STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035064	A. Building B. Wing	07/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foothills Rehabilitation Center	2250 North Craycroft Road 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 the clinical record review, staff and resident interviews, and facility policies and procedures, the facility failed to protect the resident (#8) rights to be free from physical abuse by another resident (#7). The deficient practice could result in bodily injury and emotional or mental trauma.Findings include:-Regarding Resident # 7:Resident #7 was admitted to the facility on [DATE], with diagnoses that included diffuse traumatic brain injury with loss of consciousness, essential hypertension, hereditary and idiopathic neuropathy, unspecified, intrapartum hemorrhage, unspecified, anxiety disorder, unspecified. The quarterly Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview of Mental Status (BIMS) score of 00, indicating severe cognitive impairment. The MDS revealed that the resident had no potential indicators of psychosis but exhibited physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing or abusing others sexually), verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others, and rejection of care (e.g., bloodwork, taking medications, ADL assistance), with a frequency of 1 to 3 days. Furthermore, the MDS revealed that the resident wore glasses to improve visual acuity and was usually able to make themselves understood and understand others.The resident's quarterly care plan dated June 12, 2025, revealed that the resident was at risk for elopement related to traumatic brain injury, as evidenced by attempting to leave the building. Interventions included the use of a wander guard, completion of elopement risk assessment, and placement of the resident in supervised areas. Further, the care plan revealed that the resident had the potential to exhibit behavioral symptoms, including refusal of care, cussing at staff, and swatting with arms. The resident was noted to be gaining control of functional abilities and will now swing at staff and family. The care plan revealed that the resident is now able to drag himself out of bed, climb into his wheelchair, and propel out of the room. The resident sometimes dragged himself to the toilet and poured water from the toilet onto himself. The resident had been observed wandering into other residents' rooms and taking items. The related short-term goal identified in the care plan stated that the resident will show no signs or symptoms of negative consequences or outcomes secondary to behaviors. Interventions in the care plan included the use of two staff for all care provided, staff to watch the resident when he is out of bed in common areas, and staff will assess whether behaviors endanger the resident and or others and intervene if necessary. Additional interventions included that staff will convey an attitude of acceptance toward the resident, not alienate or criticize the resident when he is resistant to care, maintain a calm environment, and provide consistent staff as much as possible.A review of the progress note dated July 18, 2025, at 09:54 P.M. revealed notes from the facility's behavioral health team meeting where the resident's behaviors and medications were reviewed. Results of the meeting revealed that the team's psychiatric provider increased the resident's valproic acid to 250 mg TID due to behaviors and review of laboratory results.A review of a progress note dated July 19, 2025, at 10:23 P.M. revealed that the resident was involved in a resident-to-resident altercation after he was noted to wander into another resident's (resident # 8) room and take the other resident's water bottle. Staff returned the water bottle, and resident # 8 witnessed the resident coming out of the room and questioned resident #7 about taking his things. Resident #7 became agitated, began cursing, and while the staff were separating the residents, reached out and made contact, striking him in the arm. No injuries to either resident were reported. An additional review of progress notes of the past 30 days revealed entries noting resistance to care or aggression on June 24, 2025, at 10:53 P.M, June 26, 2026, at 10:36 P.M., June 30, 2025 at 02:56 P.M., July 15, 2025, at 10:18 A.M., July 18, 2025, at 06:25 A.M. All other entries indicated that the resident was cooperative with care.-Regarding Resident #8:Resident # 8 was admitted on [DATE], with diagnoses that included intracranial injury with loss of consciousness of unspecified duration, major depressive disorder, recurrent, anxiety disorder, unspecified.The quarterly MDS dated [DATE], revealed a BIMS score of 13, indicating intact cognition. The PHQ-2 revealed a score of 00, indicating no mood disturbance. Behavioral symptoms identified in the MDS included no presence of delusions, physical symptoms directed towards others, rejection/refusal of care, or wandering.A review of the resident's care plan indicated that placement was required on a secured unit secondary to his psychiatric diagnosis, poor safety awareness, which resulted in the resident exhibiting behaviors that could possibly place the resident or others at risk. A review of the resident's monthly summary progress note dated June 13, 2025, revealed that the resident had mild cognitive and memory impairment and was independent in the majority of activities of daily living, requiring