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	08/29/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interviews, and review of facility policies, the facility failed to store food in accordance with professional standards for food service safety. This deficient practice has the potential to increase the risk of foodborne illness and compromise resident healthFindings Include:An initial kitchen observation was conducted on August 26, 2025 at 08:26 AM in conjunction with the Dietary Director, (Staff # 116). During observation of the food preparation area, two sanitizer buckets, one containing a dish rag, were observed in the food preparation area where a bowl of pudding/pie mix was being prepared. A portable, blue plastic fan was observed sitting on a metal rack, blowing across the food server's side of the tray line. The blades of the fan were noted to be caked with thick, brownish-gray colored dirt.An observation on August 26, 2025, revealed pork and turkey on the bottom shelf of the freezer that were not labeled or dated. Additional observations revealed that two bags of frozen breadsticks and one bag of frozen fish patties were stored with no labels, including open or expiration dates.Further observation revealed twenty-four packages of small corn tortillas, one package of cooked and peeled eggs, one bag of opened, diced onions, one thirty-two-ounce bag of Bountiful Harvest cauliflower, two bags of wilted, brown, shredded, lettuce, one open box of mushrooms, one open box of carrots and one partially peeled and used cucumber wrapped in plastic wrap stored in the refrigerator with no labels to include open or expiration dates.An observation of surface sanitation solutions containing a quaternary ammonia product was conducted on August 26, 2025 at 08:50 AM, which revealed that all Sani-buckets tested at 400 parts per million using visual assessment of test-strip color change.Temperature logs for the walk-in freezer, four-door freezer, the reach-in, and walk-in refrigerators revealed adequate temperatures and daily monitoring. Unit refrigerators reflected adequate temperature monitoring and revealed no resident or staff food items in the refrigerators.Observation of pureed food preparation on August 27,2025 at 10:40 AM revealed that pizza was prepared and pureed with tomato sauce. The observation revealed that ingredients were measured for each portion prepared. At one point, staff # 19, was observed to drop the lid of the blender that was being used to prepare the puree. The lid was taken to the sink for washing and sanitizing. The Dietary Director, (Staff #116) advised a dietary aide that it was not permissible to dry the lid with a paper towel, stating it needed to air dry completely before use. A contract dietitian, (Staff # 204) also present during the observation confirmed that using a lid that had not completely dried would not meet her expectation, as the risk would be possible cross-contamination of the food.Temperature checks of all pureed foods were adequate and within safe serving parameters. The consistency of the pureed foods revealed appropriate consistency without visible lumps or inconsistent texture.A tray-line observation was conducted on August 27, 2025, at 11:15 AM which revealed positive communication between a dietary aide (staff # 77), and cook (Staff #111), who was serving as a second dietary aide and the serving cook, (Staff # 19), who used tray-ticket software to identify and confirm dietary orders for residents. Both dietary aides performed hand-hygiene prior to starting tray preparation; the cook (Staff #111) donned gloves, the other, (Staff # 77), did not. An observation of tray line practices revealed that the facility does not use plate warmers due to the risk of using them in a facility where many residents are diagnosed with (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	behavioral symptoms. The Dietary Director (Staff # 116) stated that for similar concerns, only two units receive stainless steel utensils while the remaining units receive plastic utensils. During the tray-line service, a slice of cucumber was observed to fall off the plate onto the tray. Dietary Aide, Staff #77 was observed to pick up the item and place it back onto the plate with his hand. The tray line was stopped and Staff # 204 was asked if she had observed any breach in practice. Staff # 204 stated, he should not have touched the food with his hand and returned it to the plate. The dietitian stated that this did not meet her expectations and identified the risk as contamination of the food and possible infection. The Dietary Director (Staff #116) was advised of the observation and stated that picking up food and putting it on the plate did not meet his expectations. The Dietary Director stated that the risk would be contamination and that he would use the observation as a part of an upcoming staff in-service.Pre-service food temperatures for all prepared foods were within acceptable temperature ranges, which included: pizza at 170 degrees, mechanical soft, ground beef at 200 degrees, vegetables at 178 degrees and salad at 38 degrees. The sample food tray revealed adequate temperatures, and all foods met acceptable standards for appearance and taste.An observation of the dry food storage area was conducted on August 27, 2025, at 1:40 PM which revealed separate areas for the storage of