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	06/13/2025

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** Based on clinical record reviews, facility documentation, resident and staff interviews, and policy review, the facility failed to ensure that one resident (#235) were free from physical abuse resulting in injury by other residents (resident #205). The deficient practice could result in further incidents of resident to resident abuse. Findings include: -Resident #235 was admitted to the facility on [DATE] with diagnosis that include Diabetes Mellitus type 2, Benign Prostatic hyperplasia, Chronic obstructive pulmonary disease, Dementia, and Hypertension. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 99 which indicated the resident had severe cognitive impairment. A behavioral care plan revised June 5, 2023 revealed the resident is at risk for impaired thought processes related to vascular dementia, with a noted intervention of keeping the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. -Resident #205 was admitted to the facility on [DATE] with diagnoses that include Psychotic disorders with hallucinations, Seizures, Post-traumatic stress disorder, depression, aneurysm, cerebral infarction, and hypertension. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 12 which indicated the resident had mild cognitive impairment. Review of information received from the SA complaint tracking system revealed that on April 22, 2023 a facility reported incident was received that revealed on April 22, 2023 at 9:26 a.m. It was alleged that behavioral resident #205 had bit fellow behavioral resident #235 on the hand, causing resident #235 to pull resident #205's hair. It further stated this is the first incident between the two residents, that had resident #205 was relocated to another unit within the facility. (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 review of progress notes for resident #235 dated April 22, 2023 at 9:26 a.m. revealed a resident to resident altercation. Was observed by staff member resident #235 pulling resident #205's hair. The note continues that the resident was removed from the room after separating the two residents. Further assessment noted a puncture like area to the palm and thumb area of the left hand of resident #235. The note concludes that the don, administrator, and provider were notified. A progress note for resident #235 dated April 22, 2023 at 8:56 p.m. noted resident #235 quiet this pm with no noted behaviors. No complaint of discomfort from left palm and thumb area, will continue to monitor. A progress note for resident #235 dated April 25, 2023 at 12:29 p.m. noted resident #235 revealed resident #235 was seen by behavioral health for a follow up related to resident to resident altercation. The note concludes that no changes made to staff and will continue to monitor for issues and side effects and to follow up with behavioral health in 4 weeks. A progress note for resident #235 dated April 26, 2023 at 9:07 p.m. noted resident #235 revealed No complaint of discomfort from recent bite to left hand, and no noted signs of infection. A progress note for resident #235 dated April 29, 2023 at 1:08 p.m. noted resident #235 revealed Left hand bite punctures continue to resolve. An interview was conducted with a Certified nursing assistant (CNA/staff #78) on June 11, 2025 at 1:54 p.m. The CNA stated she has worked at the facility for 1 year. The CNA stated that when a resident conflict happens she tries to separate the residents immediately and deescalate the situation, and then notify the nurse. She further stated that when physical abuse is suspected the process in the same, separate and make the residents safe and then report to the nurse and up the chain of command. An interview with the Director of Nursing (DON/staff #21) was conducted on June 13 2025 at 11:30 a.m. The DON stated she has been here since 2011, but for the last 4 years as the director of nursing. The DON stated that she remembers resident #205, and stated that he was not aggressive and kind of kept to himself. She stated he would eat in the dining room, and that to be honest she didn't recall the incident involving the bite. The DON accessed the clinical record during this interview to review details of the incident. The DON stated after review that they did report it appropriately and provided that documentation. The DON stated that resident #205 was moved to another secured unit following the incident, and that both residents were placed on 15-minute checks. The DON further stated that both were seen by behavioral health following the incident with no medication changes noted. The DON stated that the bite was the only injury noted, and the only other contact was the hair pulling. The DON concluded that it does not meet her expectation of how residents are treated. Based on clinical record review, interviews, facility documentation and review of facility policy, the facility failed to ensure one resident (#120) was free from abuse from an employee. The deficient practice could result in residents experiencing emotional, physical, and mental trauma from the abuse. Findings include: Related to Resident #120- (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #120 was admitted to the facility on [DATE] with diagnoses that included unspecified