

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  09/23/2024
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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42319</p> <p>Based on staff and resident interviews, clinical record review, facility documents, and facility policies, the facility failed to ensure that residents do not abuse other residents. This deficient practice could result in physical and psychosocial harm to the residents.</p> <p>Findings include:</p> <p>Regarding the altercation between Resident's #4 and #10:</p> <p>A self report received 9/13/2024 included It is alleged that behavioral resident (resident #4) was walking past fellow behavioral resident (resident #10) in the Tu Jhanu Unit Dining Room. As she passed by, she apparently brushed his back with her arm. It is alleged he turned around and swung his arm potentially hitting her in the back. (resident #4) was not injured. Residents were separated. (resident #10) is being relocated to another unit in the facility. Investigation has commenced and a 5-Day Report will follow upon completion.</p> <p>-Resident #10 was admitted on [DATE] with diagnoses of dementia with agitation, and Schizoaffective disorder.</p> <p>An admission MDS dated [DATE] included that this resident was severely cognitively impaired, was independent for most ADLs, and had verbal psychiatric behaviors directed at others 1-3 days of the 7 day assessment and other psychiatric behaviors 4-6 days of the 7 day assessment.</p> <p>A psychiatric note dated 8/23/2024 included this resident is transferred from haven behavioral Hospital Phoenix to be a long-term care resident at this facility. He has history of SMI dementia, schizophrenia and bipolar disorder. He was transferred from a local group home to haven Hospital on 5/8/2024. As per a note from a psychiatry care evaluation at haven behavioral Hospital in Phoenix on 5/9/2024 by Dr. [NAME], DO, where it states that he has history of SMI managed by Kodak on a court and was brought in by EMT from urgent psychiatric center for inpatient treatment of being aggressive at this group home and displaying symptoms of psychosis. He actually became acutely psychotic at his group home assaulting others in his group. He was aggressive in the nursing home and refused to take medications. He was stabilized and subsequently transferred to [NAME] care on for ongoing long-term care.</p> <p>Multiple nursing notes from 8/24/2024 to 09/12/2024 including the resident experiencing symptoms of auditory hallucinations including agitation and aggression.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Behavior Note dated 9/12/2024 included that the resident was observed on outdoor patio yelling at himself appearing to be in an argument. This note included that the resident had his fists balled up and began punching the air while we yelled Get out of here! Get out of here! Resident then went to his room and continued to pace from his room to outdoor patio as he has been since 0400.</p> <p>A nursing note dated 9/12/2023 included that his resident was transferred to TJ unit.</p> <p>A nursing note dated 9/13/2024 included that a CNA approached nurses station stating that resident #10 had struck out at another resident and that staff states that a female resident wandered up to resident while he was sitting down in the dining room and brushed her hand up against residents' shoulder/back, and staff went to redirect resident, and as staff and the female resident walked away, he struck out, hitting the female resident in the back.</p> <p>-Resident #4 was admitted on [DATE] with diagnoses of dementia, Alzheimer's, and violent behavior.</p> <p>An admission MDS dated [DATE] included that this resident was severely cognitively impaired, was independent to walk, and had hallucination and physical behavioral symptoms 1-3 days of the 7 day assessment.</p> <p>A care plan dated 9/6/2024 included this resident has a behavior problem related to mood lability, exit seeking and PICA eating exhibited by combativeness, violent behavior and aggression related to advanced frontotemporal dementia/Alzheimer's. This focus has an intervention to intervene as necessary to protect the rights and safety of others, to divert attention and to remove from situation and take to alternate location as needed.</p> <p>A nursing note dated 9/13/2024 included that around 1515 while documenting at the nurse station heard some commotion at the dining room. This note included that during assessment redness noted around mid-back area and that ADON, ED and unit manager notified.</p> <p>A nursing note dated 9/13/2024 at 21:47 included that this resident continues to wander around the unit. Patient has been found going in and out of multiple rooms. Patient also tends to constantly touch other residents. Patient complaint with medications, requires constant redirection. Resident ambulates independently and requires moderate assistance with ADL's</p> <p>An interview was conducted on 9/24/2024 at 10:00 A.M. with an LPN (staff #23) who said that he had not directly cared for resident #4 but that she was pacing around the unit and that she did not take directions very well. This nurse said that she'll go into other patient's rooms and into nursing station. This nurse said that she doesn't talk. This nurse observed a camera and said that the resident is pushing another residents' wheelchair right now and that she will touch residents and and push their wheelchairs.