regular canned goods and dented cans. Three dented cans were observed in the storage room; however, they were located away from the regular canned goods. The Dietary Director (Staff # 116) stated that dented cans are stored separately until a full case is completed and then returned to the food vendor for crediting to the facility. An observation of emergency food and water storage areas revealed adequate storage practices and sufficient supply. The outside trash area was clean and free of evidence of pests. The lids of the dumpsters were closed; however, on August 28, 2025, at 08:00 AM, one of three dumpster lids was observed to be open upon arrival to the facility and remained open at 12:15 PM and 15:30 PM. The open dumpster lid was reported to the Dietary Director (Staff # 116) and promptly closed.An interview with the Dietary Director (Staff #116) was held on August 26, 2025 at 09:00 AM who identified Shamrock Foods as the facility's food distribution source. The facility uses contracted dieticians who hold weekly ?WIN meetings for discussion of residents' dietary needs by monitoring weight, intake, and food-related behaviors. The Dietary Director stated that fresh produce should be labeled with a use-by date, and the process for food rotation is ?first-in, first-out.' Staff #116 stated that if a staff member reported to work while ill, they would be sent home, stating, No one stays if they are sick. The Dietary Director stated that if staff are injured while working, for example, if they incur a cut on their finger,) the injury would be cleaned and bandaged, and the staff member would be instructed to apply a ?finger condom' before returning to work; and further stated that if the injury was severe, the employee would be sent out for care.The Dietary Director stated that food handler cards are not required for staff. A review of Pima County inspection notice revealed no deficiencies.A review of the policy titled Food Receiving and Storage, revised November 2022, revealed that foods shall be received and stored in a manner that complies with safe food handling practices. The policy further stated that all foods stored in the refrigerator or freezer are covered, labeled, and dated with a use-by date. The policy identified critical control points in food preparation and serving processes as those which control can be exercised to reduce, eliminate, or prevent or eliminate the possibility of a food safety hazard. The policy specified some of these points as thawing, cooking, cooling, holding, reheating of foods and employee hygienic practices.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, staff interviews, and review of policies and procedures, the facility failed to ensure that food was served in accordance with professional standards of food service safety. The deficient practices could result in food-borne illnesses.Findings Include:An initial kitchen observation was conducted on August 26, 2025, at 08:26 AM in conjunction with the Dietary Director (Staff # 116). During observation of the food preparation area, two sanitizer buckets, one containing a dish rag, were observed in the food preparation area where a bowl of pudding/pie mix was being prepared. A portable, blue plastic fan was observed sitting on a metal rack, blowing across the food server's side of the tray line. The blades of the fan were noted to be caked with thick, brownish-gray colored dirt.During observation of tray-line service on August 27, 2025, at 11:15 AM, a slice of cucumber was observed to fall off the plate onto the tray. Dietary Aide, Staff #77, was observed to pick up the item and place it back onto the plate with his hand. The tray line was stopped, and Staff # 204 was asked if she had observed any breach in practice. Staff # 204 stated, he should not have touched the food with his hand and returned it to the plate. The dietitian stated that this did not meet her expectations and identified the risk as contamination of the food and possible infection. The Dietary Director (Staff #116) was advised of the observation and stated that picking up food and putting it on the plate did not meet his expectations. The Dietary Director stated that the risk would be contamination and that he would use the observation as a part of an upcoming staff in-service.An interview with Dietary Aide (Staff # 77), was conducted on August 28, 2025, at 12:40. The Dietary Aide stated that standard kitchen practices are to wash hands on entering and exiting the kitchen at the handwashing sink. Staff # 77 stated that it is not necessary to wear gloves when working the tray line because he does not touch the resident's food. The Dietary Aide further stated that he was aware that he should not have touched the item that fell off the plate, but it was automatic. He stated that the risk to the resident would be low to medium, and the potential risk to the resident could be that whatever was on the tray could move to the food. A review of the Hand Washing Policy, located in Chapter 4: Sanitation and Infection Control, copyright 2021, from Nutrition Alliance, LLB by BDA, Inc., revealed that employees will wash hands as frequently as needed throughout the day using proper hand washing procedures (and surrogate prosthetic device washing procedures as appropriate). The procedure revealed that hands and exposed portions of arms (or surrogate prosthetic devices) should be washed immediately before engaging in food preparation and during food preparation, as often as necessary to remove soil or contamination and to prevent cross-contamination when changing tasks. The policy further revealed that staff will be educated on the importance of handwashing and retrained and reminded as necessary on the above guidelines.