STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035004	A. Building B. Wing	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Rosa Care Center	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** 42319 Based on observation, staff and resident interviews, clinical record review, facility records and facility policy, the facility failed to ensure that one resident (#28) was free from abuse. This deficient practice could lead to further incidents of resident abuse. Findings include: -Resident #28 was admitted on [DATE] with diagnoses of Major Depressive Disorder, and Schizoaffective Disorder. A quarterly Minimum Data Set (MDS) dated [DATE] included that this resident was cognitively intact, used a wheelchair and had functional limitation for range of motion in both upper and lower extremities. A review of the care plan included that this resident has behaviors including false accusations, mood lability, voicing sadness related to Major Depressive Disorder and Schizoaffective disorder. -Resident #6 was admitted [DATE] with diagnoses of sexual disinhibition, Major Depressive Disorder and cerebral ischemia. A quarterly MDS dated [DATE] included that this resident was cognitively intact, uses a walker, and has no functional impairment for range of motion in both upper and lower extremities. A care plan dated November 18, 2021 included that this resident is/has potential to be physically aggressive and hypersexual related to poor impulse control and sexual disinhibition and included interventions of assessing and anticipating the residents' needs. A care plan included that resident #6 uses psychotropic/mood stabilizing medication with targeted behaviors including but not limited to sexual disinhibition with an intervention dated April 14, 2022 to monitor/record occurrence of for target behavior symptoms: sexual disinhibition, insomnia, etc. and document per facility protocol. A physician's order dated February 28, 2022 included monitor targeted behavior of: sexual disinhibition every shift. (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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NAME OF PROVIDER OR SUPPLIER Santa Rosa Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1650 North Santa Rosa Avenue Tucson, AZ 85712	

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Medication Administration Record dated October of 2024 included that this resident had exhibited sexual disinhibition on the 4th and the 9th. However, no additional interventions were noted for this resident. An observation conducted on October 21, 2024 at 2:00 PM included residents making craft items with beads in the main dining hall. Resident #6 and #28 were sitting at the same table doing crafts, across from each other. An interview was conducted on October 21, 2024 at 2:11 P.M. with resident #28 who said that resident #6 kissed her and that he's in here doing beading. She said that he used to be in the same hall but when she told someone he got moved. She said that she still has nightmares from the incident. She said that the incident happened this month in the patio out in front of the building. She said that she was sitting there and that he came up and kissed her then he said that he didn't want nobody to see and walked away. She said that the patio lights don't work and that it was after dark, and that no other persons were out there with them. She said that she still sees resident #6 at activities and said He gives me the creeps. She said that she told everyone. This resident pointed out that resident #6 was right there sitting across the table. An interview was conducted on October 21, 2024 at 2:23 P.M with resident #6 who said that he does not really know resident #28. This resident said that he does not really talk to her. Resident #6 said that he was in front of the building and that it was late in the evening. This resident said that yes, he kissed her. He said that she did not say anything when he did. He said that the facility may have moved him because of the incident, because I was in A wing and i moved to the other side, to B. An interview was conducted on October 21, 2024 at 2:28 P.M. with an activities staff (#34) who was monitoring the table resident #28 and #6 were sitting at. This staff said that she thought the incident between resident #6 and #28 occurred 2 weeks ago because she was talking with resident #28 and the resident said they were just talking and he stood up and smooched her. This staff said that she does not think that there was a staff present because it was evening time, and that residents are allowed to go out front whenever they want. This staff said that she believed that resident #6 was moved to a lockdown unit so he does not have as much freedom as he did before. This staff said that the two residents were sitting at the same table because they were monitored. An interview was conducted on October 21, 2024 at 3:22 P.M. with a Receptionist (staff #59) who said that her shift ends at 4 P.M. and that there would not be someone sitting at the reception desk overlooking the front patio when it began to get dark at 5 P.M. or later. An interview was conducted on October 21, 2024 at 3:26 P.M. with a Licensed Practical Nurse (LPN/staff #68) who said that resident #6 was transferred from another unit and that this nurse thought he might have kissed another resident. This nurse said that they are watching for sexual or invasive behaviors but that they had not worked with the resident very long and had not seen any behaviors. (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 October 21, 2024 at 3:50 P.M. with a Unit Manager (staff #133) who said that resident #6 was transferred for kissing resident #28. This nurse said that she was told by resident #28 that it happened out in front of the building, she didn't know what day it happened. She said that resident #6 had not had sexually disinhibited behaviors for a very long time and that it was usually that he made compliments that were too friendly. This nurse said that resident#28 admitted to them that he said that he did kiss her and that he agreed to go to the locked down unit. An interview was conducted on October 21, 2024 at 4:22 P.M. with the Director of Nursing (staff #128) who said that her understanding was that residents #6 and #28 were sitting outside and resident #6 approached #28 and kissed her, she told him to stop and he did, she said she didn't report it till a week later, he admitted to it and that when she told him to stop he left her alone. This staff said that resident #28 has had a history of just sitting next to women, being close to him and that he had not had any behaviors for months. This DON reviewed the MAR which included that the resident had sexually disinhibited behaviors and said that she did not know what the incidents were but that It possibly could mean he was sitting next to or said something to a staff member, he has made comments to female staff sexually disinhibited statements. This DON said that there had not been any prior incidents between these 2 residents. This DON said that her expectations with abuse is that it never occurs. A policy titled Identifying Sexual Abuse and Capacity to Consent revealed Sexual abuse is non-consensual sexual contact of any type with a resident. A policy titled Identifying Types of Abuse revealed Neglect occurs when the facility is aware of, or should have been aware of, goods or services that a resident requires but the facility fails to provide them and this has resulted in (or may result in) physical harm, pain mental anguish or emotional distress.