Unit Manager or Charge Nurse. The policy also included that the SA requires 24 hour notification of abuse allegations. However, the regulation states that allegations of abuse/neglect are to be reported to the SA within 2 hours after the allegation is made.
F 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, staff interviews and policy review, the facility failed to ensure the care plan for one (#39) of 19 sampled residents was revised regarding hearing status. Findings include: Review of the the clinical record for resident #39 revealed a physician orders [REDACTED]. A care plan indicated the resident had moderate hearing loss, with a goal that needs will be anticipated. Interventions included to apply bilateral hearing aids in the morning, remove at bedtime, and store at nurses station. An observation was conducted on 1/2/2020 at 10:49 a.m., of resident #39 sitting in a wheelchair in the dayroom of the nursing unit. Resident #39 was yelling loudly and incoherently and was not interviewable. The resident was not wearing any hearing aides. During an interview with a Licensed Practical Nurse (LPN)/staff #62) on 1/2/2020, he stated that resident #39 does not like to wear the hearing aides.

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F 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) An observation was conducted on 1/6/20 at 8:15 a.m. and resident #39 was not wearing any hearing aides. A CNA (staff #70) stated that resident #39 refuses to wear hearing aides. When asked where her hearing aides were she stated that she did not know. Staff #70 looked in resident #39's room and was unable to find her hearing aides. Review of Certified Nursing Assistant task list for the week of 1/6/2020 revealed to apply hearing aides bilaterally in the morning and remove at bedtime for the resident. Each day the task was recorded as completed for the first week in January. During an interview with a CNA (staff #108) on 1/6/20 at 8:24 a.m., she said that she had cared for resident #39 the previous week and that the resident does not have hearing aides. During an interview with a LPN (staff #62) on 1/6/2020 at 9:00 a.m., he stated that resident #39's hearing aides were not in the nursing station or in the resident's room. During an interview with the unit manager LPN (staff #119) on 1/6/2020 at 10:26 a.m., she reviewed the clinical record and confirmed there were current physician's orders [REDACTED]. She also confirmed that the CNA's were documenting putting in and removing the hearing aides. In an interview with the Director of Nursing (DON/staff #96) on 1/6/2020 at 10:45 a.m., she stated the family had taken the hearing aides home, as resident #39 would not wear them. She confirmed there was a current physician's orders [REDACTED]. She said that they should have updated the orders and the care plan. According to a facility policy and procedure, assessments of residents are on going and care plans are revised as information about residents or condition changes.
F 0883 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Develop and implement policies and procedures for flu and pneumonia vaccinations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews, and review of policy and procedures, the facility failed to ensure 4 residents (#'s 16, 23, 94 and 72) received education regarding the risks, benefits and potential side effects of the influenza vaccination. The deficient practice could result in residents not being fully informed, which could affect their decisions regarding treatments. Findings include: -Resident #16 was initially admitted to the facility on (MONTH) 25, (YEAR), with [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated (MONTH) 9, 2019 revealed the resident scored 11 on the Brief Interview for Mental Status (BIMS) assessment, indicating he had moderate cognitive impairment. Review of an immunization audit report revealed that on (MONTH) 24, 2019, the resident had consented for and had received an influenza immunization. However, the report indicated that no immunization education regarding risks and benefits of the vaccine was provided to the resident. Further review of the clinical record did not reveal that a signed consent had been obtained prior to administration of the immunization. -Resident #23 was admitted on (MONTH) 26, (YEAR) with [DIAGNOSES REDACTED]. The quarterly MDS assessment dated (MONTH) 18, 2019 revealed the resident scored 11 on the BIMS assessment, indicating she had moderate cognitive impairment. A immunization audit report stated that on (MONTH) 23, 2019 the resident had consented for and had received, an influenza immunization. The document indicated that no immunization education regarding risks and benefits of the vaccine was provided to the resident. Further review of the clinical record did not reveal that a signed consent had been obtained prior to administration of the immunization. -Resident #94 was admitted on (MONTH) 8, 2009 with [DIAGNOSES REDACTED]. The quarterly MDS assessment dated (MONTH) 17, 2019 revealed the resident scored 11 on the BIMS assessment, indicating she had moderate cognitive impairment. An immunization audit report stated that on (MONTH) 26, 2019 the resident had consented for and had received, an influenza immunization. The document indicated that no immunization education regarding risks and benefits of the vaccine was provided to the resident. Further review of the clinical record revealed that a signed consent had not been obtained prior to administration of the immunization. -Resident #72 was admitted on (MONTH) 6, (YEAR) with [DIAGNOSES REDACTED]. The annual MDS assessment dated (MONTH) 5, 2019 revealed the resident scored 12 on the BIMS assessment, indicating he had moderate cognitive impairment. A immunization audit report stated that on (MONTH) 24, 2019 the resident had consented for and had received, an influenza immunization. The document indicated that no immunization education regarding risks and benefits of the vaccine was provided to the resident. Further review of the clinical record revealed no evidence that a signed consent had been obtained prior to administration of the immunization. On (MONTH) 7, 2020 at 2:13 p.m., an interview was conducted with the Director of Nursing (DON/staff #96). She stated that nursing provides education regarding the risks and benefits of influenza vaccines upon admission to the facility. She stated that an informed consent is obtained at that time. She stated that the education and informed consent are sufficient for the resident's stay. An interview was conducted on (MONTH) 7, 2020 at 2:38 p.m. with a Licensed Practical Nurse (LPN/staff #224). She stated that her process is to provide information sheets regarding the risks and benefits of vaccines to the resident's representative upon admission. She stated an informed consent would be obtained at that time. She said she would have to look to see if education needed to be provided every year. A facility policy titled, Influenza Vaccine included that the facility shall provide pertinent information about the significant risks and benefits of vaccines to residents (or the resident's legal representatives). The policy stated that prior to the vaccination, the resident (or the resident's legal representative) will be provided information and education regarding the benefits and potential side effects of the influenza vaccine. Provision of such education shall be documented in the resident's medical record.