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews, and facility policies, the facility failed to ensure that a Preadmission Screening and Resident Review (PASARR) level I screening was accurately completed for one resident (#41). The sample size was #21. The deficient practice could potentially lead to residents not receiving appropriate placement and services to identified mental health needs. Findings include:Resident #41 was admitted to the facility on [DATE] with diagnoses that included Hemiplegia and Hemiparesis following cerebrovascular infarction affecting right dominant side (weakness and/or complete paralysis on the left side of the body due to a stroke), schizoaffective disorder bipolar type, major depressive disorder, anxiety disorder, and vascular dementia.A review of the quarterly Minimum Data Set (MDS), dated [DATE] revealed Resident #41 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident is cognitively intact. Verbal behaviors and wandering was noted in the MDS assessment. It was also noted that Resident #41 is taking antidepressants but was not taking antipsychotics. Review of Resident #41's physician's orders from the resident's previous placement, dated October 10, 2022, identified the primary diagnosis as Hemiplegia and Hemiparesis following unspecified cerebrovascular disease. It also listed Vascular Dementia with behavioral disturbance as the 7th diagnosis.Review of Resident #41's pre-admission PASARR, dated October 11, 2022 and completed by the previous facility, indicated Resident #41 had schizoaffective disorder, major depression disorder, and anxiety disorder. The same form indicated the resident did not have a primary diagnosis of dementia or Alzheimer's disease. It was also noted that the resident had been receiving mental health services from the in-patient Behavioral Health Team and she was taking psychotropic medications. The referral determination indicated there was no referral necessary for a Level II PASARR.The care plan, initiated on October 12, 2022 and revised on July 9, 2025 indicated Resident #41 had schizoaffective disorder bipolar type and a history of opioid abuse. Identified goals included having her behaviors monitored by Behavioral Health Services. Interventions included administering medications as ordered, respect (the resident's) decisions/choices (related) to 2-person care, and attempt to figure out the cause of the behaviors. A second care plan, initiated on October 12, 2022 and revised on June 10, 2025, indicated Resident #41 was taking psychotropic medications due to irritability, voicing sadness due to her diagnosis. The goal was for Resident #41 to be free from psychotropic related complications and interventions included administering psychotropic medications as ordered, monitoring for side effects and effectiveness, and documenting and reporting adverse reactions to the physician.Review of Resident #41's post-admission PASARR, dated October 12, 2022 and signed off by the Social Services Director (SSD/Staff #522), indicated Resident #41 had a primary diagnosis of dementia or Alzheimer's disease. The same PASARR indicated that this was verified by a comprehensive mental status exam. It was noted that a psychiatric/behavioral evaluation was completed by an external Mental Health agency in 2022. The referral determination indicated that a referral was not necessary for a Level II PASARR.Review of an Encounter note from the external Mental Health agency indicated the Psychiatric-Mental Health Nurse Practitioner (PMHNP) saw Resident #41 on October 18, 2022 at the current facility for a Behavioral Health Team meeting. The Encounter note listed the following diagnosis for Resident #41:- Schizoaffective disorder, bipolar type- Opioid dependence- Cocaine dependence- Cognitive deficits following unspecified cerebrovascular diseaseAn interview was conducted on August 29, 2025 at 10:04 A.M. with Staff #522. Staff #522 confirmed that the initial PASARR from the discharging facility did not identify a primary diagnosis of dementia. When asked who completed the post admission PASARR, dated October 12, 2022, Staff #522 confirmed that she completed it and that it listed the primary diagnosis for Resident #41 as dementia. When asked how she determined that the primary diagnosis was dementia, Staff #522 shared that she looked at the resident's History and Physical, the pre-admission PASARR, and why she was being admitted - she (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was not being admitted for behaviors. Staff #522 shared that she will meet with the medical records team and they would have a round table discussion as to what the primary diagnosis would be. She indicated that she knew Resident #41 was admitted with a primary diagnosis of stroke but she was unable to locate documentation indicating the primary diagnosis should have been dementia. Staff #522 shared that she did not have a copy of the comprehensive mental status exam that she used to verify the primary diagnosis of dementia. She