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	12/18/2024

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 47911

Based on clinical record reviews, facility documentation, resident and staff interviews, and policy review, the facility failed to ensure that four residents (#11, #111, #22, #3) were free from physical abuse. The deficient practice could result in further incidents of resident to resident abuse.

Findings include:

-Resident #1 was admitted on [DATE] and subsequently discharged on [DATE] with diagnosis including unspecified schizophrenia, type 2 diabetes mellitus and unspecified atrial fibrillation.

A review of the admission MDS (minimum data set) dated October 30, 2024 revealed a BIMS (brief interview of mental status) score of 15, indicating that the resident was cognitively intact. The MDS further indicated that the resident had noted potential indicators for psychosis to include hallucinations and delusions. It was further noted that the resident has other behavioral symptoms directed toward others.

A review of the progress notes revealed a nursing note entry for December 4, 2024 at 3:37 indicating that at approximately 10:00 A.M. staff #49 witnessed resident #1 threaten and try to hit another resident because he had been singing in the hallway. It was noted that resident #1 was de-escalated and noted to be calm thereafter. At approximately 12:30 P.M. it was noted that staff #49 observed resident #1 trying to hit another resident with a lotion bottle, which was taken away and resident #1 was escorted back to his room. Then at approximately 1:30 P.M. staff #49 was informed that resident #1 had hit 2 other residents and that Tucson Police Department had been called and all other notifications transpired.

A review of the MAR (medication administration record) for resident #1 revealed that medications were administered as ordered.

A review of the care plan revealed that the resident was noted to have behavior problems due to schizophrenia and noted interventions documented. It was further noted that the resident was admitted to the secure unit secondary to behaviors.

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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 review of the facility 5-day investigative report dated December 6, 2024 revealed that a resident to resident altercation had occurred on December 4, 2024 at 1:10 P.M. It was noted that resident #1 had hit two other residents #11 and #111 with a part of his wheelchair which was hidden in a sock. It was further noted that resident #111 that a small bruise was discovered on December 5, 2024 post incident. Resident #1 was taken by the Tucson Police Department to the hospital for psychiatric treatment. It was noted that facility had substantiated the incident. -Resident #11 was admitted on [DATE] with diagnosis including diffuse traumatic brain injury with loss of consciousness of unspecified duration , type 2 diabetes mellitus, and schizoaffective disorder-bipolar type. A review of the quarterly MDS dated [DATE] revealed a BIMS score of 03, indicating severe cognitive impairment. A skin assessment conducted on December 4, 2024 revealed no new skin issues. -Resident #111 was admitted on [DATE] with diagnosis including unspecified dementia with unspecified severity and agitation, schizoaffective disorder, bipolar disorder and type 2 diabetes mellitus. A review of the quarterly MDS revealed a BIMS score of 01, indicating severe cognitive impairment. A skin assessment conducted on December 6, 2024 revealed a small bruise to the left forearm. An interview was conducted with an Licensed Practical Nurse (LPN/staff #49) on December 17, 2024 at 10:29 A.M. She stated that it started with resident #1 becoming agitated when another resident, #111, was signing in the hallway. She stated that resident #1 was taken to his room at approximately 10:00 A.M. at which time, she thought he was fine. She stated that the incident where he had hit 2 residents, #11 and #111, had occurred around noon. She stated that resident #1 would yell out but had never been violent or physically aggressive before. She stated that the morning of the incident his sister had dropped off his belongings, which she stated may have triggered the incident, as resident #1 had made comments that he just wanted to be out of here. She stated that resident #11 had no injuries and that resident #111 had a minor bruise as a result of the incident. She stated that the unit is well staffed. She stated that the expectation is that resident to resident altercations are not expected to happen and or are not okay. She stated that when a resident to resident altercation does occur, that the risk could be for a resident to get hurt. An interview was conducted with an LPN (LPN/staff #88) on December 17, 2024 at 10:43 A.M. Staff #88 stated that on the day of the incident, she was in the dining room assisting another resident and had heard noise outside. She stated that when she arrived outside, 2 other CNA's (certified nursing assistants) were already outside having separated resident #1 from the other residents. She stated that resident #1 had a leg rest from a wheelchair inside a sock which had been hidden in his jacket. She asked one of the CNA's to take resident #1 to his room. She stated that resident #1 had then ripped off the television from the night stand and used the cord to hit the CNA. She stated that she was able to de-escalate the resident. She stated that week prior the resident had an outburst wanting to leave and had kicked the door but then presented as remorseful. She stated that resident #1 had been regularly followed for his behavioral health needs. (continued on next page)

