

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  035064	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/01/2025
NAME OF PROVIDER OR SUPPLIER  Foothills Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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 0689  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.  (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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> The facility failed to ensure resident #1 was free from avoidable accidents when transferring a resident using a Hoyer lift. This deficient practice placed the resident at risk for serious injury, pain, and further decline. Findings include: Resident #1 was admitted to the facility on [DATE], with diagnoses that include obesity, chronic pain syndrome, and long-term use of anticoagulants. A review of the quarterly Minimum Data Set (MDS), dated [DATE], revealed Resident #1 had a Brief Interview for Mental Status score of 14, which indicates she was cognitively intact. A review of the care plan, dated March 19, 2025, indicated that a Hoyer lift with 2 staff will be used to safely transfer the resident, and an identified goal was that the resident would not have an injury related to transfers. A review of the physician's orders, dated March 23, 2025, revealed Resident #1 was to be transferred using a 2-person Hoyer lift. A review of the progress notes in the resident's Electronic Health Record (EHR) revealed a note, dated July 17, 2025, at 6:41 P.M., indicating Resident #1 was in her room with two CNAs who were attempting to transfer the resident from the chair to the bed. The note continues to describe that during the transfer, using the Hoyer lift, the Hoyer lift had tilted to the side, and the resident fell on the floor. The note also indicates that the resident had fallen on her buttocks and lower back and did not hit her head. An interview was conducted with Resident #1 on July 31, 2025, at 12:20 P.M. Resident #1 shared that Certified Nursing Assistant (CNA/Staff #27) and described the second staff member as a CNA who was working a different hall but could not remember her name. Resident #1 further shared that she felt staff were rushed that day, and Staff #27 had told Staff #30 to move the legs on the lift closer together. Resident #1 added that the legs of the Hoyer lift are usually spread apart to balance the Hoyer lift. Resident #1 recalled CNA/Staff #30 saying that it wasn't a good idea, and shortly after that, the Hoyer fell, and she had fallen to the ground. Resident #1 shared that usually when she is transferred, CNAs don't close the legs of the Hoyer until she is over the bed; however, Staff #27 wanted the legs together before she was over the bed so that the Hoyer legs could go under the bed more easily. Resident #1 estimated that she was about 2 feet away from the bed and suspended approximately 4 feet from the ground when the Hoyer had tipped over. Resident #1 also shared that she is still scared about using the Hoyer, so she doesn't get out of bed as often as she used to. She added that she had to get anxiety medications to help calm her. She also expressed that she no longer wanted Staff #27 to transfer her because she was not comfortable with him doing the transfer. A telephonic interview was conducted with Staff #30 on July 31, 2025, at 2:05 P.M. Staff #30 shared that she had received training on using the Hoyer lift 2 weeks after she was hired. Staff #30 shared that she was assigned to work a different hallway when Staff #27 had asked her for help with using a Hoyer lift to transfer Resident #1. They were attempting to move Resident #1 from her motorized chair to her bed when the Hoyer lift was not able to move forward due to a cord on the floor blocking the lift's forward progress. Staff #30 explained that she was working the remote for the Hoyer, and Staff #27 was using his hands to guide the resident in the sling. She continued to explain that once the Hoyer lift was stuck, she noticed that Staff #27 had his foot on the leg of the Hoyer and he was trying to push the Hoyer over the cord. It was at that time that she attempted to tell Staff #27 to wait multiple times. She shared that Staff #27 appeared to be frantic, like he was in a rush to get it done. It looked like he wasn't thinking clearly, and he was not hearing me because he was so focused on moving the Hoyer. Staff #30 then shared that it was at that point when the Hoyer fell over her, and the resident fell to the floor onto her lower back and butt from the maximum height. She also shared that Staff #27 then left the room to get help while Staff #30 was able to push the Hoyer off of herself. An interview was conducted on July 31, 2025, at 3:22 P.M. with Staff #27. He shared that he gets training on using the Hoyer lift annually and whenever there is an incident. He also shared that the last time he received training on the Hoyer lift was the same week the fall took place. Staff #27 explained that it was around 5:00 P.M., and Resident #1 was in her motorized wheelchair when she had expressed wanting to be transferred into bed. Staff #27 shared that he was in a rush that day to get everything done because he was trying to get residents changed before dinner time so they could eat comfortably as the dinner trays were close to being delivered. The other CNAs in the unit were in the dining area assisting residents, and he was in the hallway alone. He then went to another hallway to get assistance from another CNA for the Hoyer transfer. Staff #27 explained that prior to starting the process of transferring a resident, using a Hoyer lift, he ensures the area that the Hoyer lift will be used in is clear and that nothing can get caught is on the floor. He also ensures there's enough room to maneuver the Hoyer. He confirmed</p>		