added that she called Resident #41's Public Fiduciary to see if she had a copy of the exam report but she did not have it as well. Staff #522 stated that a resident with Schizophrenia and on psychotropic medications without a primary diagnosis of dementia should have been referred to a Level II PASARR. She also shared that the risk to the resident for not referring her to a Level II would be not providing the level of service that the resident might need. If a resident were to also have behavioral issues, they would need to make sure that services are commensurate with the diagnosis. Staff #522 also confirmed Resident #41 had a BIMs score of 15.An interview was conducted with the Director of Nursing (DON/Staff #61) on August 29, 2025 at 10:35 A.M. Staff #61 explained that she would get the diagnosis of an incoming resident from the Physician's orders from the previous facility or get it off the PASARR. She shared that the PASARR is primarily managed by the Admissions/Staff #8 and Social Services (Staff#522). When asked how she determines the primary diagnosis of a resident, she shared that the first diagnosis listed in the Electronic Health Record (EHR) is typically the primary. Staff #61 identified the primary diagnosis for Resident #41 as Hemiplegia and Hemiparesis following Cerebral Vascular Disease. When asked if there is ever a round-table discussion to review potential new admissions and their primary diagnosis, she shared that they don't and that (Staff #8) and the Administrator (ADM/Staff #730) will meet and screen potential residents and then the business office will verify their insurance. Once that is all done, Staff #61 then reviews the packet and looks at the resident's diagnosis, medication list, behaviors, and if they need any special equipment to determine if we are able to meet their needs. Staff #61 shared that if the PASARR is not filled out correctly, then the risk to the residents would be them not being able to get the appropriate services they need.An interview was conducted with Staff #8 on August 29, 2025 at 10:44 AM. Staff #8 shared that the incoming resident's case manager will tell her the resident's primary diagnosis or sometimes it is in their admission packet. She then confirms the primary diagnosis with the resident's insurance. When asked if dementia was the primary diagnosis for Resident #61, she shared that her primary diagnosis was Hemiplegia and Hemiparesis following cerebral infarction of the right side. Staff #8 added that it was confirmed by Resident #41's case manager. Staff #8 also shared that the primary diagnosis on the paperwork from the previous facility she was at, dated October 3, 2022, did list Hemiplegia was her primary diagnosis.Review of an undated policy titled, Pre-admission Screening and Resident Review (PASRR) states Social Services to review for PASRR on new admission/Create new PASRR for new admission for completion of assessment for non-convalescent Care Stay (SRCC stays are non-acute). Review of Diagnosis trigger PASRR II criteria: - Mental Illness, Symptoms- Adaptation to change- DDD (Developmental Disabilities)- Provide history of Developmental and psychiatric treatment (if available)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews, and facility policies, the facility failed to ensure that necessary respiratory care was provided for one resident (#2). Sample size was 23. The deficient practice could lead to residents not receiving appropriate respiratory care.Findings Include:Resident # 2 was admitted to the facility on [DATE], with diagnoses that included: acute respiratory failure with hypoxia and chronic obstructive pulmonary disease.A review of the comprehensive Minimum Data Set (MDS), dated [DATE] revealed that the resident had adequate levels of hearing and the ability to make himself understood and to understand others. However, the resident had a moderate visual impairment that permitted him to identify objects, but not to read newspaper headlines. The Brief Interview of Mental Status (BIMS) revealed a score of 09, which indicated a moderate level of cognitive impairment. The Patient Health Questionnaire-2 (PHQ-2) revealed a score of 00, which indicated no symptoms of depressed mood and required no further evaluation. The MDS revealed that Resident #2 had no hallucinations or delusions; however, they exhibited physical and verbal behaviors directed towards others and other behavioral symptoms not directed towards others, one to three days of the rating period. The MDS further revealed that the resident had a limited range of motion of both upper and lower extremities, and used a wheelchair for mobility. The MDS revealed that the resident was dependent in toileting, showering/bathing, upper and lower body dressing, putting on and taking off footwear, personal hygiene, and tub/shower transfers. The MDS identified the resident as incontinent of bowel and bladder and revealed that the resident reported occasional low back pain at a level ?9' on a 0-10 numeric scale. The MDS revealed that the resident had a stage 3 pressure ulcer, and was at risk for developing further pressure ulcer or injuries.A review of the comprehensive care plan dated August 8, 2025, revealed that the resident was dependent on staff for meeting emotional, intellectual, physical, and social needs related to immobility, anxiety, dementia, and a cognitive communication