STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER: Santa Rosa Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1650 North Santa Rosa Avenue Tucson, AZ 85712	

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** 47911 Based on record review and interviews, the facility failed to protect the rights of two residents (#4 and #1) to be free from abuse by other residents (#6 and #5). The deficient practice could result in further resident abuse. Findings include: Regarding Resident #4 Resident #4 was admitted on [DATE] with diagnosis of hemiplegia, hemiparesis, major depressive disorder, and adjustment disorder. A review of the MDS (minimum data set) assessment dated [DATE] revealed a BIMS (brief interview of mental status) score of 3 indicating severe cognitive impairment. A review of the care plan revealed that resident #4 had potential for psychosocial-well-being problem and had potential for behavior problem related to major depressive disorder with target behaviors that included taunting peers, slamming door, verbal agression, and physical aggression. Regarding Resident #6 Resident #6 was admitted on [DATE] with diagnoses of dementia with behavioral disturbance, impulse disorder, and unspecified psychosis. A review of the MDS assessment dated [DATE] revealed a BIMS score of 6 indicating severe cognitive impairment. Review of the care plan revealed that resident #6 had the potential for psychosocial well-being problem related to anxiety. Interventions include to encourage the resident to express feelings of anger, guilt, and frustration. (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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan also revealed that resident #6 had the potential to be physically and verbally aggressive related to poor impulse control, dementia and psychosis. Interventions inlcuded to monitor, document, report as needed any signs and symptoms of resident posing danger to self and others; redirections, one on one, activity distractions, and return to room; and communication by providing physical and verbal cues to alleviate anxiety. The 5-day investigative report dated July 28, 2023 revealed that resident #6 was having an argument with another resident on the patio when a certified nursing assistant (CNA/staff #80) intervened. It was noted that staff #80 was redirecting resident #6 back inside the unit when he encountered resident #4 in the hallway. It was documented that resident #4 was verbally taunting resident #6 and as the residents passed each other, resident #6 made contact with resident #4. It was noted that resident #4 had resulting redness to the left eye due to the encounter. A call was placed to a CNA (staff #80) on April 1, 2024 at 11:20 A.M. The call went to voicemail, and a message requesting a return call was left; however, no return call was received. A call was made to LPN (staff # 151) on April 1, 2024 at 1:55 P.M. The call went to voicemail and a message was left; however, no return call was received. An interview was conducted on April 1, 2024 at 2:15 P.M. with a CNA (staff #113). The CNA stated that she was not aware of any other incidents involving either of the residents. She stated that resident #4 can be a little verbally aggressive, but does not touch anyone. Staff #113 stated that all new hires were trained on the types of residents that they may encounter. She stated that she has had training on abuse and abuse prevention. She stated that the facility provides reminders when trainings are due. She further stated that abuse should not occur and if it does happen then staff should intervene, separate the residents, make sure they are safe, report the incident and conduct the written documentation of the incident. An interview was conducted April 1, 2024 at 3:36 P.M. with the ADON (assistant director of nursing). The ADON stated that both residents reside on a secure behavioral unit and that on July 23, 2023 resident #4 and resident #6 had a verbal altercation in the hall. She stated that resident #4 had called resident #6 a nigger. She stated that she did not recall further specifics of this incident, but stated that when a heated conversation or yelling is observed the focus is to separate the residents involved, get control of the situation and ensure the safety of everyone involved. She further stated that the expectation was that abuse do not occur, but when incidents do occur, that they are reported and that resident's safety is ensured, medications are reviewed and potential behavioral health referrals are made as warranted. --------------------------- Regarding Resident #1 Resident # 1 was admitted on [DATE] with diagnosis of senile degeneration of the brain, anxiety disorder, insomnia and COPD (chronic obstructive pulmonary disease). A review of the MDS assessment dated [DATE] revealed a BIMS score of 0 indicating severe cognitive impairment. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the resident's care plan revealed the resident had potential to be physically aggressive related to dementia and poor impulse. In addition, the care plan revealed that on August 22, 2023 resident was a victim of a resident to resident. Regarding Resident #5 Resident #5 was admitted on [DATE] with diagnosis of unspecified dementia, obsessive compulsive disorder, atrial fibrillation, major depressive disorder, and mood disorder. A review of the MDS assessment dated [DATE] revealed a BIMS score of 6, indicating severe cognitive impairment. Review of the resident's care plan revealed that the resident had potential for psychosocial well-being problem, non-compliance with potential risk for injury related to the noncompliance, impaired decision making, a history of being resistive to care, resident elopement risk, potential for communication problems due to impaired cognition and dementia. The care plan also noted that resident was the aggressor in a resident to resident altercation in August 22, 2023. The 5-day facility investigation report dated August 23, 2023 revealed that on August 22, 2023 at 4:40 P.M. residents #1 and #5 were in the dining room prior to dinner. Resident #1 was seated on resident #5's walker and resident #5 was seated on a chair. The report further noted that resident #5 wanted to get up and use his walker and motioned for resident #1 to get up; however resident #1 did not get up. Resident #5 then pushed resident #1 and subsequently struck resident #1 on the cheek when he failed to get up from the walker. A skin assessment for resident #1 and revealed initial redness, which was noted to have subsided by August 23, 2023 at 7:43 A.M. A telephone interview was conducted on April 1, 2024 at 1:38 P.M. with a RN (registered nurse, former staff #152). Former staff #152 stated that she did not observe the incident but did assist with separating the residents immediately after the incident and insured their safety. She stated that to her recollection, resident #1 did have some scratches as a result of the incident, but because it occurred so long ago, she stated that she was uncertain. She stated that post incident, the resident meal times were staggered to mitigate any future encounters. An interview was conducted on April 1, 2024 at 1:58 P.M with a hospitality aide (staff #153). Staff #153 stated that she had observed the incident from a distance. She stated that resident #5 had become upset with resident #1 for sitting on his walker and had observed resident #5 reaching out to hit resident #1. She stated that she told resident #5 that it was not nice to hit. Staff #153 stated that the dining room is a smaller space and that on this date chairs were limited and that resident #1 had sought out any available place to sit. Staff #153 stated that resident #5 did not like resident #1 taking things from him. She stated that there have been no further incidents between the two residents as resident #1 just ignores resident #5 now. She stated that there were enough staff on the unit that day but not present in the day room. She further stated that that there were days where she was in the day room all by herself with a large number of residents making it hard to keep track of everyone. She stated that sometimes, especially in the mornings it could get a little overwhelming. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on April 1, 2024 at 2:15 P.M. with a CNA (staff #113). Staff #113 stated that she was familiar with both resident and that staff #1 was noted to be a wanderer and on occasion would take things from other residents. She stated that on occasion she has had to redirect resident #5 regarding the placement of his walker in the dining room. She stated that the outburst from resident #5 that day would have been willful. Staff #113 further stated that the facility provided regular training regarding abuse and abuse prevention. Staff #113 stated that abuse should never occur. She stated that if there was an incident, she would separate the resident, ensure their safety, report it to the nurse and conduct her write-up. An interview was conducted on April 1, 2024 at 3:48 P.M. with the Administrator. The Administrator stated that training regarding abuse was conducted annually and post any abuse related incidents. The administrator stated that the expectation was that abuse do not occur and that if everyone followed policy, then there would be no need for these types of investigations. A review of the facility policy entitled abuse, neglect, exploitation and misappropriation prevention program, revised April 2021, noted that residents have the right to be free from abuse; however, per facility documentation and interviews, both verbal and physical abuse occurred.