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on 9/24/2024 at 10:15 with a CNA (staff #39) who said that resident #4 is our wanderer and that the moment she's up she will walk through hallway and dining room, will exit seek, and that they redirect her when necessary and redirect her from rooms. This CNA said that she likes to touch arms so we redirect when she does that. This CAN said that she was there at the incident and that resident #10 was sitting at the u shaped table, and that he already seemed like agitated. This CAN said that resident #4 touched resident #10, so she redirected her away from resident #10 and as soon as she walked away he did like this hitting motion on her back. This staff said that resident #4 said ow loud, and that you could hear that it was a hard hit. This staff said that resident #4 was brought to the nurse and she checked her out. This CNA said the staff redirect the best they can and that they do every 15 minute checks but not 1 to 1. This CNA said that resident 4 is not doing a bad or aggressive touch but that they keep an eye on it. This CAN said that resident #10 was in our unit a day or two before the incident happened and then they took him out so she did not know him well but that he paced, and would loudly let you know he didn't want people around.</p> <p>An interview was conducted on 9/24/2024 at 10:28 A.M. with an LPN (staff #96) who said that resident #4 is very pleasant, very touchy and will pat on back or shoulder, and that she wanders everywhere. This nurse said that she was not there for the incident and that when she came onto shift a few days later there was no mark on resident #4. This nurse said that resident #10 was on the unit for a couple days and that he was pleasant, and did pace a lot and would repeat stuff.</p> <p>Regarding the altercation between resident #3 and #8</p> <p>A complaint received by the Department of Health dated 9/13/2024 included that In the facility Dining Room, behavioral resident( #8) threw his cup of coffee at behavioral resident (#3), hitting her in the face with liquid. (Resident #3) was immediately removed from the dining room and taken to the unit. She stated she told him he should not be smoking, and that he became angry and threw his drink on her. (Resident #8) initially denied the allegation, but then admitted to it, stating I had to do it. She talks too much. No injuries were noted to either party.</p> <p>-Resident #8 was admitted on [DATE] with diagnoses of Major Depressive Disorder, and Schizoaffective disorder, Bipolar type.</p> <p>A discharge return anticipated MDS dated [DATE] included that the resident was moderately impaired for daily decision making and had verbal and other behavioral symptoms 1-3 days of the 7 day assessment. This document included that this resident was independent for most ADL's.</p> <p>A care plan dated 6/5/2024 included that the resident has a behavior problem with intrusiveness, auditory and visual hallucinations and verbal aggression related to schizoaffective disorder bipolar type and Major depressive disorder. Interventions included intervene as necessary to protect the rights and safety of others.</p> <p>A review of the clinical record did not include notes regarding this incident.</p> <p>A Behavior Note dated 7/10/2024 included that this resident is being monitored for target behaviors of verbal aggression, intrusive, door slamming, audio and visual hallucinations. This note includes that the resident is impulsive and intrusive and that he gets easily agitated with staff when attempts to redirect are made.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A communication note dated 9/12/2024 included that the writer spoke with resident regarding increase in verbal outbursts, and irritability towards others. Resident states that he has anger issues and gets mad fast he is aware that his behavior is not acceptable but states he cant help it. writer spoke with resident about moving to secure unit r/t increase in behaviors. resident agrees to move to secure unit and has signed secure unit consent.</p> <p>-Resident #3 was admitted on [DATE] with diagnoses of Schizoaffective Disorder, Bipolar Disorder and Major Depressive Disorder.</p> <p>A Quarterly MDS dated [DATE] included that this resident was not cognitively impaired and had no behaviors during the 7 day period. This assessment included that the resident was independent with most ADLs.</p> <p>A care plan dated 12/21/2021 included The resident has potential to be verbally aggressive related to ineffective coping skills and included interventions of when the resident becomes agitated: Intervene before agitation escalates and guide away from source of distress.</p> <p>A review of the clinical record did not include notes regarding this incident.</p> <p>An interview was conducted on 9/24/2024 at 9:54 A.M. with resident #3 who said that she liked it in the building, however one of the people sitting at her table threw coffee in her face. She said that the person who did was a wrestler, and he was violent at times. She said that he took things in the wrong manner. She said that the coffee was hot and got into her eyes and hurt her. She said that staff #53 helped her and that she was ok. She said that she was glad to get away from the person who did it because he hated her and wasn't done with her yet because he said she was a narc. She said that she was afraid to leave her room because he said he was going to hurt her and that she believed him. She said that she was doing good since he was put into lockdown but that for a little while she had to deal with him.