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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 - Some	An interview was conducted with a Certified Nursing Assistant (CNA/staff #63) on December 17, 2024 at 10:58 A.M. Staff #63 stated that the resident had been going off all day. She stated that she only came on the scene after hearing all the commotion occurring in resident #1's room, when he was attacking the CNA. Staff #63 identified what the types of abuse were, that trainings were conducted almost on a monthly basis, steps to be taken when abuse occurs and further stated that she felt staffing was sufficient on the unit. A telephone interview was conducted with a CNA (CNA/staff #201) on December 17, 2024 at 11:04 A.M. Staff #201 stated that she had observed the incident. She stated that she was sitting in the dining room when resident #1 came out with a part of his wheelchair hidden in jacket. She stated that he had been targeting resident #111 all day. She said that she had gone out immediately to separate the residents when she saw what happened and had taken resident #1 to his room, at which time she stated that he started throwing things at her and hitting her and whipping her with the television cord. She stated that she thought it all started in the morning when resident #111 was singing in the hallway which upset resident #1, she stated that the nurse was made aware. ___________________________ -Resident #2 was admitted on [DATE] and passed away on June 3, 2023 with diagnosis including dementia of unspecified severity with agitation, primary open angle glaucoma-severe stage, chronic obstructive pulmonary disease and type 2 diabetes mellitus. A review of the quarterly MDS dated [DATE] revealed a BIMS score of 01, indicating severe cognitive impairment. The MDS further revealed noted potential indicators of psychosis to include delusions. It was further noted that the resident exhibited physical behavioral symptoms 1-3 days per week and other behavioral symptoms 4-6 days per week. A review of the facility 5-day investigative report revealed that on January 30, 2023 at approximately 2:35 P. M. resident #2 had asked for coffee and was told to shut-up by resident #22. It was further noted that resident #22 then rolled in his wheelchair across to resident #2 and scratched his face. It was noted that resident #2 had a small scratch on his cheek and under his right eye. A review of the skin assessment dated [DATE] revealed no new noted skin issues. -Resident #22 was admitted on [DATE] with diagnosis including hemiplegia and hemiparesis, aneurysm, mild cognitive impairment, unspecified psychosis, major depressive disorder-recurrent, post-traumatic stress disorder and localization related symptomatic epilepsy. A review of the admission MDS dated [DATE] revealed a BIMS score o evidence of a BIMS score; however, the 5-day investigative report from the facility did indicate a BIMS score of 11, indicating moderate cognitive impairment. A psychiatric encounter noted dated February 7, 2023 revealed that since risperdal started that the resident's behaviors have subsided. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A telephonic interview was conducted with a Registered Nurse (RN/staff #215) on December 17, 2024 at 1:08 P.M. She stated that she had not worked at the facility for over a year but that she did recall the incident. She stated that she did not directly observe the incident but had come when she heard the CNA's hollering. She stated that resident #22 had come up to resident #2 and that resident #2 had wanted resident #22 to get out of his face and had raised his hand at which time resident #22 scratched resident #2's face. She stated that she thought there may have been a couple of scratches. Staff #215 stated that the residents were separated and assessed for injuries. She stated that she felt the residents were receiving appropriate services prior to the incident, that staffing was appropriate and that abuse training was conducted yearly and also after each incident. A telephone call was placed to an LPN (LPN/staff #227) on December 17, 2024 at 1:26 P.M. The call went to voicemail and a message was left requesting a call back. No return call was received. ______________________________ -Resident #3 was admitted on [DATE] with diagnosis including hemiplegia and hemiparesis, subarachnoid hemorrhage affecting left non-dominant side, major