deficit. The care plan revealed that the resident had Chronic Obstructive Pulmonary Disease (COPD), with a related goal of remaining free from signs or symptoms of respiratory infections through the review date. Interventions supporting this goal included giving aerosol or bronchodilators as ordered, monitoring any side effects and effectiveness, monitoring for difficulty breathing, reminding the resident not to push beyond endurance, monitoring for signs or symptoms of acute respiratory insufficiency, including anxiety, confusion, restlessness, shortness of breath at rest, cyanosis, or somnolence. The care plan further stipulated that the resident would be monitored for anxiety, staff would offer support and encourage the resident to vent frustrations, fears and provide reassurance and PRN medications for anxiety as ordered. The care plan also indicated that the resident would receive oxygen administration via nasal prongs as ordered.A review of a physician's progress note dated August 8, 2025, indicated that the resident had COPD, and that he would receive Ipratropium-Albuterol nebulizer treatments every 4 hours as needed, Symbicort Inhalation every 12 hours, self-report dyspnea with exertion, and use continuous supplemental oxygen at 2 liters per minute at rest and with exertion. The progress note revealed that the goal oxygen saturation level was to remain above 88%, and that if oxygen saturation rate fell below 88% with exertion, the oxygen would be increased to 3-4 liters per minute. A review of the resident's oxygenation records revealed that his pulse oximetry ranged between 90 and 97 percent, and they had no episodes of oxygen desaturation.A progress note dated August 19, 2025, at 15:46 PM, revealed that the resident received a chest x-ray to screen for tuberculosis, with results indicating positive infiltrates in the left lower lung. The same note revealed that the resident stated that he was always short of breath and used supplemental oxygen. However, the resident denied fever, chills, cough, or increased fatigue. The progress notes revealed that the resident was being treated by the wound care team for a pressure ulcer of the left ear related to the use of the oxygen cannula; however, a care plan conference summary dated August 14, 2025, revealed that the skin was intact. Additionally, the care (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	plan conference note made no reference to oxygenation or oxygen orders.A review of physician orders revealed that the resident received orders to start a ten-day course of cefdinir 300 mg twice daily and doxycycline 100 mg twice daily for community-acquired pneumonia on August 19, 2025.An order dated January 23, 2025, included a notation to change oxygen tubing and mask every month on the 1st and the 15th; however, no order for oxygen administration was identified in the physician orders. During an observation on the unit on August 28, 2025, at 10:43 AM the resident was seated in his wheelchair with the nasal oxygen cannula in place, the cannula in his nose, however, the concentrator was turned off. Closer observation revealed that the oxygen tubing was connected to a portable oxygen tank in a holder on the wheelchair. The oxygen tank was also turned off. The resident stated when asked if he was having trouble breathing or felt short of breath, Yes, I am short of breath. The resident also stated that he felt no oxygen flowing through the cannula, stating, No, I cannot feel any air in my nose. Certified Nursing Assistant (CNA), Staff # 118, was called to the room, upon checking the oxygen tank, turned it on, stating that she had been helping the resident prepare for an off-site appointment. Staff #188 stated that if oxygen is ordered, it should be on.An interview was conducted with Licensed Practical Nurse (LPN), Staff #59, on August 28, 2025, at 10:46 AM, who stated that the oxygen was off because the resident was getting ready to go to a dental evaluation in hopes of being fitted for dentures. The LPN stated that the oxygen was not off for too long and that the resident's reports of shortness of breath were behavioral. The LPN stated that the expectation for continual oxygen is that the resident will have oxygen on and working at all times. Staff # 59 stated that the event would not meet orders for oxygen administration, but it was understandable due to the resident's situation. The LPN assessed the resident and confirmed oxygen delivery at two liters per minute and reported that the resident's respirations appeared unlabored and that the resident was able to speak in full sentences.A new verbal order was entered on August 28, 2025, at 13:33 PM by staff #59 from the resident's current primary care provider to administer oxygen continuously via nasal cannula or concentrator, may titrate to maintain Spo2 greater than 90 percent.An interview with Certified Nursing Assistant (CNA), Staff # 114, was conducted on August 29, 2025, at 09:16 AM. The CNA reported that oxygen is administered for shortness of breath, and if a resident's oxygen level is lower than 90 percent, she would let the nurse know. The CNA confirmed that resident # 2 was on oxygen continuously. Staff # 114 stated that the resident received a shower the previous Friday, and the staff did not take the oxygen tank into the shower. The CNA stated that without oxygen, the resident got