</p> <p>An interview was conducted on 9/24/2024 at 11:07 P.M. with a RNA (staff #87) who said that she saw the incident when resident #8 had already thrown the coffee cup and it was midair. She said that the staff immediately went over there and asked one of the CNA's to remove resident #3 and then asked resident #8 asked why he had done it because they were not arguing. This staff said that both resident involved said they were talking about smoking and resident #8 was very annoyed and said she needs to shut up, she talks too much. This staff said resident #3 had said that he should stop smoking that shit, got more agitated after that. This staff said that resident #3 and #8 were friends prior to the incident and that she believed that resident #3 she came from a friendly place but resident #8 didn't appreciate it. This staff said the nurse was asking him questions about the incident like asking why and advising him not to do it again. This staff said resident #8 got very agitated, and he told the nurse to get away, I'm gonna beat you or maybe I'm going to hit you, something like that. This staff said she walked up and got in between because she thought resident #8 was going to throw his walker. This staff member said that staff asked him to go to his room and that she would take his tray to him and that she did and he stayed in his room. This staff said that resident #3 was ok, and had no burn marks and that she was just scared.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on 9/24/2024 at 10:50 A.M. with a **Nurse (staff #53) who said that residents #3 and #8 were on different wings and that the CNA's who were in the dining rooms saw and that they came to her right after. This nurse said that staff #87 witnessed it, and #54 witnessed the second part, when she spoke to resident #8 and he got physically and verbally aggressive. She said that there was no visible injury on resident#3 and that usually by the time they served the coffee it was probably lukewarm. This nurse said resident #3's face and clothes and clothing was wet, and that there was no redness to the skin, no burn. She said that there were 3 residents that sat at that table and that the other resident and resident #8 were talking about vaping, THC pens and that she believes that resident #3 overheard that and she was lecturing them on the downfalls of doing that. This nurse said that she had a long talk with resident #3 about reporting to her instead of confronting residents. This nurse said that resident #8 was originally on a locked unit and was placed back on a secured unit. This nurse said that when resident #3 she told me, i had no doubt because he was an aggressive person.This nurse said that resident #3 and a CAN came over and told me what happened, then she went to the dining room and told the CAN and the resident to stay at the nurses station. She said that resident #8 initially told her that he had dropped the cup but that she could see from the pattern of the coffee that it had not been dropped. This nurse said that she told resident #8 that he should not confront other residents or throw things and that he got really upset really quick, once he thought he was going to be confronted, he jumped up and he was pretty foul, saying fuck you, going to kill you and that's when staff #54 came up. She said that they rearranged seating once the situation was resolved but that resident #8 was pretty quickly put on the locked unit. This nurse said that resident #3diana was upset but that she could be reactive and we reassured her. She said that they were sitting on opposite ends of the dining room but that she was afraid because of his size and he was more mobile. She said that resident #3 is now back at bingo, and it was just a one or two day thing.</p> <p>An interview was conducted on 9/24/2024 at 11:18 A.M. with a CNA (staff #54) who said I was walking in after it happened, resident #3 was being wheeled away, and that she saw her dripping, didn't know what happened yet, so this staff followed resident #3 and the aids. This staff said that the aids said that resident #8 put coffee in resident #3's face and so this staff walked to dining room. This staff said that when the nurse spoke to resident #8, he first denied throwing it then then admitted and said it because she didn't shut up. This staff said that the nurse continued talking to resident #8 and he stood up and grabbed walker like he was going to throw the walker at her, then a CAN asked him to not eat in dining room. This staff said that he then wrote a report on the incident and cleaned the floor.</p> <p>An interview was conducted on 9/24/2024 at 12:30 with the Director of Nursing (DON/staff #30) who said that her expectations were that abuse does not occur and that we prevent it from happening. This DON said that for the incident for resident #4/#10 she said that the resident were immediately separated and resident #10 was immediately taken to another unit. She said that there has been no more incidents since he was moved to the new unit. She said that resident #4 will just innocently will try to console or touch residents on the shoulder and that she gets redirected every time it is attempted.</p> <p>The DON said that regard residents #3/#8 that she was informed that all of the residents involved were sitting at same table and were having a discussion and resident #8 became angry and threw the coffee. This DON said that the coffee did hit resident #3. This DON said that she asked resident #3 about it and she said that she was talking to them about smoking and reprimanding them and resident #8 became offended.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program revised April 2021 included that residents have the right to be free from abuse and neglect.</p>