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	02/20/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the facility observation, staff and resident interviews, and policy review, the facility failed to report to state agencies a serious injury to a resident within the required timeframe for 1 of 3 (Resident #1) residents. Failure of reporting could result in delay in investigation of possible abuse by the appropriate agencies. Findings include:Resident # 1 was re-admitted on [DATE] with diagnoses that included hemiplegia and hemiparesis due to cerebral infarct involving the right dominant side, contracture of the right wrist, need for assistance with personal care, muscle weakness, schizoaffective disorder, bipolar type, major depressive disorder, and anxiety disorder. A comprehensive care plan initiated on November 26, 2025, revealed that the resident had right-sided hemiplegia/hemiparesis due to cerebrovascular disease. Further review of the care plan revealed that the resident had behaviors, including false accusations. A quarterly Minimum Data Set (MDS) dated [DATE], revealed that the Brief Interview for Mental Status (BIMS) assessment was a 15, which indicated Resident # 1 is cognitively intact. Further review of the MDS revealed the resident did not have any mood or behavioral indicators.A comprehensive care plan initiated on January 7, 2026, revealed that the resident has an activity of daily living (ADL) self-care performance deficit. Further review of interventions revealed Resident # 1 on two person cares due to false accusations.A Nursing note dated January 23, 2026 at 10:26 a.m. revealed that Resident # 1 reported right shoulder pain. The nursing note also revealed that the physician was notified, and a STAT x-ray order was placed. The Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager (UM), and administrator were notified. A Nursing note dated January 23, 2026, at 2:53 p.m. revealed the x-ray finding of a moderately displaced comminuted fracture of the surgical neck of the right humerus. An Orthopedic Report dated January 23, 2026, revealed that Resident # 1 was being transferred when she started having pain in her right shoulder. Further examination revealed swelling and bruising over the proximal humerus with tenderness on palpation. A facility investigation dated January 23, 2026 revealed an interview with the Certified Nursing Assistant (CNA/Staff #34) who reported that he and another CNA (Staff #10) transferred Resident # 1 from the wheelchair to the bed using a Hoyer lift in accordance with facility protocol and safe transfer procedures without incident. A reportable incident was reported to the state agency by the facility regarding the transfer of Resident # 1 on February 18, 2026, 26 days after the facility was made aware of the fracture. The facility started its investigation with regard to the transfer of Resident # 1 on January 23, 2026, but did not report to the appropriate state agency until after Adult Protective Services (APS) reported the incident to the facility on February 18, 2026. An Interview with Resident # 1 on February 20, 2026, at 11:42 a.m. revealed that on January 22, 2026, Certified Nursing Assistant (CNA/Staff # 34) picked up Resident # 1 by wrapping his arms around the Resident's shoulders and picked her up from the wheelchair to the bed even though Resident #1 was to be transferred by Hoyer lift. Resident # 1 reported hearing a crack and feeling pain. Resident #1 (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed that she let Staff #34 know there was pain, but did not do anything about it. She reported that she notified the morning Licensed Practical Nurse (LPN/Staff # 60) about the pain and bruising to the Resident's arm. Resident # 1 revealed that at the time of the transfer, there was another CNA (Staff # 10) in the room with Staff # 34. Resident #1 did report the incident to the Director of Nursing (DON/Staff # 82), who had interviewed Resident #1 regarding the incident. A phone call with Staff # 34 on February 20, 2026 at 12:09 p.m., was attempted, but staff member did not answer, and voicemailbox was full. An interview with LPN (Staff # 60) on February 20, 2026, at 12:43 p.m., revealed that on January 23, 2026, resident #1 came to staff #60 during med pass, requesting to see the doctor, but did not say why. Staff #60 made notifications of the pain to the provider, DON and Assistant Director of Nursing (ADON/Staff #2). Staff # 60 reported that the provider came out and talked with Resident # 1 regarding the injury and ordered an x-ray of her right shoulder. Staff # 60 reported that the results of the x-rays came in on her shift and she reported a fracture to Resident #1's right arm to her ADON. An interview with CNA (Staff # 108) on February 20, 2026, at 1:04 p.m. revealed that on the morning of January 23, 2026, Resident # 1 had informed Staff # 108 that her arm was sore, but Resident # 1 let Staff #108 and CNA (Staff # 129) transfer her via the Hoyer lift with no reported pain. Once up, she stated that Resident # 1 went to tell LPN Staff # 60 about the pain. Staff # 108 revealed that Resident # 1 is always a 2-person Hoyer lift.In an interview with ADON (Staff # 2) on February 20. 2026, at 1:13 p.m., revealed that she received a call from Staff #60 regarding Resident #1's pain and that Staff # 60 was going to notify the doctor. Staff # 2 also revealed that she was notified of the fracture that same day and notified the DON, who had followed up with orders from the physician. An interview with DON (Staff # 82) on February 20, 2026, at 1:43 p.m. revealed that on January 23, 2026, Resident # 1 approached the DON and reported that her right shoulder hurt and that someone had incorrectly transferred Resident # 1. DON revealed that the physician was immediately notified, and an investigation was started. She reported interviewing the accused staff on January 23, 2026, as well as other staff and residents. The DON revealed not making the required notifications to the state agency, APS, Ombudsman, and Police because she thought she did not have to if the complainant was known to give false accusations, even though a major injury had occurred and the DON was investigating the cause of the injuryA policy and procedure titled Reporting Alleged Violations of Abuse, Neglect, Exploitation, Mistreatment dated July 2025, revealed that the facility will ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made if the events that cause the allegation involves abuse or results in serious bodily injury.