scared and stated that he could not breathe. Staff # 114 stated that if the resident refused to use oxygen or if he was short of breath, she would notify the nurse.An interview with Licensed Practical Nurse (LPN), Staff # 59, on August 29, 2025, at 09:22 AM. The LPN stated that when a resident is on oxygen and reports shortness of breath, she would check for crimps in the tubing, make sure that the oxygen is on, raise the head of the bed, check the oxygen saturation level, and observe for dusky fingernails or clamminess. In the event that the symptom was related to resident behaviors, the LPN stated that she would go through all the motions, just the same. The LPN stated that if the resident was symptomatic, such as being lethargic, non-responsive, or with oxygen saturation below the doctor's specified parameters, she would immediately notify the doctor. Staff #59 stated that she was aware that resident #15 is on continuous oxygen except for in the shower. When asked if the shower exception was noted in the physician's orders, she stated that she was not sure. The LPN stated that when residents are known to take off the cannula, additional rounding is initiated to ensure that they keep it on. The LPN further stated that resident # 15 will ask for oxygen when his oxygen saturation levels are at ninety-five percent.An interview with Unit Manager, Staff # 412, was conducted on August29, 2025, at 09:41 AM. The Unit Manager stated that it was her expectation that all orders for oxygen should be in Point Click Care (PCC), the facility's electronic health record. Staff # 412 further stated that she may have missed the order, but would check to confirm that it was there. The Unit Manager stated that she processed resident #15's admission orders and did not put in an order for oxygen and identified the potential risk to the resident as hypoxia.An interview was conducted with (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the Director of Nursing (DON), Staff # 61, on August 29, 2025, at 10:45 AM. The DON stated that it was her expectation that oxygen should only be administered when ordered by a physician. The DON further stated that if administered without a physician's order, it would not meet her expectations, as the resident may not get the correct care.A review of the Oxygen Administration Policy, (C)2001 MED-PASS, Inc., Respiratory and Pulmonary conditions chapter, Level III, indicated that staff are to verify that there is a physician's order and review the physician's order or facility protocol for oxygen administration. The policy further stated that staff would review the resident's care plan to assess for any special needs of the resident.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews, and facility policy review, the facility failed to ensure that one resident (#16) had a physician's order for dialysis. The sample size was 23. This deficient practice has the potential to result in residents receiving dialysis without appropriate medical authorization.Findings include:Resident #16 was admitted to the facility on [DATE] with diagnoses that include End Stage Renal Disease (ESRD), unspecified atrial fibrillation, and chronic pain syndrome.A review of the Minimum Data Set (MDS), dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14 which indicated the resident is cognitively intact. The same MDS also indicated the resident was receiving dialysis.Review of Resident #16's care plan, initiated on October 14, 2024 and revised on October 21, 2024 indicated he needed hemodialysis related to renal failure and ESRD. Interventions identified on the care plan indicated dialysis days was on Tuesdays, Thursdays, and Saturdays.A review of the physician's orders revealed no current orders for dialysis. However, there was an order, dated that indicated the resident was to hold their blood pressure medications on dialysis days which was identified as Mondays, Wednesdays, and Fridays.The Treatment Administration Record (TAR) and Medication Administration Record (MAR) did not reveal a current order for dialysis.An interview was conducted on August 27, 2025 with Certified Nursing Assistant (CNA/Staff #118) at 12:50 P.M. When asked if Resident #16 received dialysis, she stated that she did not know. She added that she typically works weekends but was working today for additional coverage.An interview with Resident #16 was conducted on August 27, 2025 at 12:55 P.M. He shared that he received dialysis on Mondays, Wednesdays, and Fridays. He added that he usually leaves the facility at 1:30 P.M. and returns at 6:00 P.M.On August 27, 2025 at 1:00 P.M. [NAME] Clerk/Staff #506 was overheard telling Staff #118 that Resident #16 was going to be leaving for his dialysis appointment soon.An interview was conducted on August 28, 2025 at 9:14 A.M. with CNA/Staff #54. Staff #54 shared that Resident #16 went to his dialysis appointment yesterday (August 27, 2025) and she believed that he goes twice a week.An interview was conducted on August 28, 2025 with Licensed Practical Nurse (LPN/Staff #414) at 9:21 A.M. When asked how he knows if a resident is receiving dialysis, Staff #414 explained that the resident would have a shunt bracelet, he would then ask the patient (if they were receiving dialysis), he gets reports from the CNAs and other nurses, and he would check the resident's orders as there would be orders indicating what