depressive disorder-recurrent, adjustment disorder with depressed mood, and polyneuropathy A review of the quarterly MDS dated [DATE] revealed a BIMS score 3, indicating severe cognitive impairment. The MDS further noted potential indicators of psychosis including hallucinations and delusions as well as verbal and other behaviors 1-3 days a week. -Resident #33 was admitted on [DATE] with diagnosis including unspecified dementia with unspecified severity and other behavioral disturbance, impulse disorder, unspecified psychosis, insomnia, anxiety disorder and extrapyramidal and movement disorder. A review of the MDS dated [DATE] revealed a BIMS score of 06, indicating severe cognitive impairment as well as noted potential indicators for psychosis to include hallucinations and delusions. A review of the progress notes for resident #33 revealed a nursing note entry on June 23, 2023 at 12:48 P.M. indicating that around 10:20 A.M. a verbal altercation had occurred on the patio between 2 residents. One resident, #3, was noted to be taunting the other, #33, and then #33 reached out and made light contact with resident #3. The progress notes revealed that there was redness to the left eye of resident #3. It was noted that notifications transpired. A review of the facility 5-day investigation dated July 28, 2023 noted that resident #33 was having a verbal argument with resident #3 on the unit patio. It was noted that a CNA, staff#116 had intervened and when she was redirecting resident #33 back inside, resident #3 was in the hallway. It was noted that resident #3 began taunting resident #33 who then reached out and made contact with resident #3. It was noted that resident #3 incurred redness to the left eye as a result of the interaction. The residents were noted to be separated and no further injuries were identified. Resident #3 was subsequently transferred to a different unit. A telephone call was placed to a CNA (CNA/staff #116) on December 17, 2024 at 10:20 A.M., the call went to voicemail and a message was left requesting a call back. (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 the Administrator (admin/staff #77) on December 17, 2024 at 11:23 A.M. Staff #77 stated that the expectation is that resident to resident abuse does not occur, if the residents have a low BIMS score. Staff #77 stated that the frequency of abuse cases had been a little more in the past couple of months. She further stated that the facility had been going through renovations and room changes to ensure a good fit among residents. Staff #77 stated that the risk for resident to resident altercations could result in harm or death to the resident. An interview was conducted with an LPN (LPN/staff #109) on December 17, 2024 at 2:45 P.M. Staff #109 stated that the she recalled the incident but not the specifics. She stated that at the time resident #33 was able to walk, had mood swings and certain triggers, but did not recall the triggers. She stated that she could not recall if there were resulting injuries from the interaction, but did recall that contact was made. She stated that resident #3 was moved to another unit post interaction. She stated that staff receive abuse training at least every 6 months and that staffing at the time of the incident was not an issue. A follow-up telephone call was placed to a CNA (CNA/staff #116) on December 17, 2024 at 3:25 P.M. A second message was left requesting a call back. No return call received. An interview was conducted with the Director of Nursing (DON/staff #25) on December 17, 2024 at 3:12 P.M. Staff #25 stated that she was aware that the incidents had occurred and was familiar with it. She stated that her expectation is that abuse does not occur and if it should happen that staff would be knowledgeable enough to know how to deal with the situation to ensure resident safety, conduct notifications and follow the chain of command. She stated that the risk for a resident to resident altercation could be that it could cause a traumatic event for the alleged victim and the risk for the alleged aggressor could be that he could do it again. A review of the facility policy entitled Abuse, Neglect, Exploitation and Misappropriation and Prevention Program revised April 2021 revealed that residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. It is further noted that this includes physical abuse by a wide variety of individuals to include other residents.