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	10/31/2025

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 - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, and review of facility policy and procedures, the facility failed to ensure one resident (#87) was free from abuse from another resident (#16). The deficient practice resulted in one resident (#87) sustaining injuries.Based on clinical record review, interviews, and review of facility policy and procedures, the facility failed to ensure one resident (#87) was free from abuse from another resident (#16). The deficient practice resulted in one resident (#87) sustaining injuries.Findings include:Related to Resident #87-Resident #87 was admitted to the facility on [DATE] with diagnoses that included Aphasia, other specified intracranial injury without loss of consciousness, sequela, Anxiety disorder and Schizoaffective disorder, Bipolar type.Review of the quarterly Minimum Data Set (MDS), dated [DATE] indicated the Brief Interview for Mental Status (BIMS) was not completed. However, staff assessed Resident #87's cognitive skills for daily decision making to be moderately impaired. The same assessment also noted that Resident #87 exhibited other behavioral symptoms that were not directed towards others every 4-day days during the assessment period.Review of the care plan, initiated on December 21, 2021, indicated Resident #87 had a behavior problem related to his Schizoaffective disorder, Bipolar type and intermittent explosive disorder as evidenced by his restlessness, irritability, and decreased appetite. Interventions included administering medications as ordered, monitoring and documenting the side effects of the medications, anticipate and meet the resident's needs, and 1:1 attempt to figure out why or what is causing the behaviors due to the resident's word salad and difficulty communicating his thought process.Review of a Nursing Note, dated October 12, 2025 at 6:03 P.M., revealed that the Assistant Director of Nursing (ADON/Staff #41) notified the resident's provider and case manager of a resident-to-resident altercation, via e-mail. Review of an Incident Note, dated October 12, 2025 at 10:01 P.M., revealed it was created by Licensed Practical Nurse (LPN/Staff #8). The note indicated that around 5:27 P.M. Resident #87 had a verbal disagreement with his roommate (Resident #16) regarding a light in the room. The roommate had pushed Resident #87 which caused the resident to lose his balance and fall. The same note indicated that an assessment of Resident #87 was done and it was determined that he sustained a 4-centimeter (cm) laceration to the back of his head. The bleeding was cleaned and bandaged and Resident #87's vital signs were within normal limits. The note shared that both residents were able to be successfully redirected and the roommate was moved to a different room.An interview with Resident #87 was attempted on October 30, 2025 at 3:26 P.M. However, the resident was not interviewable. He was observed to have a hat on his head so alleged wounds were not able to be observed. Resident #87 was not willing to remove the hat when asked.Related to Resident #16-Resident #16 was admitted to the facility on [DATE] with diagnoses that included Dementia, mild with other behavioral disturbance, adjustment disorder with mixed anxiety and depressed mood, and insomnia.Review of the admission MDS, dated [DATE] indicated Resident #16 had a BIMS score of 12 which indicated he has moderate cognitive impairment. The same MDS also noted Resident #16 exhibits hallucinations, delusions, wandering, and other behavioral symptoms not directed towards others every 1-3 days during the assessment period.Review of the care plan, initiated on September 8, 2025 indicated Resident #16 had a behavioral problem related to Dementia with agitation and anxiety as exhibited by his exit seeking, restlessness, delusions, and inability to fall/stay asleep. Interventions included administering medications as ordered, monitoring and documenting side effects of the medications, anticipate and meet the resident's needs, and to intervene as necessary to protect the rights and safety of others.Review of the clinical record revealed a Psych follow-up note dated October 8, 2025 at 12:45 P.M. The note indicated that Resident #16 was to restart Risperidone 0.5 milligrams (mg) every evening due to increased behaviors and delusions after recent discontinuation. The note also indicated the resident was to be monitored for changes in behavior or perception and that a follow-up will be done in two weeks.Review of a Progress Note, dated October 11, 2025 at 8:01 P.M. revealed that Resident #16 was transferred to the current facility, from another facility, after assaulting another resident. It also noted that Resident #16 did not recall assaulting another resident at his previous facility.Review of a Nursing Note, dated October 11, 2025 at 10:17 P.M. was exhibiting increased irritability and was verbally aggressive when being redirected. It took staff several attempts to have the resident take his bed time medications.Review of an Incident Note, dated October 12, 2025 at 9:38 P.M. and created by Staff #8, revealed that around 5:27 P.M. a verbal disagreement took place between Resident #16 and his roommate regarding a light in the room. It also noted that the roommate sustained a 4 cm