days the resident would go to dialysis and where they would go. He would then communicate this information to the resident. Staff #414 indicated that he believed Resident #414 goes to dialysis and he then checked the resident's order list. As Staff #414 was checking the orders on the laptop, another unnamed staff walked by and was heard telling him to check the resident's appointment book/sheet. Staff #414 then pointed out the schedule in the appointment book that listed Resident #16's transportation and dialysis information. Staff #414 was then asked if Resident #16 had a current order for dialysis. He then shared that he did not see an order for dialysis for Resident #16. Staff #414 acknowledged that if a resident is sent out for dialysis, they need to have an order for it.An interview was conducted with the Director of Nursing (DON/Staff #61) on August 28, 2025 at 9:37 A.M. Staff #61 confirmed that if a resident was receiving dialysis, they would need an order. Staff #61 was asked to confirm that Resident #16 had a current order for dialysis. After reviewing the physician's orders list, she shared that she did not see a current order. She did share that they had an order for dialysis in the past that indicated Resident #16 received dialysis on Tuesdays, Thursdays, and Saturdays. However, he was recently at the hospital and came back on August 25, 2025. Staff #61 continued to explain that the dialysis order was not put back into the system. Staff #61 shared that not having a current order in the system did not meet her expectations. She expected orders to be put into the system with the correct days when the return from the hospital. Staff #61 shared that by not having current orders for dialysis, the resident would be at risk for adverse effects in various ways. (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	08/29/2025

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.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	They might receive treatment that they don't need depending on what the treatment is.On August 28, 2025 at 10:05 A.M. a secondary review of Resident #16's Physician's orders revealed a new order for Dialysis on Mondays, Wednesdays, and Fridays at an offsite Dialysis facility. The order was transcribed by The Assistant Director of Nursing (ADON/Staff #119) on August 28, 2025 at 9:40 A.M.Review of the facility's policy, titled Hemodialysis, indicated that it was implemented in April 2025. The policy indicates that the facility will ensure that the physician's orders for dialysis include: the type of access for dialysis and location, the dialysis schedule, the nephrologist name and phone number, transportation arrangements to and from the dialysis facility, any medication administration or withholding of specific medications prior to dialysis treatments, and any fluid restrictions if ordered by the physician.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews, and facility observations, the facility failed to ensure that medications were stored in accordance with professional standards for one resident (#66) out of a sample of 23. This deficient practice has the potential to compromise medication safety.Findings Include:Resident # 66 was admitted on [DATE], and readmitted on [DATE], with diagnoses that included: chronic obstructive pulmonary disease, atherosclerotic heart disease, morbid obesity, hypothyroidism, major depressive disorder, anxiety disorder, tremor, hyperlipidemia, osteoarthritis, fibromyalgia, obstructive sleep apnea, Type II Diabetes Mellitus with diabetic neuropathy, restless legs syndrome gout, edema, insomnia, cataracts, alcohol use, unspecified with alcohol-induced persisting dementia, personal history of Covid-19, heart failure, chronic respiratory failure, vitamin D deficiency, low back pain, paroxysmal atrial fibrillation, and hyperesthesia. A review of the quarterly Minimum Data Set (MDS) dated [DATE], revealed that the resident had a visual impairment that interfered with the ability to read regular print in newspapers or books. The resident was able to understand others and make herself understood. The Brief Interview of Mental Status (BIMS) revealed a score of 15 that indicated intact cognition. The MDS further revealed that the resident exhibited no hallucinations, delusions, or physical behavioral symptoms directed towards others, but exhibited verbal behaviors and other behavioral symptoms not directed to others 1-3 days during the rating period. The MDS revealed that the resident had range of motion limitation to bilateral upper and lower extremities and was non-ambulatory. The MDS further revealed that the resident required set-up assistance for eating and oral hygiene, maximum assistance for upper body dressing and was dependent in toileting, hygiene, shower, lower-body dressing, personal hygiene, and putting on and taking off footwear. The MDS revealed that the resident was always incontinent of bowel and bladder. The resident was identified as being totally dependent on 1 staff member for locomotion using a wheelchair.Physician orders revealed orders for weekly skin assessments on scheduled shower days and an order for Nystatin Powder 100,000 units/gram to be applied to the peri-area and abdominal folds topically, two times a day for candidiasis; may be applied following incontinence episodes. The physician orders further revealed that