dementia, anxiety disorder, and cognitive communication deficit. Review of the admission MDS, dated [DATE], revealed the resident had a BIMS score of 03 which indicated the resident had severe cognitive impairment. The same MDS also indicated Resident #120 exhibited hallucinations, delusions, and rejection of care. Review of the care plan indicated it was initiated on July 21, 2023. The care plan included that the resident had a behavior problem related to her dementia and anxiety. Interventions indicated staff were to anticipate and meet the resident's needs, provide opportunities for positive interactions, approach/speak in a calm manner, and to monitor the behaviors. A review of Resident #120's clinical record revealed a progress note, dated September 2, 2023 at 10:40 PM. The progress note was written by Licensed Practical Nurse (LPN/Staff #125) and indicated that she was informed that a staff member allegedly abused a resident. The progress note also indicated that Staff #125 had assessed the resident and there were no injuries noted. Resident #120 was unable to remember the situation. An employee separation information form was reviewed on 5/16/2025 and it indicated Staff #150 was fired/discharged for physical/verbal altercation. The termination date was listed as September 2, 2023. An interview was conducted on June 13, 2025 with LPN/Staff #125 at 10:02 AM. Staff #125 defined abuse as when you're doing something wrong towards another person. When you're being physical with them and not treating them the way you would want to be treated. Staff #125 recalled Resident #120 and stated that she was staffed 1:1 due to her behaviors. She also noted that she was calmer when her husband visited and he visited often. She also described Resident #120 as someone who would wander into other residents' rooms often due to her dementia. Staff #125 explained that Resident #120 would sometimes be combative. However, Resident #120 would eventually be redirectable as staff de-escalate her in a calming manner. She shared that she did not directly witness the alleged abuse, but was alerted to it by Certified Nursing Assistant (CNA/Staff #44). She remembered assessing Resident #120 and asking her, in several different ways, what had happened. Staff #125 indicated the resident was unable to recall the incident. An interview was conducted on June 13, 2025 with Staff #44 AT 11:13 AM. Staff #44 defined abuse as mentally harming residents, physically hurting them or restraining them. She also indicated that the facility provides some sort of abuse training on a monthly basis. Staff #44 indicated that she remembered Resident #120 and recalls her being a wanderer who would mumble when she spoke. She also indicated that the resident was not physical towards others during her stay. Staff #44 recalled the incident and shared that Resident #120 had gone into another resident's room and CNA/Staff #150 went into the room to get her out. Staff #44 also indicated that she was walking down the hallway to assist Staff #150, due to her being new, when she heard Staff #150 say If you hit me, I'm going to hit you back. She explained that she went into the room and saw Staff #150 hit Resident #120 on the face with a closed fist. Staff #44 then went between Resident #120 and the staff person in an effort to de-escalate the resident and had told Staff #150 that she was going to report her. Staff #44 then removed Resident #120 from the room and went to the nurses' station to notify staff #125 and another nurse what had happened. (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 on June 13, 2025 with the Director of Nursing (DON/Staff #21) at 12:25 PM. Staff #21 indicated that when staff are hired, they are trained on abuse. She also added that ongoing abuse trainings occur twice a month and this also included trainings provided by the Behavioral Health team as well. Staff #21 defined abuse as an unwanted action against another person. She explained that her expectation of staff, when they are de-escalating a resident, was to give them their space and provide the resident with privacy as well as ensuring that others around them are safe. If the resident was not able to be de-escalated, then they would call 911. Staff #21 recalled the incident with Resident #120 and Staff #150. She indicated that Resident #120 was being aggressive and had grabbed Staff #150's breast. When she grabbed the staff member's breast, staff then slapped the resident in the face. Staff #21 indicated that the altercation was witnessed by a CNA and that CNA had interjected herself between Resident #120 and staff #150. Staff #21 shared that she had spoken with Staff #150 after the incident and the staff person had told her that her first reaction was to slap the resident when she grabbed her breast. Staff #21 added that the situation did not meet her expectations of how staff are to interact with residents because she would never expect a staff person to strike a resident no matter what and that it was absolutely a form of abuse. Based on clinical record reviews, facility documentation, resident and staff interviews, and policy review, the facility failed to protect the rights of four residents (#106; #107; #108; #104) to be free from abuse by other resident(s) (#88; #105). The deficient practice could result in further resident