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	11/01/2024

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 - Some	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** 48932 Based on clinical record review, interviews, facility documentation, facility surveillance video, and policy review, the facility failed to ensure two residents (#1 and #4) were free from abuse from other residents (#2 and #5). The census was 123. The deficient practice can result in additional incidents of staff to resident abuse. Findings include: Regarding residents #4 and #5 - Resident #4 was admitted to the facility on [DATE] with diagnoses that included dementia, anxiety, and chronic heart disease. The quarterly Minimum Data Set (MDS), dated [DATE], included a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident has no cognitive impairement. - Resident #5 was admitted to the facility on [DATE] with diagnoses that included Dementia, anxiety, and major depressive disorder. The admission MDS, dated [DATE], indicated that a BIMS assessment was not able to be completed. However, a staff assessment for resident #5's cognitive skills for daily decision making was determined to be severely impaired. Review of the care plan for resident #5, revised on October 29, 2024, revealed there was no focus or interventions related to resident #5's behaviors. A progress note for resident #4, dated October 26, 2024 AT 3:52 PM, revealed that an incident had occurred at 11:10 AM between resident #4 and another resident (resident #5) in the hallway. Resident #4 had stated that the first attack took place in resident #4's room when resident #5 had entered. Resident #4 attempted to redirect resident #5 prior to the start of the attack. The note explained that the 2nd altercation in the hallway was witnessed by staff and staff was able to separate the two residents. Resident #4 had a small laceration on the right eyebrow and on the middle back. Wound care was provided and there was no other pain or complaints from resident #4. (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 - Some	A progress note for resident #5, dated October 26, 2024 at 7:30 PM, revealed resident #5 was witnessed having a physical altercation with another resident. The note also indicates that the victim of the altercation told staff that resident #5 had attacked (resident #4) while he was laying in his bed. The note also noted that resident #5 was observed punching resident #4 on his face which resulted in a small laceration on resident #4's right eyebrow. An interview was conducted with resident #4 on October 31, 2024 in his room. Resident #4 indicated that he currently felt safe in the facility and did not recall the altercation with resident #5. An interview was conducted with Certified Nursing Assistant (CNA/Staff #14) on October 31, 2024 at 1:11 PM. Staff #14 confirmed that she was working on October 26, 2024 and had witnessed the 2nd altercation between resident #4 and resident #5. Staff #14 indicated she was a resident's room when she had heard sounds like someone was punching a wall. When she had gone to investigate the sound when she saw resident #4 on the floor. Staff #14 indicated she asked for assistance from another CNA and they both assisted resident #4 from the floor. She observed resident #4 bleeding from the right eyebrow and attempted to de-escalate him as he was visibly upset. Staff #14 also indicated that the altercation took place right under a hallway security camera. Resident #4 was placed on 15-minute vital checks until 6:00 PM that day and resident #5 was moved to a different unit. An interview was conducted with Licensed Practical Nurse (LPN/Staff #15) on October 31, 2024 at 1:38 PM. Staff #15 confirmed that she was working on October 26, 2024 and she had witnessed part of the altercation between resident #4 and resident #5 via the security camera at the nurses station. Staff #15 stated that she saw resident #5 walk towards resident #4 in the hallway. Staff #15 indicated that when she went to the scene of the incident, she had not observed any physical altercation between the two residents. Staff #15 had indicated that resident #5 had just been admitted to the facility the night before the incident and they were still getting to know him. She had noticed that he would be triggered fast, but couldn't identify what the triggers were. Staff #15 also indicated that resident #5 was extremely confused before and after the incident and was still getting used to the new environment. After the altercation, resident #5 was moved to a new unit and both residents were placed on 15-minute neuro checks. A request was made on October 31, 2024 for a copy of the surveillance video. A copy of the video was received at 2:07 PM from the Administrator's (ADM/Staff #67) cell phone however, the video was not clear. A request was made to record the surveillance video with the State issued cell phone with staff #67 present. Surveyor and staff #67 recorded the surveillance video at 2:18 PM in the Human Resource office. An interview was conducted with the Director of Nursing (DON/Staff #41) on October 31, 2024 at 2:45 PM. When asked what abuse was, staff #41 indicated that it was willful touching or verbalizing anything that is going to have a negative effect on a patient. Staff #41 confirmed the incident took place between residents #4 and #5. She confirmed resident #4 received injuries above his left eye and a scratch on his back. Staff #41 indicated that resident #5 was just admitted so they did not any behavioral history to go on and his previous placement did not disclose the resident was aggressive. Staff #41 also confirmed that both residents were on and continued with the neuro checks and that resident #5 was moved to a different unit. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A second interview was conducted with staff #41 on November 1, 2024 at 10:04 AM. The surveillance video was shown on surveyor's laptop and staff #41 was asked to describe what was taking place in the video. Staff #41 indicated that she saw resident #4 walking down the hall and start attacking resident #5 and they both started to hit each other. She also indicated that she saw several staff members enter the picture and a nurse went into a room to escort resident #4 out of a room. She also saw resident #5 continue to walk down the hall. Regarding residents #1 and #2 -Resident #1 was admitted to the facility on [DATE] with diagnoses that included bipolar disorder, antisocial personality disorder, narcissistic personality disorder, and trigeminal neuralgia (chronic pain disorder in the face). The quarterly MDS, dated [DATE], included a BIMS score of 01 indicating resident #1 had severe cognitive impairement. Resident # 2 was admitted to the facility on [DATE] with diagnoses that included schizophrenia, nicotine dependence, dementia, and bipolar disorder. The quarterly MDS, dated [DATE], revealed resident #2 had a BIMS score of 15 which indicates the resident was cognitively intact. The same MDS also indicated that resident #2 did have behaviors during the look back period but it was not directed towards others. The care plan, last revised on March 7, 2023, indicated resident #2 had the potential to be verbally and physically aggressive due to his diagnoses and that his behaviors fluctuated. Interventions included anticipating the resident's, assessing his coping skills, administer medications as ordered and maintain boundaries/personal space. Review of resident #1's progress notes revealed a progress note, dated October 26, 2024 at 7:35 PM. The progress note indicated that resident #1 was sitting in his wheelchair and another resident (resident #2) had kicked resident #1 in the right leg. The note indicates there was no injury or pain reported. Review of progress notes for resident #2 reveals an entry dated October 26, 2024 at 7:32 PM. The note indicated that resident #2 had returned from a smoke break and was upset which led to him kicking another resident (resident #1). The note indicated the incident was witnessed by a CNA (staff #14). An interview was conducted with a CNA (CNA/Staff #14) on October 31, 2024 at 1:23 PM. Staff #14 confirmed that she witnessed the altercation between staff #1 and #2 on October 26, 2024. She stated that prior to the altercation, resident #2 was off after he had a visit from his wife and brother, was more jumpy than normal, and was exit seeking. She stated that resident #2 is usually easily redirected and is able to calm down when staff talk with him but it wasn't the case on that day. Several residents including resident #2 were going back to the unit after the smoke break and resident #2 had stated that he wanted to fight staff #14 and was cursing. When they all went back to the unit and staff #14 informed the floor nurse of the situation. She then saw resident #2 hit resident #1 on the right leg as she was standing behind resident #2. Staff #14 stated that resident #1 was assessed and there were no injuries. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with an LPN (LPN/Staff #15) on October 31, 2024 at 1:38 PM. Staff #15 explained that resident #2 was returning from a smoke break and the CNA (staff #14) was holding the door open. She stated that both residents #1 and #2 were in their wheelchairs and resident #2 was going to his room from the hallway and kicked resident #1 with no warning. Staff #15 indicated that when resident #2 gets upset, there are no warning signs prior to the incident. An interview was conducted with the DON (DON/Staff #41) on October 31, 2024 at 2:57 PM. Staff #41 explained that residents who smoke go to the smoking area together as they move from their unit to the outdoor smoking area. She explained that resident #2 had gotten upset because he had finished smoking and did not want to wait for everyone to return back to the unit. When the CNA had asked him to wait, resident #2 had become agitated. Staff #41 indicated there was no injuries sustained during the incident and both residents were separated and placed on 15-minute checks. She also indicated that the facility changed the route that residents take to the smoking area and that specific unit is now able to go directly to the smoking area from their unit which allows residents to leave the smoking area once they are done instead of having to wait for everyone. If asked if there was anything staff could have done differently to prevent the incident from occurring, staff #41 indicated that staff could have recognized resident #2 being more aggressive than usual ad not allow him to walk by other residents when he was agitated. She stated that she is working with staff to recognize warning signs prior to an incident happening. A review of the facility policy titled Abuse shows abuse being defined as Physical abuse includes, but is not limited to hitting, slapping, biting, punching, or kicking. It also revealed that abuse can be resident-to-resident as well.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48932 Based on clinical record review, interviews, and policy review, the facility failed to ensure one resident's (#3) rights were honored related to refusing medications. This deficient practice could result in further violations of resident's rights. Findings include: Resident #3 was admitted to the facility on [DATE] with diagnoses of Parkinson's disease, type 2 diabetes, and major depressive disorder. Review of the quarterly Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 10 indicating resident #3 had mild cognitive impairement. A review of the physician's orders indicated there was an order for Dulcolax suppository inserted rectally, as needed, if no bowel movement in 3 days. A review of resident #3's bowel elimination task chart reveals resident #3 having bowel movement on October 17, 2024 at 2:48 PM. The October medication administration record indicated Dulcolax suppository was administered on October 18, 2024 by Licensed Practical Nurse (LPN/staff 120). A progress note in resident #3's electronic health record (EHR), dated October 18, 2024 at 2:45 PM indicated that the resident was given a medication that she did not want and the resident's Power of Attorney (POA) was notified. An interview was conducted with resident #3 on November 1, 2024 at 8:53 AM. Resident #3 recounted a nurse (Staff #120) giving her a suppository two weeks prior. She shared that she had told her (staff #120) that she did not want the suppository but was given it anyways. An interview was conducted on November 1, 2024 at 9:05 AM with an LPN (LPN/staff #81). Staff #81 explained that if she is needing to offer a suppository to a resident she would try to encourage them to take it by educating them the purpose of the medication. If that didn't work then she would re-approach the resident later. When administering a suppository, staff #81 indicated they would figure out why a resident was needing a suppository and ask them if they wanted it. If they said no, then they wouldn't give it to them and let the provider know. Staff #81 also indicated that they would not give a resident a suppository if they did not agree to it because it would be a dignity issue and you cannot do something to a resident without their permission. An interview was conducted on November 1, 2024 at 9:15 AM with an LPN (LPN/staff #107). Staff #107 explained that she would offer a suppository as a PRN if they wanted it. If they didn't want it then she would let the provider know. Staff #107 also indicated she would not give the resident the suppository if they said no to it. She explained that it could cause the resident to feel violated and embarrassed. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on November 1, 2024 at 9:26 AM with an LPN (LPN/Staff #15). Staff #15 indicated she would follow the bowel movement protocol when needing to give a resident a suppository. First, she would try to give a resident oral medication to see if it works and if it didn't work she would try a suppository. If the resident did not want a suppository then she would notify the provider and go from there. Staff #15 also indicated that it was not an acceptable practice to give a resident a suppository if they had refused it. She continued by saying it could be a traumatic experience for them and there could be a reason behind why they had declined the medication. An interview was conducted with the Director of Nursing (DON/staff #41) on November 1, 2024 at 10:10 AM. Staff #41 indicated that she would give a resident a suppository after following the bowel protocol which indicates if the resident does not have bowel movement in 3 days they are to be administered oral medications. If after two doses of the oral medications there are no results, then a suppository is administered. If the suppository does not work then an enema is given. Staff #41 explained that if a resident did not have bowel movement after 3 days, then an alert would pop up in the EHR alerting staff of the issue. Staff #41 indicated that she would expect staff to explain the risks and benefits of not getting a suppository to the resident a few times to be sure they did not want the medication. Staff #41 also added that in this situation, the resident was alert and oriented so staff #41 believed resident #3 when she said she did not want it. Staff #41 indicated that it was not an acceptable practice to give resident #3 a suppository after she said she didn't want it. The harm to a resident when giving them medications, after they said no, would be psychological harm because it's a very evasive thing that is happening to them and the resident would not be as trusting of staff, especially nurses. Staff #41 concluded that (staff #120) did not act within my expectations and staff #120 was terminated after the facility's investigation. A review of the facility's bowel movement protocol indicates that normal bowel function is considered to be at least 3 stools a week and less than 3 stools a day. It also indicates that if there were no bowel movements in more than 3 days, staff are to ensure there are bowel sounds, determine if there is abdominal discomfort/distension, ensure the resident is drinking fluids and fiber, increase resident activity, obtain an order for bowel regimen protocol, and discuss additional interventions with the resident's physician.