

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  02/07/2025
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> 48932</p> <p>Based on clinical record review, interviews, facility documentation, and review of facility policy, the facility failed to ensure resident #1 was free from abuse from resident #2. The deficient practice could result in further incidents of resident to resident abuse.</p> <p>Findings include:</p> <p>Related to resident #1-</p> <p>Resident #1 was admitted to the facility on [DATE] with diagnoses that include alcohol induced Dementia, peripheral vascular disease, and major depressive disorder.</p> <p>Review of the quarterly Minimum Data Set (MDS), dated [DATE], revealed resident #1 had a Brief Interview for Mental Status (BIMS) assessment completed and scored a 03 which indicated the resident was cognitively impaired.</p> <p>Review of resident #1's care plan indicated that the resident had a behavior problem which included exit seeking, restlessness, and irritability. Interventions included administering psychotropic medications, monitoring for behaviors and remove him from the situation when staff notices he starts to escalate.</p> <p>Review of resident #1's Electronic Health Record (EHR) revealed a progress note dated January 30, 2025 at 5:39 AM. The note indicated that resident #1 was found in another resident's room with blood on his face and neck. The note further indicates that resident #1 reported that another resident (resident #2) had punched me real hard. The explained that the other resident (resident #2) had told staff that resident #1 was in his bed. Resident #1 was then removed from the room and his injuries were cleaned up.</p> <p>A second progress note, dated January 30, 2025 at 7:28 AM noted that resident #1's left cheek bone area was bruised and swelling was noted. The note also indicated that Registered Nurse (RN/Staff #87) contacted the Doctor to request an order for x-rays.</p> <p>Review of the facility's skin observation note, dated February 1, 2025, indicated that the resident had bruising on the left side of the face.</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>An observation of the resident was conducted on February 6, 2025 at 10:55 AM. Resident #1's left cheekbone was purple and blue in color and there was a cut approximately 1/2 an inch on the same left cheekbone.</p> <p>An interview was conducted on February 6, 2025 at 11:02 AM and the resident indicated that he had fallen in the front yard.</p> <p>Related to resident #2-</p> <p>Resident #2 was admitted to the facility on [DATE] with diagnoses that include Dementia, schizoaffective disorder, and bipolar disorder.</p> <p>Review of the quarterly MDS, dated [DATE], indicated the resident completed a BIMS assessment and scored a 01 which indicated the resident was cognitively impaired. The same MDS also noted that resident #2 did have verbal behaviors directed towards others during the look-back period.</p> <p>Review of the care plan indicated that resident #2 had behaviors that included physical and verbal aggression, delusions, and hallucinations. Interventions included administering medications as ordered, monitoring the resident, and redirecting him as needed.</p> <p>Review of resident #1's EHR revealed a progress note, dated January 30, 2025 at 5:25 AM. The progress note indicated that staff heard resident #2 yelling get out of my bed! and staff found another resident (resident #1) standing at the foot of resident #2's bed. The note further indicates that resident #2 was observed to have blood on the back of his right and fourth knuckle. It also indicated that resident #2 told staff that he had hit (resident #1).</p> <p>An interview was conducted with resident #2 on February 6, 2025 at 10:36 AM in the unit courtyard outside. When asked if he had gotten into an altercation with another resident, resident #2 explained that another resident was in his room and it made him feel mad and nervous. Because of that, he hit him (resident #2) in the face. Resident #2 also added, that he wanted to stay at the facility and that he didn't hit him that hard.</p> <p>An interview was conducted with Certified Nursing Assistant (CNA/Staff #101) on February 6, 2025 at 10:14 AM. Staff #101 indicated that she did not see any physical contact between resident #1 and resident #2 however, she heard yelling when she was doing patient care around 5:15 AM on January 30, 2025. She saw resident #1 in room [ROOM NUMBER] standing at the foot of resident #2's bed with blood on his face. She also saw resident #2 in the room but doesn't remember where he was standing. Staff #101 explained that resident #1 tended to wander and she has had to remove him from other residents' rooms a few times to prevent them from escalating. She also indicated that she had not experienced resident #2 being physically aggressive during his shift as he would typically be verbally aggressive towards himself when he experiences hallucinations.</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 with the Director of Nursing (DON/Staff #113) on February 6, 2025 at 3:30 PM. When asked what had transpired between residents #1 and #2, staff #113 indicated that she was informed that resident #1 was in resident #2's room and was touching his things. Resident #2 had gotten upset and told him to leave. When resident #1 wouldn't leave, resident #2 then struck resident #1 in the nose. Staff #113 also shared that the nurse had intervened and separated the residents and then provided first aid to resident #1. Staff #113 also explained that resident #1 was always disoriented and doesn't know what is going on which was his baseline. Staff #113 also explained that they had a hall monitor that day of the incident to monitor residents but when the incident took place, the hall monitor had gone into another resident's room to assist someone.</p> <p>An interview was conducted with Registered Nurse (RN/Staff #87) on February 7, 2025 at 7:49 AM. Staff #87 confirmed that she was working on January 30, 2025 on the unit that housed residents #1 and #2. Staff #87 explained that during rounds she had heard resident #2's voice saying get out of my room. She then went to the resident's room and resident #1 was standing at the foot of the bed on the left side. She further explained that resident #2 had told her that he had punched resident #1 because resident #1 was in his bed and wouldn't get up. Staff #87 couldn't recall if resident #2 had injuries but she did recall that resident #1's left cheekbone was open and was swelling up. She also recalled resident #1 telling her that resident #2 had hit him. Staff #87 assessed both residents for injuries and removed resident #1 from the room and assisted with cleaning him up. Once the resident was cleaned up, she recalled giving him medication for the pain and a cold compress. When asked if either resident had behaviors in the past, staff #87 explained that resident #2 would clench his fists when he became upset but he had never hit anyone. He did make verbal threats to hurt people but had not acted upon it. She also explained that resident #1 was exit seeking and was very disoriented. When he exhibited those behaviors, staff watched him more closely due to him being confused as to where he was. When asked what the risks were to the residents when they are subjected to abuse, staff #87 explained that they could sustain injuries and anything could happen.</p> <p>Review of the policy titled Resident-to-Resident Altercations revised in September 2022 indicated that all altercations including resident-to-resident abuse are investigated and reported to the nursing supervisor. It also provided the following interpretation: Staff were to monitor residents for aggressive/inappropriate behaviors towards other residents including physically aggressive behaviors. It also explained that behaviors that may provoke a reaction by residents include wandering into others' rooms/space.</p>