abuse. Findings included: -Regarding Resident #88 and #106; #107; #108 Resident #88 was admitted into the facility on January 10, 2023, readmitted on [DATE], and had medical history that included unspecified dementia with other behavioral disturbance, unspecified psychosis, and anxiety disorder. A review of the Quarterly MDS (minimum data set) assessment dated [DATE] revealed a BIMS (brief interview of mental status) score of 8 which indicated that the resident was moderately cognitively impaired. Care-plan initiated on January 11, 2023 with revision date of June 10, 2024 revealed that on April 13, 2024, May 22, 2024, and June 6, 2024 Resident #88 had incidents of aggression initiated resident to resident altercations. Interventions included: - April 13, 2024 behavioral evaluation after resident to resident altercation; - May 23, 2024 added to behavioral for re-evaluation and 1:1 supervision from staff for 30 days. Additional interventions related to behavior problem included: intervene as necessary to protect the rights and safety of others; divert attention; remove from situation and take to alternate location as needed, 1:1 attempt to figure out why/what is causing the behaviors; reorient and supervise as needed. Review of the electronic medical records (EMR) progress note dated April 13, 2024, 17:47, revealed resident came back from activities; commotion heard on hallway; staff intervene; Resident stated, I was heading to the patio, and Resident #106 kept grabbing and squeezing my hand, so punched him. Resident #88 placed in 15-minute checks and 1:1. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the electronic medical records (EMR) progress note dated May 18, 2024, 14:15, revealed Resident #107 spends his time pacing the hallway, pleasant mood but is easily agitated and triggered by others, resident has delusions about others talking about him, threatens to fight others. An additional progress note dated May 27, 2024, 00:21, revealed resident continues on 1:1 monitoring due to aggressive behavior. Further, progress note date May 28, 2024 revealed resident was seen by nurse practitioner for follow up after resident to resident altercation. Review of the electronic medical records (EMR) progress note dated June 05, 2024, 17:57, revealed resident hit his roommate; I asked what happened to the CNA that was the resident's one on one. Resident #108 stated My roommate (Resident #88) hit me in the face hitting the cheek and upper lip. An addition progress note revealed, Resident #88 hit his roommate in the face. Resident #88 stated, I don't like Mexicans and I will hit him again. Writer asked the assigned 1:1 how did Resident #88 get passed you to hit Resident #108, who stated he was so fast. Further, it was documented in the progress note Resident #108 stated, No, that f***** hits like a b****regarding to the details of the incident. Resident #106 was admitted into the facility on February 17, 2020 and had medical history that included tremor, aphasia following cerebral infarction, hemiplegia, and bipolar disorder. A review of the Quarterly MDS (minimum data set) assessment dated [DATE] revealed a BIMS (brief interview of mental status) score of 3 which indicated that the resident was severely cognitively impaired. Care-plan initiated on November 26, 2021 with revision date of December 30, 2024 revealed that on April 13, 2024 Resident #106 had incident of resident to resident altercation with bruise to left eye. Interventions included: 15-minute monitoring related to resident to resident altercation on April 13, 2024. Review of the electronic medical records (EMR) progress note dated April 13, 2024, 17:47, revealed resident came back from activities; commotion heard on hallway; staff intervene; Resident stated, I was heading to the patio, and Resident #106 kept grabbing and squeezing my hand, so punched him. Resident #106 had swelling and discoloration to left eye. Review of the facility investigation report dated April 17, 2024, revealed Resident #106 was found to have discoloration of the left eye. Concluding details of facility's investigation revealed that Resident #106 was in his wheelchair when Resident #88 passed, Resident #106 grabbed Resident #88 by the hand then Resident #88 hit Resident #106 in the left eye; and that, the facility substantiated the allegation of abuse between these residents. An interview was conducted by Assistant Director of nursing (Staff #58) with Resident #88 who stated, That fool grabbed my hand and squeezed it, so I punched him. Staff #58 interviewed Resident #106 who stated, some guy was walking by me, and then I said, can I have something? He said, what do you want, I went Ha, Ha, Ha then he punched me. The investigation report was signed by facility Administrator (Staff #95). Resident #107 was admitted into the facility on June 15, 2023 with diagnoses that included schizoaffective disorder, bipolar disorder, antisocial personality disorder, and narcissistic personality disorder. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Quarterly MDS (minimum data set) assessment dated [DATE] revealed a BIMS (brief interview of mental status) score of 3 which indicated that the resident was severely cognitively impaired. Care-plan initiated on June 15, 2023 with revision date of July 08, 2024 revealed that on May 23, 2024 Resident #107 had unit change due to aggressive behaviors following incident of resident to resident altercation. Interventions included: monitor/record/report to Medical Doctor as needed risk for harming others. Review of the facility investigation report dated May 24, 2024, revealed Residents #88 and #107 were arguing, then separated. Following review of video surveillance - at 12:36 PM, Resident #107 wheeled over to Resident #88 who was at a bench in the patio. Resident #107 began flailing his arms and kicked Resident #88 who then moved Resident #107's wheelchair away then sat back in the bench. Resident #107 again reproached and kicked Resident #88, both postured to fight, and then Resident #88 took several [NAME] one of which caught Resident #107 in the face. Further, the investigation report revealed that as time went on Resident #107 developed discoloration and swelling under the right eye. Director of nursing (Staff #21) interviewed Resident #88 who stated, I hit him because he was trying to kick me. Staff #21 interviewed Resident #107 who stated, Resident #88 punched him after the one o'clock smoke break. The facility substantiated the allegation of abuse between these residents. The investigation report was signed by facility Administrator (Staff #95). Resident #108 was admitted into the facility on April 14, 2024 with diagnoses that included schizoaffective disorder, suicidal ideations, and diffuse traumatic brain injury with loss of consciousness. A review of the Quarterly MDS (minimum data set) assessment dated [DATE] revealed a BIMS (brief interview of mental status) score of 14 which indicated that the resident was cognitively intact. Care-plan initiated on April 17, 2024 with revision date of June 30, 2024 revealed that Resident #108 had a behavior problem related to schizoaffective disorder bipolar. Interventions included: intervene as necessary to protect the rights and safety or others; approach/speak in a calm manner; divert attention; remove from situation and take to alternate location as needed. Review of the electronic medical records (EMR) progress note dated June 06, 2024, 09:10, revealed Resident #106 was moved to different room; and that, daughter was notified about the resident to resident altercation. Review of the facility investigation report dated June 06, 2024, revealed after the incident the certified nursing assistant (CNA/Staff #182) was suspended pending the outcome of the investigation after Staff #182 revealed, Resident #88 punched Resident #108; and that, assistant DON (Staff #58) took over the 1:1 post on Resident #88. The facility documented that Staff #182 shirked his duties as 1:1 which directly resulted in the incident. Staff #182 was terminated from employment and reported to the board of nursing for neglect. (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 on June 11, 2025 at 2:30 PM with licensed practical nurse (LPN/Staff #122) who stated abuse training is provided annually. Staff #122 state if abuse is suspected, staff report and take action right away, and move aggressor. If the abuse involves an employee they get suspended for 3 days while an investigation is conducted. Staff #122 stated abuse can be mental, physical, verbal, or sexual. Staff #122 stated physical abuse includes injury in skin or discoloration. Staff #122 stated that ideally 1 on 1 is to prevent incidents, the staff are there to prevent, ensure that no behavior is going to occur; and that, it would not meet the facility's expectation if an incident of abuse occurs while a staff are 1 on 1 with a resident because the staff should be arm's length. Staff #122 recalled incident between Residents (#88 and #107) occurred due to Resident #107 being the instigator. Staff #122 recalled incident between Residents (#88 and #108) occurred when they were new roommates. Staff #122 stated Resident #88 was a very aggressive guy he was 1 on 1 for a long time. Staff #122 stated he was physically aggressive and would mad dog a lot of the guys; and that he targeted certain residents a lot, he picked on staff as well - I would try to deescalate him a lot. An interview was conducted on June 12, 2025 at 11:01 AM with charge registered nurse (RN/Staff #60) who stated in-service training on abuse is received about at least every 2 months or after a new incident. Staff #60 stated abuse is reported Immediately - we have a 2-hour window to report and included physical, mental/emotional like condescending behavior or name calling, financial, sexual, physical as well as neglect if they weren't taken care of appropriately. Staff #60 stated physical abuse would include restraint, slapped, pinched, hair pulled, any type of physical contact that would result in distress or physical pain to the resident. Staff #60 confirmed it was a behavior policy that usually people with behavior will have a 1 to 1 to prevent any physical or verbal altercation; and that, physical abuse wouldn't meet the facilities expectations for residents who have 1 to 1 assignment. Staff #60 stated if staff are assigned 1 to 1 they would be responsible for the patient's needs, they would shadow, not allowed to leave them alone - all the duties fall on that staff non-stop. Staff #60 stated staff should be looking for target behavior would be able to tell by body language and always try to redirect; if they are dead set, separate them immediately; and that, it's my experience that if someone is 1 to 1 you can usually see the triggers and try to be preventative and proactive and be ahead of that to prevent the abuse. An interview was conducted on June 13, 2025 at 09:22 AM with staffing coordinator (Staff #110) who stated that Resident #88 was very unpredictable, his temperament always varied from being happy then doing what he wanted, so facility had to place a 1 to 1 with him. Staff #110 could not recall incidents, however recalled that they would occur readily around the smoking area, something always happens around the smoking patio. (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 on June 13, 2025 at 09:34 AM with assistant director of nursing (ADON/Staff #58) who stated, regarding the incident between Resident #88 and #106, Resident #106 was alert and was in a wheel chair and liked to antagonize. Staff #58 stated Resident #106 would name call and after antagonizing Resident #88 got up and hit Resident #106. Staff #58 stated that Resident #107 also liked to antagonize and would kick from his wheelchair. Staff #58 stated, regarding the incident between Resident #88 and #107, that Resident #88 was impulsive and Resident #107 being antagonistic did not really go together. Staff #58 stated that, regarding the incident between Resident #88 and #108, Resident #88 was 1 to 1 at that time to prevent any resident to resident incidents, therefore would not meet facility expectations if he hit another resident. Staff #58 stated that for that particular incident, I believe the staff that was assigned was afraid of the Resident (#88), so after that incident we had to be mindful of what staff we put 1 to 1. Staff #58 stated that the facility expectations are that resident to resident abuse do not occur. An interview was conducted on June 13, 2025 at 10:22 AM with director of nursing (DON/Staff #21) who stated that if staff are assigned 1 to 1 with a resident the expectation is that they are with the resident all the time and they should be engaging with the residents based on the resident's preferences. Staff #21 stated that during 1 to 1 assignment she does not want staff helping with anything else because that is their main task. Staff #21 stated that abuse occurring while a resident is 1 to 1 with staff or any physical abuse would not meet the facility's expectations. -Regarding Residents #105 and #104 Resident #105 was initially admitted into the facility on November 11, 2022 and readmitted on [DATE] and had medical history that included degenerative diseases of nervous system, major depressive disorder, and chronic kidney disease, stage 3A. A review of the Quarterly MDS (minimum data set) assessment dated [DATE] revealed a BIMS (brief interview of mental status) score of 3 which indicated that the resident was severely cognitively impaired. Care-plan initiated on March 04, 2024 with revision date of May 30, 2024 revealed that on March 04, 2024 Resident #105 was moved to different room due to increased aggression. Additionally, Resident #105 was placed on 15-minute checks. Interventions included: monitor/document/report as needed any signs or symptoms of resident posing danger to self and others; when the resident becomes agitated: intervene before agitation escalates; guide away from source of distress. Review of the electronic medical records (EMR) progress note dated March 03, 2024, revealed one day prior to incident a nurse documented behaviors of aggression at 0700, Resident #105, ran at me with both fists fighting position and yelling that he was going to kill. On March 04, 2024, 05:31, note revealed Resident #105 in physical aggression with roommate causing injury. Resident #104 was initially admitted into the facility on December 18, 2017 and readmitted on [DATE] and had medical history that included alcohol-induced persisting dementia, psychotic disorder with delusions, and violent behavior. A review of the Quarterly MDS (minimum data set) assessment dated [DATE] revealed a BIMS (brief interview of mental status) score of 1 which indicated that the resident was severely cognitively impaired. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Care-plan initiated on December 27, 2021 with revision date of April 19, 2024 revealed that on March 04, 2024 Resident #104 was moved to different room after roommate moved to other unit following altercation. Goal included: the resident will not harm self or others through the review date; the resident will seek out staff/caregiver when agitation occurs through the review date. Review of the electronic medical records (EMR) progress notes dated March 4, 2024, revealed Resident #104 was seen by behavioral nurse practitioner for resident to resident altercation; and that resident was moved to different room down the hall after altercation., Review of the facility investigation report dated March 06, 2024, revealed that on March 04, 2024 at 0515, behavioral residents (#104 and #105) and roommates were heard arguing. Resident #104 was relocated. The unit certified nursing assistants were providing care to other residents when Resident #105 could be heard saying, come get your buddy out of here. CNA/Staff #55 immediately went to the room and found Resident #104 bleeding above his right eye brow and had blood at his mouth. Investigation findings revealed Resident #104 was found with a laceration at the right eye brow. Upon interview, Resident #104 stated, he hit me. Facility investigation revealed adult protective services verified the allegations of neglect. The investigation report was signed by facility Administrator (Staff #95). An interview was conducted on June 13, 2025 at 09:34 AM with assistant director of nursing (ADON/Staff #58) who stated that if abuse occurs in the facility they will notify herself, director of nursing, or administrator whoever they are able to reach first. Staff #58 stated the types of abuse included verbal, physical, financial, sexual, and neglect; and, described physical abuse included hitting, and scratching. Staff #58 stated that the facility had a 2-hour time frame to report abuse. Staff #58 confirmed having a role in conducting the facility's 5-day investigations including making sure residents are safe, assessed for injuries, interview residents, set behavior evaluations, notify family of residents and update care plans. Staff #58 stated, regarding the incident between Resident #104 and #105, Resident #104 was very active and impulsive at the time of the incident; and that, I recall the incident occurring, but cannot recall details. Staff #58 stated that the facility expectations are that resident to resident abuse do not occur. An interview was conducted on June 13, 2025 at 10:22 AM with director of nursing (DON/Staff #21) who stated that staff are provided annual abuse and neglect training by psychiatry provider and if an incident occurs additional training is provided. Staff #21 stated during any new allegations of abuse she needs to be notified immediately and are reported to the health department, adult protective services, and the unit nurse will contact the police department. Staff #21 stated that if the nurse on the floor must provide some type of intervention if they have not done so after reporting. Staff #21 stated that any abuse would not meet the facility's expectations. -Regarding resident #24 (alleged victim): Resident # 24 was admitted to the facility on [DATE] with diagnoses that included: intracranial injury without loss of consciousness, sequela, aphasia following cerebral infarction, schizoaffective disorder, bipolar type, alcohol abuse (in remission), intermittent explosive disorder, major depressive disorder, recurrent, anxiety disorder, and epilepsy. (continued on next page)

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	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Rosa Care Center	1650 North Santa Rosa Avenue Tucson, AZ 85712

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(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	Review of resident #24's care plan revealed a focus, revised on April 21, 2022 that the resident is/has the potential to be verbally aggressive in regards to schizoaffective disorder. Resident's care plan reveals no focus for physical aggression. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 01, indicating severe cognitive impairment. Additionally, the MDS revealed that the resident exhibited behavioral symptoms not directed towards others 1-3 days during the assessment period. A nursing progress note dated June 6, 2025 at 1:58 p.m. stated that resident #24 was sitting on his bed with a laceration, swelling and a bruise to his left eye. According to the note, the resident stated that he was sitting on the toilet when another resident (#71) came into the restroom. Resident #24 told resident #71 to leave and when he refused, resident #24 was hit in the face by resident #71. Staff separated both residents and notified administration and management. At 2:26 p.m. another nursing progress note documented that resident #24 had slight bruising to the left eye and with no swelling noted. A nursing note dated June 8, 2025 indicated that resident had left eye bruising. The note stated that resident did not note any discomfort or pain. A progress note dated June 11, 2025 documented that resident has a bruise to his left eye which was healing. Review of resident #24's care plan revealed a focus, revised on April 21, 2022 that the resident is/has the potential to be verbally aggressive in regards to schizoaffective disorder. Resident's care plan reveals no focus for physical aggression. An observation and interview of resident #24 on June 11, 2025 at 1:32 p.m. revealed a red and swollen injury to his left eye. In an interview, resident #24 stated that his eye was still sore and that his injury was the result of being punched by another resident. He could not recall the date of the incident or the circumstances. -Regarding resident #71 (alleged perpetrator): Resident #71 was admitted to the facility on [DATE] with diagnoses that included: dementia with anxiety, parkinsonism, anxiety disorder, chronic ischemic heart disease, peripheral vascular disease, heart failure, Wernicke's encephalopathy, alcohol abuse (in remission), type 2 diabetes mellitus without complications, chronic obstructive pulmonary disease, presence of automatic implantable cardiac defibrillator, and iron deficiency anemia. A care plan revised May 22, 2024 revealed that resident #71 had the potential for verbal/physical aggression elated to his dementia with behaviors. Interventions included for staff to intervene prior to [TRUNCATED]