the resident may use transfer bars and side rails to assist with bed mobility. There were no observed changes in physician orders, and a review revealed no orders for self-administered medications. The physician orders further revealed that the resident used oxygen via nasal cannula at 1-3 liters per minute by nasal cannula to maintain oxygen saturation greater than 88 percent.A review of the comprehensive care plan dated June 3, 2025, revealed that the resident had a self-care deficit and was at risk for skin breakdown due to limited mobility related to incontinence, disease processes and morbid obesity. The care plan further revealed that the resident could be resistant to care.A review of skin assessments on August 13, 2025, August 16, 2025, August 20, 2025, and August 22, 2025 revealed that no new skin issues or conditions were identified. The investigation revealed no deficient practices in the identification, monitoring, and treatment of moisture-associated skin damage.An observation during initial resident screening revealed a container of miconazole powder 25% at the resident's bedside on an overhead shelf behind and above the resident's bed.An interview was conducted with Certified Nursing Assistant (CNA), Staff #118, on August 26, 2025 at 09:48 AM. The CNA stated that she had been working at the facility for only two weeks and would defer questions about medications to the nurse. Staff #188 further stated that medications are kept in locked medication carts and that medications are not allowed in the resident's room. The CNA stated that the risk of medications in the room could be related to HIPAA. An interview was conducted with Licensed Practical Nurse (LPN), Staff #59, on August 26, 2025, at 09:52 AM. The LPN stated that a medication is anything that is prescribed by a doctor's (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	orders, including over-the-counter medications, IV medications, oral medications, injectable medications, topical preparations, or powders. When asked if a powder could be a medication, the LPN stated, Yes, I consider everything a medication. Staff # 59 stated that there should never be a medication at the patient's bedside unless there is a doctor's order for it. When questioned about the risk to the resident if a medication was at the bedside, the LPN stated that many residents have a cognitive decline and that if an order for medications at the bedside was obtained, she would complete an assessment to make sure that the resident was able to use the medication correctly. Staff #59 reported that there was one resident in the hallway that had an order to self-administer ear drops for ear wax removal, but that she monitored the resident when using the drops. The LPN was advised of the observation of the antifungal medication at resident #66's bedside and asked her to pull up the resident's orders for review. Staff #59 pulled up the resident's electronic health record, checked for the order, and stated that no order for self-administration of medications was identified. The LPN stated that this did not meet her expectations as the medication should not be at the bedside and identified that the related risk could be overuse or increased cost. The LPN stated that there could also be a risk of infection, but this was unlikely since both residents in the room are bedridden, and further stated, this was no excuse. The LPN also noted a possible risk of medication ingestion. Staff #59 stated that she is strict with the team in her hallway and provides oversight and training to all staff on her assigned hallway, providing daily orientation. An interview with the Director of Nursing (DON), Staff #203, was conducted on August 28, 2025, at 11:55 AM regarding medication administration. The DON stated that medication self-administration requires a physician's order that permits the resident to administer their own medication. Staff #203 stated that If ordered, the nurse would assess the patient's ability to administer their own medication. The DON stated that she thought that there may have been one resident on the A hall who had this type of order, for an inhaler, but the request came in recently, and she had not yet had time to follow up. The DON stated that if the resident was assessed to have the ability to self-administer the medication, an update to the care plan would also be required. Staff # 203 stated that finding a medication at a patient's bedside that has not been ordered would not meet her expectation and identified the risk as because many of the residents at the facility have behavioral issues, someone could ingest the medication, the resident could use the medicine incorrectly, or another resident could find the medication and use it. The DON stated that she will do a sweep of all resident rooms and remove any medications that are not ordered to be held at bedside, and conduct an in-service, reminding all clinical staff that this is not acceptable.A review of the Administering Medication Policy from the Nursing Services Policy and Procedure Manual for Long-Term Care, Copywrite 2001, MED-PASS, INC, Version 2.1, revised April 2019, revealed that only persons licensed or permitted by this state to prepare, administer, and document the administration of medications may do so. The policy further revealed that residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely.