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 03/28/2026
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 0600 Level of Harm - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, interviews, facility documentation and policy review, the facility failed to ensure the rights of four residents (#19, #144, #146 and #167) to be free from abuse and neglect by other residents and staff. The universe was 25. The deficient practice resulted in actual harm and placed other residents at risk for further abuse, ongoing harm, and serious adverse outcomes. Findings include:Regarding Resident #167 -Resident #167 was admitted to the facility on [DATE] with diagnoses that included persistent vegetative state, chronic respiratory failure with hypoxia, traumatic subarachnoid hemorrhage without loss of consciousness, and Crohn's disease. Review of the admission Minimum Data Set (MDS), dated [DATE], did not assess Resident #167's cognitive status. The same MDS also noted that Resident #167's functional status for bathing was total dependence and required 1-person physical assist. The care plan indicated dated December 6, 2022 revealed the resident required total assist for all Activities of Daily Living (ADLs) which included bathing; was at risk for falling related to weakness; and, transfers using a Hoyer lift. The goal was that the resident will remain free from injury. Interventions included frequent checks by staff while in bed; to observe frequently and place in supervised area when out of bed; and, when utilizing Hoyer lift, resident will transfer safely with 2 staff. The Quarterly MDS assessment dated [DATE], indicated that a staff assessment for mental status was completed. It was noted that Resident #167's cognitive skills for daily decision making was severely impaired. The MDS also revealed that Resident #167's functional status for bathing was total dependence and required 2-person physical assist. The assessment also included that the resident had 1 fall with injury since admission or prior assessment. The care plan dated July 20, 2023 included that the resident had behavioral symptom of placing self on the floor. Intervention included to assess whether the behavior endangers the resident and/or others; maintain a calm environment and approach to the resident; redirect as necessary and notify provider if behaviors interfere with orsignificantly impact residents care; and, provide consistent staff as much as possible.A Monthly Summary form, dated August 29, 2023, indicated the resident was totally dependent for bathing and required one-person physical assist. The quarterly MDS assessment dated [DATE], indicated that staff assessed Resident #167's cognitive skills for daily decision making as severely impaired. It was also noted that his functional status for bathing was total dependence and required 2-persons physical assist. The assessment also (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 - Actual harm Residents Affected - Few	included that the resident had 2 falls with no injury and 2 falls with injury since admission or prior assessment. The Monthly Summary form, dated October 5, 2023, indicated Resident #167 was total dependence for bathing and required two+ persons physical assist. The nursing progress note dated November 19, 2023 revealed resident was alert and oriented x2 and required maximum assistance with ADLs The Monthly Summary form dated November 23, 2023, indicated Resident #167 was total dependence for bathing and required two+ persons physical assist. The nursing note dated November 23, 2023 included that the resident was alert, non-verbal, responded to simple commands and at times can track staff with eyes, was totally dependent for all ADLs was often very restless in bed and can be found sideways in bed. According to the documentation, resident had bilateral floor mats for safety. The progress note dated November 29, 2023, at 11:26 A.M. created by Registered Nurse (RN/Staff #138) noted that Resident #167 was restless and had pushed the rail on the gurney while a Certified Nurse Assistant (CNA) had turned to throw away a razor. It also noted that the resident had fallen from the gurney and sustained an abrasion to the left side of his head and a hematoma on the right side of his head. It further noted that bleeding was noted in his mouth but staff was unable to determine the cause of the bleeding. The documentation also included that Resident #167 was sent to the emergency room per the physician's order for evaluation. The physician note dated November 29, 2023 included that the resident had a fall and head injury; and, to transfer the resident to acute care hospital. The undated [NAME] Fall Form included that the resident fell from the gurney on November 29, 2023; and that, the resident was sent to the hospital for evaluation and treatment. The progress note dated November 30, 2023 at 1:10 P.M revealed the Interdisciplinary Team (IDT) reviewed the incident and indicated that it was crucial to note that the resident was at a high risk for falls due to his history of falling, subdural hemorrhage, schizoaffective disorder, encephalopathy, persistent vegetative state (PVS), Crohn's disease, slowness and poor responsiveness, as well as muscle wasting. Interventions in place included, but were not limited to, sending the resident to the emergency room for a CT scan. The documentation also included that it was imperative to re-evaluate the resident upon his return from the hospital. The social service note dated December 1, 2023 included that social service spoke with a case manager and discussed the resident's fall and that the resident went to the hospital and had surgery for brain bleed. The fall care plan was revised on December 8, 2023 to include that the resident had an actual fall in the shower on November 29, 2023. The ADLs care plan was revised on December 20, 2023 by the Director of Nursing (DON/Staff #7) to include requiring 2-person assist with showers. It was noted that the start date for the updated intervention was December 11, 2023. There was no evidence that the care plan was revised to include (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	2-person assist for bathing was identified prior to December 20, 2023. Review of the facility's 5-day investigation report, for the alleged incident, revealed there was one CNA present with Resident #167 when he fell during a shower on November 29, 2023. It also noted that the CNA was following the resident's care plan. An interview with a registered nurse (RN/staff #150) was conducted on March 27, 2026 at 10:01 a.m. The RN stated that CNAs were supposed to check on the resident, turn/reposition and change the resident at least every 2 hours. She said that residents were transferred by using a Hoyer which required 2 persons; and that, staff cannot use Hoyer if there was only one staff transferring the resident. A telephonic interview was conducted with CNA (staff #1) on March 28, 2026 at 7:37 A.M. The CNA stated that she know if the resident was a 2-person assist if there was a green sticker next to their name on the name card outside of their room. Staff #1 said she remembered Resident #167 and she was with Resident #167 in the shower room and showers was just completed when Resident #167 jerked and crossed his legs which then went over the railing on the gurney that resulted in resident falling. The CNA stated that she then opened the shower room door and yelled for help from the nurses; and that, Resident #167 went to the hospital after the fall. The CNA further stated that she was by herself with Resident #167 in the shower room because at the time of the fall, Resident #167 was a 1-person assist. She said that after the fall, the resident then became a 2-person assist. In an interview with a CNA (staff #131) conducted on March 28, 2026 at 7:58 a.m., the CNA said that all residents lifted for any transfers or when providing baths using the Hoyer required 2-person to operate. An interview was conducted on March 28, 2026 at 8:23 A.M. with the MDS/Care Plan Coordinator/Licensed Practical Nurse (Staff #59). Staff #59 explained that the MDS is created upon admission and is updated if there is a change in condition or if a quarterly review is due. She further explained that once the MDS assessment is completed, the comprehensive care plan is triggered with information obtained from the MDS assessments. She added that she and another MDS staff person also create and update the care plans after completion of the MDS. Staff #59 reviewed Resident #167's June 2, 2023 MDS assessment and shared that he was total dependence for bathing and required 2-person assist. Staff #59 reviewed Resident #167's September 2, 2023 MDS assessment and shared that he was total dependence for bathing and required 2-person assist as well. Staff #59 also reviewed Resident #167's comprehensive care plan and shared that it was noted he was a total assist for all ADLs however, it did not specifically say that he was a 2-person assist for bathing. She further shared that she did not know why the care plan did not reflect that the resident was a 2-person assist for bathing. An interview was conducted on March 28, 2026 at 8:41 A.M. with the Director of Nursing (DON/Staff #7). Staff #7 shared that abuse and neglect training is provided to staff on an annual basis and as needed to provide re-education. When asked whether providing a 1-person assist to a resident assessed as requiring a 2-person assist for bathing, resulting in a fall, would constitute neglect, she shared that it would be if the care plan indicated the resident was a 2-person assist and only 1-person assist was done. When asked if not updating the care plan to reflect the MDS assessment as neglect, Staff #7 shared that it would be because the MDS did not link to the care plan so it was not adequately implemented. She further shared that this could lead to residents sustaining an injury because something happened to them due to not getting the proper care. Staff reviewed the (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	September 2, 2023 MDS for Resident #167 and shared that he was total dependence and required 2-person assist for bathing. When reviewing the care plan for Resident #167, she shared that it identified that Resident #167 was a 2-person assist with showers starting December 11, 2023. She further shared that there was no information, regarding bathing with 2-person assist, in the care plan prior to December 11, 2023. Staff #7 explained that the care plan should have reflected that the resident was a 2-person assist prior to that date and confirmed that the care plan did not match the information in Resident #167's MDS. An interview with CNA (Staff #156) was conducted on March 28, 2026 at 11:04 A.M. Staff #156 revealed that neglect occurs when staff fail to meet residents' needs. Staff #156 shared she receives abuse and neglect training during monthly in-services and annual in-depth sessions. When asked whether providing a 1-person assist to a resident assessed as requiring a 2-person assist for bathing, resulting in a fall, would constitute neglect, she confirmed that it would, as the resident did not receive the required level of assistance An interview was conducted on March 28, 2026 at 11:13 A.M. with Licensed Practical Nurse (LPN/Staff #120) who stated that neglect occurs when pain medications were given without a proper pain assessment or when cares were not being provided to the resident. She said providing a 1-person assist to a resident assessed to require a 2-person assist for bathing and resulting in a fall, would constitute neglect. She said that the resident is a 2-person assist because the resident moves a lot; and, if a resident was a 2-person assist, then there must be 2 people helping the resident. The LPN further stated that neglecting the residents could result in injury, skin damage, residents could be emotionally affected and they could lose their trust in staff to keep them safe. Regarding Resident #146 and Resident #145 -Resident #146 was admitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy (brain dysfunction due to chemical imbalances), Schizoaffective disorder, and Bi-polar disorder. Review of the quarterly MDS, dated [DATE], indicated that Resident #146 had a BIMS score of 11 indicating moderate cognitive impairment. The same MDS also noted Resident #146 exhibited behavioral symptoms not directed towards others. Review of the Progress Notes, in the clinical record, revealed there were no entries related to an alleged incident of abuse.-Resident #145 was admitted to the facility on [DATE] with diagnoses that included hemiplegia, unspecified affecting unspecified side (paralysis or weakness affecting one side of the body); anoxic brain damage; Schizoaffective disorder; Bio-polar disorder; and generalized anxiety disorder. Review of the quarterly MDS, dated [DATE] revealed that Resident #145 had a BIMS score of 06 indicating severe cognitive impairment. The same MDS also noted that Resident #145 had other behavioral symptoms not directed towards others. Review of the Care Plan, implemented on January 20, 2022 and revised on March 26, 2023, revealed Resident #145 was taking psychotropic medications related to her Bipolar disorder diagnosis. Interventions included assessing if the resident's behavioral symptoms presented a danger to herself and others and to intervene as needed. It was also noted that her behavior and response to medication was to be monitored as well. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A review of the progress notes, revealed she was exhibiting behaviors such as using profanity towards staff, refusing cares, attempting to physically injure staff when personal cares are being provided and crying throughout the day. A Progress Note, dated February 21, 2023 noted that Resident #145 had started Risperdal (anti-psychotic). Additional review of the Progress Notes found no documentation regarding an alleged incident of abuse. Further review of the clinical record did not find evidence that a skin assessment was conducted on February 7, 2023 however, an assessment was completed on February 9, 2023 and it was noted that there were no skin issues. Review of a complaint, submitted via the SA's complaint portal, alleged that Residents #146 and #145 were witnessed having a verbal altercation and then one Resident struck the other Resident. Review of the 5-day investigation report, conducted by the facility, revealed that Resident #145 had struck Resident #146 on the arm after a verbal altercation. It also noted that the altercation was witnessed by LPN/Staff #76. The investigative report revealed that interviews were conducted with both residents, post-incident. The report noted that Resident #146 was attempting to get away from Resident #145 so she wouldn't get into trouble. Resident #146 was noted saying that Resident #145 had hit her in the arm before Staff were able to redirect Resident #145. The same investigative report also indicated that Resident #145 was interviewed and was clear on what had taken place. However, she did indicate that she will hit Resident #146 if she finds her (Resident #146) in her space. An interview was conducted on March 26, 2026 at 7:48 A.M. with Staff #17. Staff #17 shared that abuse is when someone harms a resident physically, emotionally and financially. She also shared that she receives training on abuse once a year. Staff #17 recalled working with both Residents #145 and #146. She described Resident #145 as someone who was paralyzed on one side and would sometimes become upset and explode out of the blue. Staff #17 further shared that Resident #145 would try to hit other residents when she was upset. She also explained that because Resident #145 was sometimes hard to understand, when she spoke, she would often get frustrated because staff couldn't understand her and she wouldn't get things the way she wanted them. Regarding, Resident #146, Staff #17 explained that she used to hit herself and would threaten to hit other residents but never did. Staff #17 recalled Residents #145 and #146 having verbal altercations but did not recall them being physical with each other. Staff #17 was read her statement that she provided to the facility during their investigation. The statement indicated that she was working the floor on February 7, 2023 around 2:20 P.M. and was assisting another resident when she had heard Resident #146 screaming for help. It also noted that she did not witness the incident take place. Staff #17 indicated that she still stood by that statement she had provided at the time of the facility's investigation. An interview was conducted on March 26, 2026 at 8:00 A.M. with CNA/Staff #22. Staff #22 recalled both Resident #145 and #146. She described Resident as someone who would get upset when she didn't get what she wanted. She would also get impatient. Staff #22 shared that management had provided training to staff on how to redirect Resident #145 and anticipate when she might hit other residents so they could redirect her. She also shared that Resident #145 had never hit another resident. Staff #22 recalled Resident #146 as someone who was angry with other residents and had tried to hit them however, she couldn't recall if Resident #146 had actually hit anyone. Staff #22 was read her statement that she provided to the facility during their investigation. The statement indicated that Staff #22 was working on February 7, 2023 and was providing cares to a resident around 2:15 (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	P.M. It also noted that she did not witness the incident in the day room. Staff #22 added that she recalled both residents were arguing and she had helped separate them but did not see either residents hit each other. An interview was conducted on March 26, 2026 at 8:23 A.M. with LPN/Staff #76. Staff #76 recalled being in the day room of the unit when Resident #145 and #146 were too close to each other and had started yelling at each other. She indicated that she had separated both residents but didn't think they physically touched each other. Staff #76 shared that Resident #146 tended to be very behavioral was okay as long as no one triggered her. She further shared that Resident #146 was always supervised and she had her own room due to not doing well with roommates. Staff #76 was read her statement that she provided to the facility during their investigation. The statement indicated that she had witnessed Resident #145 yelling, cursing, and moving towards Resident #146 in her wheelchair. It further indicated that Resident #145 had hit Resident #146 once before Staff #76 had separated them. Staff #76 shared that she stood by the statement that she had provided to the facility. She also shared that Resident #146 had no injuries and added that she did not document that she had done a skin check on the resident regarding there not being any injuries. She added that she should have documented everything that she did in the clinical chart. Staff #76 shared that if residents are abused, they are at risk of being injured and could be impacted emotionally and mentally. An interview was conducted on March 28, 2026 at 2:01 P.M. with DON/Staff #7. Staff #7 recalled Resident #145 being in the behavioral unit and that she would hit people. She also recalled Resident #146 and described her as being in the behavioral unit as well. She further shared that Resident #146 would swear, yell, and would seek attention by putting herself on the floor. Staff #7 couldn't recall if both residents had an altercation with each other so she read her copy of the facility's investigation. She shared that both residents had gotten into an altercation and there were no injuries sustained. Staff #7 shared that they try to keep residents, who might have issues with other residents, separate. She further shared that they also involve psychiatrists and have them evaluate residents as well. Regarding Resident #19 -Resident #19 was admitted to the facility on [DATE] with diagnoses that included Dysphagia following cerebral infarction, Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, Aphasia following cerebral infarction, Type 2 diabetes mellitus with diabetic neuropathy, Cerebrovascular disease. Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #19 scored a 9 for the Brief Interview for Mental Status (BIMS) which indicated she had moderate impairment. Care plan dated May 22, 2023 included resident required dependent assist for all ADL's to include bathing, grooming, hygiene, toileting, bed mobility, and dressing. Also, the resident required extensive assistance with meals, and was a two person assist with Hoyer lift. A progress note dated July 24, 2023 at 5:30 p.m. stated a CNA reported to Staff # 321 that Resident #19 needed a splint for her right hand and wrist. The resident was crying in pain when the CNA attempted to move the wrist. The resident also had blood on her lower right lip. An order dated July 24, 2023 10:03 p.m. was for Resident #19 to be transferred to an acute hospital emergency room (ER) for a CT scan of the head and X-rays of the right wrist and right leg. Hospital (ER) report dated July 24, 2023 stated, the resident was nonverbal [AGE] year-old presented to the (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	ER with right wrist pain. There is some swelling and tenderness without any evidence of erythema or warmth and there are no open wounds have a low suspicion for septic joint. Per EMS report, the injury was from staff moving her. She has also been pointing to her leg and complaining of pain there as well. The facility initial report to the State Agency dated July 24, 2023 7:25 p.m. said a resident was hurt by a tall man and had pain the right hand. Further information received stated the resident was sent out to the emergency room for X-rays. The facility 5-day report revealed that Resident #19 complained of right-hand pain, and also said that a tall guy hurt her. The resident was transported to the hospital because of right arm swelling. The report also revealed a CNA was suspended pending an investigation, and that he was the only CNA working with the resident that matched the description. The reported had an interview with the CNA and he said a nurse asked him to lay the resident down. The CNA changed the bedding and he used a gait belt to transfer the resident back to her bed. The 5-day report was concluded with the facility investigation being inconclusive because, the X-ray and CT were done and it was not a clear diagnosis if the resident has a fracture or not. The resident has a new diagnosis of decrease mineralization to the bone. She also has a new diagnosis of osteoarthritis to hand. Review of the personnel file of the alleged CNA (staff #325) revealed that a report dated July 25, 2023 and an attached corrective action form that indicated that Staff #325 was terminated for failure to follow safety rules and unsatisfactory job performance. An interview with a registered nurse (RN, Staff #138) was conducted on March 26, 2026, at 2:43 p.m. The RN stated that any allegation of abuse is reported to the Administrator or the Director of Nursing (DON#7), who then has two hours to report the incident to the State Agency (SA). She further stated that upon receiving an allegation of abuse, she ensures the involved residents are safe, gathers details by speaking with both residents, documents the information, and reports the incident to the DON. On March 27, 2026 at 10:15 a.m. and interview was conducted with the legal guardian of Resident #19. The legal guardian said that Resident #19 would shook her head 'no' when asked if there were any concerns with facility staff; would shook her head 'yes' when asked if she felt safe; and would communicate with staff by mumbling and the use of a word board The legal guardian said there was an issue about a year after Resident #19 was admitted to the facility; and that, during a transfer Resident #19 sustained a fracture her right wrist. The guardian stated that he did not know the specifics of what happened but was told by the facility that it was not the facility's fault. An interview was conducted on March 27, 2026 1:35 p.m. with DON, she said the 5-day report was sent to the SA on July 31, 2023. DON said the initial facility investigation was the CNA reported that he changed the sheets on the bed and used a gait belt to transfer the resident back into bad. The residents brief was changed and he left the room. The facility investigation revealed the resident began crying during a care procedure. a staff member was called to the resident's room for a complaint of pain. The DON said the resident was sent to the ER for x-ray and evaluation. She said the final facility investigation was determined to be inconclusive due to: X-ray and CT were done and it was not a clear diagnosis if the resident has a fracture or not. She said the resident was diagnosed at the hospital with a diagnosis of decrease mineralization to the bone and a new diagnosis of osteoarthritis to hand. The DON said Resident #19 did not go to an optional MRI. Resident #19 was given a splint and started physical therapy when she returned to the facility. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted on March 27, 2026 at 3:45 p.m. with Staff #170. Staff #170 stated she remembered the incident and was working. She was called to the room by a Respiratory Therapist (RT) to help assess a resident. She said Resident #19 had dried blood on her mouth and was holding her right hand. The resident had very limited speech but through the use of a speech board Staff #170 was trying to find out what happened and who caused the injury. Resident #19 identified the staff as a male. Resident #19 said that day there was only one male CNA and all other staff was female. She said the Resident #19 was bed bound and would be a two-person Hoyer lift assist. On March 27, 2026 at 4:20 p.m. an interview with Administrator was conducted. She said the incident happened before her employment began. The Administrator said all reports of abuse are investigated fully, but she did not know the specifics of this incident. She said she was pretty sure that Staff #325 wa terminated because of the incident. An interview was conducted on March 28, 2026 at 7:52 a.m. with Staff #110. She said, every room in the 600 hall every resident was a two person assist which is designated by an orange dot outside the room. Linen changes are conducted using two people, one on each side of the bed, if keeping the resident in bed. The process is to gown up, carefully roll the resident from one side to the other side removing the dirty linen. The process is reversed putting the clean linen on. During this careful attention is paid to making sure the trach line is not tangled. Once done the can call an RT if needed. She said nurses can be a second person. If there a visible sign or complaint of injury it to be investigated as an abuse and the floor nurse, DON and Administrator must be notified. An interview was conducted on March 28, 2026, at 10:08 a.m. with a licensed practical nurse (LPN/staff #51) who stated that any allegation of abuse, such as reports of a resident being hit by staff or another resident, was immediately reported to the Administrator, and an investigation was initiated. Regarding Incident between Resident #144 (alleged victim) and Resident #85 (alleged perpetrator) -Resident #144 was admitted on [DATE] with diagnoses of acute and chronic respiratory failure, schizoaffective disorder bipolar type and PTSD (post-traumatic stress disorder. The care plan revised on December 6, 2022 included that the resident required placement on secured unit secondary to psych diagnosis, poor safety awareness, and/or history of substance abuse, which resulted in resident exhibiting behaviors that could potentially place resident or others at risk; had impaired decision making related to long history of mental illness; had difficulty understanding others related to anxiety, schizoaffective bipolar disorder and PTSD; and, had exhibited verbally abusive behavioral symptoms (others were threatened, screamed at, cursed at). Interventions included setting expectations and limits, calming resident if signs of distress develop during the decision-making process (feeling overwhelmed, fatigue, agitation, restlessness, withdrawal), facing the resident when speaking, using a calm tone of voice, speaking clearly and adjusting tone as needed, avoiding over-stimulation (e.g., noise, crowding, other physically aggressive residents), encouraging resident not to block the entry of the dayroom, redirecting resident when he has episodes of aggressive behavior, taking resident to his room and provide 1:1 redirection, assessing whether the behavior endangers the resident and/or others, and intervening if necessary. The nursing note dated January 20, 2023 included the resident had exhibited exit-seeking behavior; and that, the resident attempted to exit from the unit multiple times, was redirected with some improvement noted. (continued on next page)

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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 - Actual harm Residents Affected - Few	The nursing monthly summary note dated January 26, 2023, indicates that the resident was alert to self but intermittently confused, frequently refused care, exhibited exit-seeking behavior by attempting to leave the unit, and persistently requested fluids. A nursing note dated February 6, 2023 included that at 5:30 a.m., Resident #144 self-propelled his wheelchair in the hallway and approached another resident (#85) who was in a wheelchair and was looking out the window by the double doors from behind. The documentation included that the other resident (#85) then turned his upper body around and struck the left side of the upper chest of Resident #144 who then struck the other resident (#85) back with a closed fist. According to the documentation, a certified nurse assistant (CNA/staff #171) was present, saw the incident and immediately separated Resident #144 and the other resident (#85). The documentation included that Resident #144 had slight redness noted to his left upper chest. -Resident #85 was admitted on [DATE] with diagnoses of Schizoaffective disorder, personality disorder, anxiety and major depressive disorder. The care plan dated May 28, 2021 included resident exhibited behaviors such as yelling out profanities, argued with self, hit hand into other hand in a threatening manner even when he was alone in the room. Interventions included increasing sessions with counselor and distracting the resident with things he likes. The care plan dated June 28, 2022 included that resident was on 2:1 for cares related to false accusations and safety. Interventions included 2:1 for all cares, redirection as needed and offering phone and outdoor time. The care plan revised on October 10, 2022 included resident exhibited verbally inappropriate behavioral symptoms towards peers. Interventions included to allow distance in seating other residents around resident #85, to avoid over-stimulation/reducing external stimuli (e.g., noise, crowding, other physically aggressive residents), to provide 1:1 sessions with resident with every disruptive blow up, to remove resident from group activities when behavior is unacceptable, to redirect /divert resident's behavior by engaging with topics that interest him, to redirect from others when behaviors increase, and, when resident becomes verbally abusive or disruptive, move resident to a quiet, calm environment. The behavior notes dated February 2 and 3, 2023 included that the resident was spitting on towels and trash cans, making negative statements toward staff, exhibiting exit-seeking behavior, and repeatedly yelling, cursing, and throwing items throughout the shift. According to the documentation, staff attempted redirection and education, which were only briefly effective. Additional interventions—including distraction, offering food and fluids, and modifying the environment—were implemented; however, these measures did not result in change in the resident's behavior. The nursing note dated February 3, 2023 revealed Resident #85 continued to propel his wheelchair around the unit talking to people who were not there, had loud

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, interviews, and review of the facility's policy and procedures the facility failed to ensure their policy was implemented and followed related to abuse/neglect and abuse investigation for Residents #19, #56, #139, #144, #149, #167 and #174. The universe was 25. The deficient practice could result in failure to recognize, respond and take appropriate action to prevent residents from continued abuse and neglect and risk for ongoing harm, exploitation and serious adverse outcomes.Findings include:Regarding Resident #167 -Resident #167 was admitted to the facility on [DATE] with diagnoses that included persistent vegetative state, chronic respiratory failure with hypoxia, traumatic subarachnoid hemorrhage without loss of consciousness, and Crohn's disease. Review of the admission MDS, dated [DATE], did not assess Resident #167's cognitive status. The same MDS also noted that Resident #167's functional status for bathing was total dependence and required 1-person physical assist. Review of the Quarterly MDS, dated [DATE], indicated that a staff assessment for mental status was completed. It was noted that Resident #167's cognitive skills for daily decision making was severely impaired. The MDS also revealed that Resident #167's functional status for bathing was total dependence and required 2-persons physical assist. Review of a Monthly Summary form, dated August 29, 2023, indicated Resident #167 was total dependence for bathing and required 1-person physical assist. An additional review of a Quarterly MDS, dated [DATE], indicated that staff assessed Resident #167's cognitive skills for daily decision making as severely impaired. It was also noted that his functional status for bathing was total dependence and required 2-persons physical assist. Review of a Monthly Summary form, dated October 5, 2023, indicated Resident #167 was total dependence for bathing and required 2-persons physical assist. Review of a Monthly Summary form, dated November 23, 2023, indicated Resident #167 was total dependence for bathing and required 2-persons physical assist. Review of Resident #167's Progress Notes revealed an entry, dated November 29, 2023, at 11:26 A.M. created by Registered Nurse (RN/Staff #138). It was noted that Resident #167 was restless and had pushed the rail on the gurney when a Certified Nurse Assistant (CNA) had turned to throw away a razor. It also noted that the resident had fallen from the gurney and sustained an abrasion to the left side of his head and a hematoma on the right side of his head. It further noted that bleeding was noted to be in his mouth but staff was unable to determine the cause of the bleeding. The Progress Note also indicated that Resident #167 was sent to the emergency room per the physician's order for evaluation. Additional review of the Progress Note revealed an entry, dated November 30, 2023 at 1:10 P.M. The entry noted that the Interdisciplinary Team (IDT) reviewed the incident and indicated that the resident was a high risk for falls due to his medical conditions. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #167's Care Plan indicated that Resident #167 required total assist for all Activities of Daily Living (ADLs) which included bathing. The care plan further indicated that this was initiated on December 6, 2022. The Care Plan also revealed that interventions were revised on December 20, 2023 by the Director of Nursing (DON/Staff #7) to include requiring 2-person assist with showers. It was noted that the start date for the updated intervention was December 11, 2023. There was no evidence, in the Care Plan, that 2-person assist for bathing was identified prior to December 20, 2023. Review of the facility's 5-day investigation report, for the alleged incident, revealed there was one CNA present with Resident #167 when he fell during a shower on November 29, 2023. Review of the facility's incident reports for Resident #167 revealed an undated Lancaster fall form that indicated he fell from the gurney and was sent to the hospital for evaluation and treatment. A telephonic interview was conducted with CNA/Staff #1 on March 28, 2026 at 7:37 A.M. Staff #1 shared that she identifies if the resident is a 2-person assist if they have a green sticker next to their name on the name card outside of their room. Staff #1 indicated that she remembered Resident #167. She shared that he was in the shower room with her and they had just completed the showering cares. Staff #1 further shared Resident #167 then jerked his legs, crossed them, and his legs went over the railing on the gurney and he fell. Staff #1 explained she then opened the shower room door and yelled for help from the Nurses. Staff #1 recalled Resident #167 going to the hospital after the fall. Staff #1 also shared that she was by herself with him in the shower room due to him being a 1-person assist at the time of the fall. She added that after the fall, he then became a 2-person physical assist. An interview was conducted on March 28, 2026 at 11:13 A.M. with Licensed Practical Nurse (LPN/Staff #120. Staff #120 revealed that neglect occurs when pain medications are given without a proper pain assessment or when cares are not being provided to the resident. She shared she receives abuse and neglect training often during monthly in-services. When asked whether providing a 1-person assist to a resident assessed as requiring a 2-person assist for bathing, resulting in a fall, would constitute neglect, she confirmed that it would, as the resident is a 2-person assist because the resident moves a lot. Staff #1 gave an example of a staff being on one side of the resident while washing them, the resident can move towards the other side of the gurney, fall and get hurt. She further explained that if a resident is a 2-person assist, then there must be 2 people helping the resident. Staff #1 shared that neglecting the residents could result in injury, skin damage, residents could be emotionally affected and they could lose their trust in staff to keep them safe. An interview was conducted on March 28, 2026 at 8:23 A.M. with the MDS/Care Plan Coordinator/Licensed Practical Nurse (Staff #59). Staff #59 explained that the MDS is created upon admission and is updated if there is a change in condition or if a quarterly review is due. She further explained that once the MDS assessment is completed, the comprehensive care plan is triggered with information obtained from the MDS assessments. She added that she and another MDS staff person also create and update the care plans after completion of the MDS. Staff #59 reviewed Resident #167's June 2, 2023 MDS assessment and shared that he was total dependence for bathing and required 2-person assist. Staff #59 reviewed Resident #167's September 2, 2023 MDS assessment and shared that he was total dependence for bathing and required 2-person assist as well. Staff #59 also reviewed Resident #167's comprehensive care plan and shared that it was noted he was a total assist for all ADLs however, it did not specifically say that he was a 2-person assist for bathing. She further shared that she did not know why the care plan did not reflect that the resident was a (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2-person assist for bathing. An interview was conducted on March 28, 2026 at 8:41 A.M. with DON/Staff #7. Staff #7 shared that abuse and neglect training is provided to staff on an annual basis and as needed to provide re-education. When asked whether providing a 1-person assist to a resident assessed as requiring a 2-person assist for bathing, resulting in a fall, would constitute neglect, she shared that it would be if the care plan indicated the resident was a 2-person assist and only 1-person assist was done. When asked if not updating the care plan to reflect the MDS assessment as neglect, Staff #7 shared that it would be because the MDS did not link to the care plan so it was not adequately implemented. She further shared that this could lead to residents sustaining an injury because something happened to them due to not getting the proper care. Staff reviewed the September 2, 2023 MDS for Resident #167 and shared that he was total dependence and required 2-person assist for bathing. When reviewing the care plan for Resident #167, she shared that it identified that Resident #167 was a 2-person assist with showers starting December 11, 2023. She further shared that there was no information, regarding bathing with 2-person assist, in the care plan prior to December 11, 2023. Staff #7 explained that the care plan should have reflected that the resident was a 2-person assist prior to that date and confirmed that the care plan did not match the information in Resident #167's MDS. An interview was conducted on March 28, 2026 at 9:16 A.M. with the Administrator (Staff #116). She reviewed Resident #167's June 2, 2023 MDS assessment and shared that he was total dependent for bathing and required 2-person support indicating 2 people were to help him. Staff #116 reviewed Resident #167's September 2, 2023 MDS assessment and shared that he was total dependent for bathing and required 2-person assist. Staff #116 explained that in November 2023, based off of her interview with staff, a CNA had taken Resident #167 to the shower on a gurney. The CNA had stated that the resident had jerked or seized and fell off the gurney. She further explained that the fall had taken place in the shower. Staff #116 shared that there was one CNA providing bathing assistance to Resident #167 at the time of the incident. However, she added, that based off the information in the MDS, Resident #167 was supposed to have two people helping him. Staff #116 indicated that this did not meet her expectations and the risk of not providing adequate support, identified in the MDS assessments, can cause harm to the residents. Regarding Resident #174 -Resident #174 was admitted on [DATE] and discharged on February 14, 2024 with diagnosis including acute/ chronic respiratory failure with hypoxia and hypercapnia, muscle weakness, Parkinson's disease, chronic obstructive pulmonary disease, obstructive sleep apnea, morbid obesity, transient ischemic attack, hypoventilation syndrome, atrial fibrillation, chronic systolic congestive heart failure, aneurysm of other specified arteries, anemia, sick sinus syndrome, dyspnea, asthma, gastroparesis, osteoarthritis-right knee and shoulder, chronic kidney disease-stage 2, dependence on supplemental oxygen, hypertension, cardiac pacemaker, localized edema, hypotension and hyperlipidemia. A review of the 5-day MDS (minimum data set) dated November 15, 2023 revealed a BIMS (brief interview of mental status) score of 8, indicating moderate cognitive impairment. A review of the careplan noted that the resident had a focus area of impaired skin integrity due to impaired mobility. Interventions included that the resident is to receive supplements per orders, that chartable tasks to include the CNA (certified nursing assistant) tasks are to be documented and signed off in the electronic health record, dressings are to be changed as ordered, pressure ulcers are (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to be assessed, pain is to be assessed, skin inspections are to be conducted, areas is to be kept clean and dry, incontinence care is to be provided after each episode, friction is to be reduced by use of lubricants, moisture barrier is to be applied and that the resident is to be turned and repositioned every 2- 4 hours. A review of the facility 5-day investigation revealed that the investigative report was submitted on November 27, 2023. The allegation made by the complainant included that resident #174 had not been repositioned and subsequently developed blisters in the rectal area. The report documented that the allegation was made on November 19, 2023, which was noted to have been a weekend, via voicemail, but the report did not reveal whose voicemail message it had been left on. The report further noted that the voicemail was retrieved on Monday November 20, 2023 at which time notifications and investigation ensued. The investigative report revealed no evidence that staff, resident or complainant had been interviewed regarding the alleged incident. An interview was conducted on March 28, 2026 at 8:46 AM with staff #19, Nurse Manager. Staff #19 stated that resident care is the number one priority and that if there are concerns that call for an investigation, policy is followed to ensure a thorough investigation. She stated that the policy outlines the investigative process. Staff #19 further stated that the risk for not following policy could include not having a complete and accurate investigation of the allegation. An interview was conducted on March 28, 2026 at 2:28 PM with staff #7, DON (Director of Nursing). Staff #7 stated that a 5-day investigation needs to be thorough, documenting what happened. Staff #7 stated that first steps included removing the alleged perpetrator from the schedule, and then to investigate by interviewing staff and residents. The DON further stated that interviews, per policy, are always required on an investigation to ensure it is thorough. Staff #7 stated that she did not interview anyone for this investigation, because she went on the unit and saw the process and as a result knew the cause. She further stated that that she felt that there was no need to identify any specific staff member regarding a potential lapse as multiple staff members had been providing care to the resident. Staff # 7 stated that per the facility policy, interviews need to be conducted for a thorough investigation. An interview was conducted on march 28, 2026 at 2:57 PM with staff #116 Administrator. Staff #116 stated that her expectation is that investigations are thoroughly investigated, per policy, which includes interviews with staff and with everyone who may have been involved, witnessed the above incident and or was present to make sure that everything makes sense regarding the investigation. Staff #116 stated that the risk for not conducting a thorough investigation would include the inability to come to an accurate conclusion. Regarding Resident #19 -Resident #19 was admitted to the facility on [DATE] with diagnoses that included Dysphagia following cerebral infarction, Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, Aphasia following cerebral infarction, Type 2 diabetes mellitus with diabetic neuropathy, Cerebrovascular disease. Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #19 scored a 9 for the Brief Interview for Mental Status (BIMS) which indicated she had moderate impairment. Care plan dated May 22, 2023 included resident required dependent assist for all ADL's to include (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bathing, grooming, hygiene, toileting, bed mobility, and dressing. Also, the resident required extensive assistance with meals, and was a two person assist with Hoyer lift. A progress note dated July 24, 2023 at 5:30 p.m. stated a CNA reported to Staff # 321 that Resident #19 needed a splint for her right hand and wrist. The resident was crying in pain when the CNA attempted to move the wrist. The resident also had blood on her lower right lip. An order dated July 24, 2023 10:03 p.m. was for Resident #19 to be transferred to an acute hospital emergency room (ER) for a CT scan of the head and X-rays of the right wrist and right leg. Hospital (ER) report dated July 24, 2023 stated, the resident was nonverbal [AGE] year-old presented to the ER with right wrist pain. There is some swelling and tenderness without any evidence of erythema or warmth and there are no open wounds have a low suspicion for septic joint. Per EMS report, the injury was from staff moving her. She has also been pointing to her leg and complaining of pain there as well. The facility initial report to the State Agency dated July 24, 2023 7:25 p.m. revealed a resident was hurt by a tall man and had pain the right hand; and that, the resident was sent out to the emergency room for X-rays. The facility 5-day report revealed that Resident #19 complained of right-hand pain, and also said that a tall guy hurt her. The resident was transported to the hospital because of right arm swelling. The report also revealed a CNA (staff #325) was suspended pending an investigation, and that he was the only CNA working with the resident that matched the description. The reported had an interview with the CNA and he said a nurse asked him to lay the resident down. The CNA changed the bedding and he used a gait belt to transfer the resident back to her bed. The 5-day report was concluded with the facility investigation being inconclusive because, the X-ray and CT were done and it was not a clear diagnosis if the resident has a fracture or not. The resident has a new diagnosis of decrease mineralization to the bone. She also has a new diagnosis of osteoarthritis to hand. Further review of the facility investigation revealed that the facility did not interview the resident's family, other resident's to whom the alleged CBA provided care; and, the facility did not interview family/guardian or responsible party of the roommate of Resident #19 who was identified in their report as in a vegetated state and non-interviewable Review of the personnel file of the alleged CNA (staff #325) revealed that a report dated July 25, 2023 and an attached corrective action form that indicated that Staff #325 was terminated for failure to follow safety rules and unsatisfactory job performance. An interview with a registered nurse (RN, Staff #138) was conducted on March 26, 2026, at 2:43 p.m. The RN stated that any allegation of abuse is reported to the Administrator or the Director of Nursing (DON#7), who then had two hours to report the incident to the State Agency (SA). She further stated that upon receiving an allegation of abuse, she would ensure the involved residents were safe, would gather details by speaking with both residents, would document the information, and would report the incident to the DON. On March 27, 2026 at 10:15 a.m. and interview was conducted with the legal guardian of Resident #19. The legal guardian said that Resident #19 would shook her head 'no' when asked if there were any concerns with facility staff; would shook her head 'yes' when asked if she felt safe; and would communicate with staff by mumbling and the use of a word board The legal guardian said there was (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	an issue about a year after Resident #19 was admitted to the facility; and that, during a transfer Resident #19 sustained a fracture her right wrist. The guardian stated that he did not know the specifics of what happened but was told by the facility that it was not the facility's fault. An interview was conducted on March 28, 2026, at 10:08 a.m. with a licensed practical nurse (LPN/staff #51) who stated that any allegation of abuse, such as reports of a resident being hit by staff or another resident, was immediately reported to the Administrator, and an investigation was initiated. An interview was conducted on March 27, 2026 at 3:45 p.m. with Staff #170 who said that she remembered and was working at the time of the incident with Resident #19. She was called to the room by a Respiratory Therapist (RT) to help assess Resident #19 who had dried blood on her mouth and was holding her right hand. The resident had very limited speech but through the use of a speech board, Resident #19 identified the staff as a male. Staff #170 said that there was only one male CNA (staff #325) and all other staff was female that day. She said the Resident #19 was bed bound and would be a two-person Hoyer lift assist. An interview was conducted on March 28, 2026 at 7:52 a.m. with Staff #110. She said, every room in the 600 hall every resident was a two person assist which is designated by an orange dot outside the room. Linen changes are conducted using two people, one on each side of the bed, if keeping the resident in bed. The process is to gown up, carefully roll the resident from one side to the other side removing the dirty linen. The process is reversed putting the clean linen on. During this careful attention is paid to making sure the trach line is not tangled. Once done the can call an RT if needed. She said nurses can be a second person. If there a visible sign or complaint of injury it to be investigated as an abuse and the floor nurse, DON and Administrator must be notified. In an interview conducted on March 27, 2026 1:35 p.m. with DON, she said the 5-day report was sent to the SA on July 31, 2023. DON said said the initial facility investigation was the CNA reported that he changed the sheets on the bed and used a gait belt to transfer the resident back into bad. The residents brief was changed and he left the room. The facility investigation revealed the resident began crying during a care procedure. a staff member was called to the resident's room for a complaint of pain. The DON said the resident was sent to the ER for x-ray and evaluation. She said the final facility investigation was determined to be inconclusive due to: X-ray and CT were done and it was not a clear diagnosis if the resident has a fracture or not. She said the resident was diagnosed at the hospital with a diagnosis of decrease mineralization to the bone and a new diagnosis of osteoarthritis to hand. The DON said Resident #19 did not go to an optional MRI. Resident #19 was given a splint and started physical therapy when she returned to the facility. On March 27, 2026 at 4:20 p.m. an interview with Administrator was conducted. She said the incident happened before her employment began. The Administrator said all reports of abuse are investigated fully, but she did not know the specifics of this incident. She said she was pretty sure that Staff #325 was terminated because of the incident. Regarding Resident #56: -Resident #56 was admitted on [DATE] with diagnoses of anoxic brain damage, contracture of muscle, dysphagia, and muscle wasting and atrophy The care plan revised on August 8, 2022 included resident was completely incontinent of bowel and (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bladder. Interventions included to provide incontinence care after each incontinent episode and report signs of skin breakdown or perianal excoriation. The nursing note dated August 8, 2022 included the resident required 1-2 person maximum assist with ADLs (activities of daily living) and had been turned and repositioned every 2-4 hours. A nursing note dated August 10, 2022 revealed resident was incontinent for bowel and bladder, required total assist for all ADLs, was turned and repositioned every 2-4 hors, and was on LAL (low air loss) mattress for skin maintenance. The nursing note dated August 13, 2022 revealed the resident was unable to make needs known, unable to follow simple commands and was incontinent of bowel and bladder with use of pads and brief with sufficient amount of urine output throughout the shift. Review of a nursing notes dated August 21 and 28, 2022 included the resident was incontinent of bowel and bladder with use of pads and brief with sufficient amount of urine output throughout the shift. The nursing note dated August 28, 2022 included a report was received from the night nurse that there was edema noted to the posterior tip of the resident's penis. The documentation included that the provider was notified; and that, the provider saw the resident and ordered nystatin (topical antifungal) as treatment. The physician progress note dated August 28, 2022 revealed that the resident had penile edema, without discharge. Treatment included application of nystatin daily and to check CBC (complete blood count) in the morning. Review of systems included that the resident had no leg edema. The nursing notes dated August 29 and August 31, 2022 revealed the resident was alert but was unable to make needs known, was incontinent for bowel and bladder, required total assistance with ADLs and continued to have swelling on the dorsal side of glans penis with no drainage or redness noted. The facility 5-day investigation submitted on August 30, 2022 revealed that on August 29, 2022, the DON (Director of Nursing) received a message from resident's family that the resident had been abused because the resident's son's penis was swollen. Further review of the investigation found no evidence that interviews were conducted with witnesses, staff who cared for the resident, the staff member identified as responsible, or other residents cared for by that staff member. There was also no review of the events leading up to the incident. The care plan dated August 31, 2022 included the resident had potential for infection and/or skin breakdown related to being uncircumcised. Interventions included conducting skin check no less than 2 x weekly and PRN (as needed); and when providing care, ensure that the foreskin of the penis was retracted to adequately clean the penile area and to let resident know what you are doing and why. An interview with a registered nurse (RN/staff #150) was conducted on March 27, 2026 at 3:38 p.m. The RN stated that resident #56 was non-verbal, had a trach, was on ventilator and had a gastrostomy tube. She stated that she could not recall any incident of the resident having swollen penis. In an interview with the respiratory therapy director (RTD/staff #170) conducted on March 27, 2026 at (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3:52 p.m., the RTD stated that she had not seen or heard any reports that the resident had a swollen penis; and that, this was beyond her scope of practice. During an interview with the Director of Nursing (DON/staff #7) conducted on March 28, 2026 at 2:28 p.m., the DON stated that she received a call from the resident's family of an allegation of abuse. However, she stated that she did not interview any staff or residents because when she went to see Resident #56, she saw it and knew what the cause of the swelling of the resident's penis. She further stated that she did not feel the need to identify one person as everyone was involved in the resident's care. However, the DON stated that per their policy on abuse, she needs to conduct interviews during the investigation. Regarding Resident #144 and Resident #85: -Resident #144 was admitted on [DATE] with diagnoses of acute and chronic respiratory failure, schizoaffective disorder bipolar type and PTSD (post-traumatic stress disorder. A care plan dated February 20, 2020 included resident had difficulty understanding others related to anxiety, schizoaffective bipolar disorder and PTSD; had impulse control as evidenced by physical and verbal aggression towards staff and peer and had exhibited verbally abusive behavioral symptoms (others were threatened, screamed at, cursed at). Interventions included speaking clearly/adjusting tone/repeating phrases as needed; asking resident to repeat what has been said to confirm the message was understood; if resident had an increase in behavior and is unable to be redirected, he may lose his next cigarette break, approaching resident in a calm, empathetic manner; removing resident from stimuli, if resident refuses, to attempt to remove stimuli near resident0, avoiding over-stimulation (e.g., noise, crowding, other physically aggressive residents); redirecting the resident when he has episodes of aggressive behavior; taking the resident to his room and provide 1:1redirection; and, assessing whether the behavior endangers the resident and/or others and intervening if necessary. The care plan dated December 23, 2020 included resident required placement on secured unit secondary to psych diagnosis, poor safety awareness, and/or history of substance abuse, which results in resident exhibiting behaviors that could potentially place resident or others at risk. The nursing note dated January 20, 2023 included the resident had exhibited exit-seeking behavior; and that, the resident attempted to exit from the unit multiple times, was redirected with some improvement noted. A nursing note dated February 6, 2023 included that at 5:30 a.m., Resident #144 self-propelled his wheelchair in the hallway and approached another resident (#85) who was in a wheelchair and was looking out the window by the double doors from behind. The documentation included that the other resident (#85) then turned his upper body around and struck the left side of the upper chest of Resident #144 who then struck the other resident (#85) back with a closed fist. According to the documentation, a certified nurse assistant (CNA/staff #171) was present, saw the incident and immediately separated Resident #144 and the other resident (#85). The documentation included that Resident #144 had slight redness noted to his left upper chest. -Resident #85 was admitted on [DATE] with diagnoses of Schizoaffective disorder, personality disorder, anxiety and major depressive disorder. (continued on next page)

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	035064	A. Building B. Wing	03/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foothills Rehabilitation Center	2250 North Craycroft Road Tucson, AZ 85712

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan dated May 28, 2021 included resident exhibited behaviors such as yelling out profanities, argued with self, hit hand into other hand in a threatening manner even when he was alone in the room. Interventions included increasing sessions with counselor and distracting the resident with things he likes. The care plan dated June 28, 2022 included that resident was on 2:1 for cares related to false accusations and safety. Interventions included 2:1 for all cares, redirection as needed and offering phone and outdoor time. The behavior note dated February 3, 2023 included resident had exhibited behaviors all morning, yelling and cursing at staff, talking to people who were not present, hitting self in head, throwing cups/water, and throwing medications in trash can. Per the documentation, multiple attempts were made to redirect, offer of food, fluids, snack, and was given choices on how he would like his medications as well as and attempted to provide a change in environment. However, all attempts were unsuccessful; and, the PRN (as needed) medications for anxiety was administered with minimal effect noted. The nursing note dated February 3, 2023 revealed Resident #85 continued to propel his wheelchair around the unit talking to people who were not there, had loud outbursts, periodic yelling at staff, was cursing, and hitting self in head. The documentation also included that the resident had active delusions and hallucinations stating that he lost 319 pounds in the past 6 months and maybe he can eat a piece of white bread to keep from dying. Per the documentation, the resident received his PRN medication but with minimal effect; and, staff continued to provide NPI (non-pharmacological interventions) to assist with de-escalation of his behaviors. A nursing note dated February 6, 2023 at 5:30 a.m., Resident #85 was sitting in his wheelchair looking out the window on the double door when another resident (#144) in a wheelchair approached Resident #85 from behind. The documentation included that Resident #85 then turned his upper body and struck the other resident (#144 on the left upper chest with his forearm According to the documentation, the other resident (#144) then struck Resident #85 with a closed fist in the center of his back. According to the documentation, a certified nurse assistant (CNA/staff #171) was present, saw the incident and immediately separated Resident #85 and the other resident (#144); and that, Resident #85 did not have any injuries noted. The initial self-report dated February 6, 2023 included that Resident #85 had an altercation with Resident #144. Per the documentation, Resident #85 was at the doorway and Resident #144 came to the doorway too; and that, Resident #85 turned around and hit Resident #144. The undated facility

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, facility documentation and policy reviews, the facility failed to ensure allegations of abuse for 5 of 25 sampled residents (#19, #174, #149, #139 and #56) were thoroughly investigated. The deficient practice could result in failure to recognize, respond and take appropriate action to prevent residents from continued abuse and neglect and risk for ongoing harm, exploitation and serious adverse outcomes.Findings include: -Resident #174 was admitted on [DATE] and discharged on February 14, 2024 with diagnosis including acute/ chronic respiratory failure with hypoxia and hypercapnia, muscle weakness, Parkinson's disease, chronic obstructive pulmonary disease, obstructive sleep apnea, morbid obesity, transient ischemic attack, hypoventilation syndrome, atrial fibrillation, chronic systolic congestive heart failure, aneurysm of other specified arteries, anemia, sick sinus syndrome, dyspnea, asthma, gastroparesis, osteoarthritis-right knee and shoulder, chronic kidney disease-stage 2, dependence on supplemental oxygen, hypertension, cardiac pacemaker, localized edema, hypotension and hyperlipidemia. A review of the 5-day MDS (minimum data set) dated November 15, 2023 revealed a BIMS (brief interview of mental status) score of 8, indicating moderate cognitive impairment. A review of the care plan noted that the resident had a focus area of impaired skin integrity due to impaired mobility. Interventions included that the resident is to receive supplements per orders, that chartable tasks to include the CNA (certified nursing assistant) tasks are to be documented and signed off in the electronic health record, dressings are to be changed as ordered, pressure ulcers are to be assessed, pain is to be assessed, skin inspections are to be conducted, areas is to be kept clean and dry, incontinence care is to be provided after each episode, friction is to be reduced by use of lubricants, moisture barrier is to be applied and that the resident is to be turned and repositioned every 2- 4 hours. A review of the facility 5-day investigation revealed that the investigative report was submitted on November 27, 2023. The report documented that the allegation was made on November 19, 2023, which was noted to have been a weekend, via voicemail, but the report did not reveal whose voicemail message it had been left on. The report further noted that the voicemail was retrieved on Monday November 20, 2023 at which time notifications and investigation ensued. The investigative report revealed no evidence that staff, resident or complainant had been interviewed regarding the alleged incident. The allegation made by the complainant included that resident #174 had not been repositioned and subsequently developed blisters in the rectal area. An interview was conducted on March 28, 2026 at 2:28 PM with staff #7, DON (Director of Nursing). Staff #7 stated that a 5-day investigation needs to be thorough, documenting what happened. Staff #7 stated that first steps included removing the alleged perpetrator from the schedule, and then to investigate by interviewing staff and residents. The DON further stated that interviews are always required on an investigation to ensure it is thorough. Staff #7 stated that she did not interview anyone for this investigation, because she stated that she went there and saw it herself and as a result knew the cause and just proceeded to educate the staff. Ashe further stated that that she felt that there was no need to identify a specific staff member as multiple staff members had been providing care to the resident. Staff # 7 stated that per the facility policy, interviews need to be conducted for a thorough investigation. An interview was conducted on march 28, 2026 at 2:57 PM with staff #116 Administrator. Staff #116 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated that her expectation is that investigations are thoroughly investigated which includes interviews with staff and with everyone who may have been involved, witnessed the above incident and or was present to make sure that everything makes sense regarding the investigation. Staff #116 stated that the risk for not conducting a thorough investigation would include the inability to come to an accurate conclusion. -Resident #19 was admitted to the facility on [DATE] with diagnoses that included Dysphagia following cerebral infarction, Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, Aphasia following cerebral infarction, Type 2 diabetes mellitus with diabetic neuropathy, Cerebrovascular disease. Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #19 scored a 9 for the Brief Interview for Mental Status (BIMS) which indicated she had moderate impairment. A progress note dated July 24, 2023 at 5:30 p.m. stated a CNA reported to Staff # 321 that Resident #19 needed a splint for her right hand and wrist. The resident was crying in pain when the CNA attempted to move the wrist. The resident also had blood on her lower right lip. An order dated July 24, 2023 10:03 p.m. was for Resident #19 to be transferred to an acute hospital emergency room (ER) for a CT scan of the head and X-rays of the right wrist and right leg. Hospital (ER) report dated July 24, 2023 stated, the resident was nonverbal [AGE] year-old presented to the ER with right wrist pain. There is some swelling and tenderness without any evidence of erythema or warmth and there are no open wounds have a low suspicion for septic joint. Per EMS report, the injury was from staff moving her. She has also been pointing to her leg and complaining of pain there as well The facility initial report to the State Agency dated July 24, 2023 7:25 p.m. said a resident was hurt by a tall man and had pain the right hand. Further information received stated the resident was sent out to the emergency room for X-rays. The facility 5-day report was submitted on July 31, 2023 revealed that Resident #19 complained of right-hand pain, and also said that a tall guy hurt her. The resident was transported to the hospital because of right arm swelling. The report also revealed a CNA was suspended pending an investigation, and that he was the only CNA working with the resident that matched the description. The reported had an interview with the CNA and he said a nurse asked him to lay the resident down. The CNA changed the bedding and he used a gait belt to transfer the resident back to her bed. The 5-day report was concluded with the facility investigation being inconclusive because, the X-ray and CT were done and it was not a clear diagnosis if the resident has a fracture or not. The resident has a new diagnosis of decrease mineralization to the bone. She also has a new diagnosis of osteoarthritis to hand. Further review of the facility investigation revealed that the facility did not interview the resident's family, other resident's to whom the alleged CBA provided care; and, the facility did not interview family/guardian or responsible party of the roommate of Resident #19 who was identified in their report as in a vegetated state and non-interviewable. -Resident #56 was admitted on [DATE] with diagnoses of anoxic brain damage, contracture of muscle, dysphagia, and muscle wasting and atrophy. The care plan revised on August 8, 2022 included resident was completely incontinent of bowel and (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bladder. Interventions included to provide incontinence care after each incontinent episode and report signs of skin breakdown or perianal excoriation. The nursing note dated August 8, 2022 included the resident required 1-2 person maximum assist with ADLs (activities of daily living) and had been turned and repositioned every 2-4 hours. A nursing note dated August 10, 2022 revealed resident was incontinent for bowel and bladder, required total assist for all ADLs, was turned and repositioned every 2-4 hors, and was on LAL (low air loss) mattress for skin maintenance. The nursing note dated August 13, 2022 revealed the resident was unable to make needs known, unable to follow simple commands and was incontinent of bowel and bladder with use of pads and brief with sufficient amount of urine output throughout the shift. Review of a nursing notes dated August 21 and 28, 2022 included the resident was incontinent of bowel and bladder with use of pads and brief with sufficient amount of urine output throughout the shift. The nursing note dated August 28, 2022 included a report was received from the night nurse that there was edema noted to the posterior tip of the resident's penis. The documentation included that the provider was notified; and that, the provider saw the resident and ordered nystatin (topical antifungal) as treatment. The physician progress note dated August 28, 2022 revealed that the resident had penile edema, without discharge. Treatment included application of nystatin daily and to check CBC (complete blood count) in the morning. Review of systems included that the resident had no leg edema. The nursing notes dated August 29 and August 31, 2022 revealed the resident was alert but was unable to make needs known, was incontinent for bowel and bladder, required total assistance with ADLs and continued to have swelling on the dorsal side of glans penis with no drainage or redness noted. The facility 5-day investigation submitted on August 30, 2022 revealed that on August 29, 2022, the DON (Director of Nursing) received a message from resident's family that the resident had been abused because the resident's son's penis was swollen. Further review of the investigation found no evidence that interviews were conducted with witnesses, staff who cared for the resident, the staff member identified as responsible, or other residents cared for by that staff member. There was also no review of the events leading up to the incident. The care plan dated August 31, 2022 included the resident had potential for infection and/or skin breakdown related to being uncircumcised. Interventions included conducting skin check no less than 2 x weekly and PRN (as needed); and when providing care, ensure that the foreskin of the penis was retracted to adequately clean the penile area and to let resident know what you are doing and why. An interview with a registered nurse (RN/staff #150) was conducted on March 27, 2026 at 3:38 p.m. The RN stated that resident #56 was non-verbal, had a trach, was on ventilator and had a gastrostomy tube. She stated that she could not recall any incident of the resident having swollen penis. In an interview with the respiratory therapy director (RTD/staff #170) conducted on March 27, 2026 at (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3:52 p.m., the RTD stated that she had not seen or heard any reports that the resident had a swollen penis; and that, this was beyond her scope of practice. During an interview with the Director of Nursing (DON/staff #7) conducted on March 28, 2026 at 2:28 p.m., the DON stated that she received a call from the resident's family of an allegation of abuse. However, she stated that she did not interview any staff or residents because when she went to see Resident #56, she saw it and knew what the cause of the swelling of the resident's penis. She further stated that she did not feel the need to identify one person as everyone was involved in the resident's care. However, the DON stated that per their policy on abuse, she needs to conduct interviews during the investigation. -Resident #149 was admitted on [DATE] with diagnoses of sepsis, delirium and anxiety. The care plan dated November 23, 2022 included that the resident was a 2:1 with care. Intervention included 2 staff present when caring for the resident. Another care plan dated January 17, 2023 revealed the resident chose not to use the call at times instead he yells out for help. Intervention included resident re-education on using the call light instead of yelling for help. The nursing notes dated March 3, 4 and 5, 2023 included resident was alert and oriented x 3, was able to make needs known and 2:1 care maintained throughout the shift. A nursing note dated March 6, 2023 included the resident was alert and oriented x 3-4, used the call light to make needs known and remained on 2:1 for all personal cares. Review of the facility's grievance log revealed that on March 6, 2023, the resident filed a grievance that staff did not wake him up when care was provided. The facility initial report dated March 8, 2023 revealed that the resident alleged being intimidated by the way staff spoke to him in a loud tone regarding his numerous complaints; and, how 2 CNAs can no longer care for him as a result of his complaints. The undated facility investigation included that on March 8, 2023, at about 11:44 a.m., Resident #149 reported feeling intimidated by the way staff spoke to him; and, said that a staff member used a loud tone while discussing his frequent complaints about caregivers, which he said resulted in two caregivers no longer being allowed to care for him. The investigation included an interview with a registered nurse (RN/Staff #32) who reported that he was in the resident's room with a CNA providing care and that any discussion about staff not being allowed to care for the resident was only with CNAs and respiratory therapists, not with the resident. Per the documentation, the RN denied speaking to the resident about this issue and denied raising his voice; and, the RN reported that he did not recall the resident apologizing to him. The documentation also included that the RN reported that during the night shift from March 5 to March 6, 2023, he worked with one CNA because another CNA could not work with the resident; and that, he administered bedtime medications, spoke with the resident, gave PRN medications when needed, and changed the resident's dressing at 1:00 a.m., noting the resident was awake during the treatment. The investigation included interviews of two CNAs (staffs #131 and #182and who worked with the RN (staff #32) when the RN provided care with Resident #149. The documentation included that both CNAs denied witnessing the RN tell the resident anything except that they were to change the resident's brief. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Continued review of the facility investigation revealed no evidence that interviews were conducted with other residents to whom the alleged RN provided care or service. -Resident #139 was admitted on on May 21, 2021 with diagnoses of stage 4 CKD (chronic kidney disease, dependence on renal dialysis, anxiety and type 2 diabetes with diabetic neuropathy. A nursing note dated October 20, 2022 included that the resident complained of of chest pain and was sent out to the hospital ER (emergency room). The discharge MDS (Minimum Data Set) assessment dated [DATE] included that the resident had an unplanned with return anticipated discharge to acute hospital on October 20, 2022. The nursing notes dated October 21, 2022 revealed that the resident was back at the facility; and that, the resident was sent back to the hospital because of high blood sugar level. The nursing note dated October 25, 2022 included that the resident arrived back at the facility and reported that she was missing $70 missing from before she left to hospital. A nursing note dated October 26, 2022 revealed that the resident continued to talk about her missing money. Per the documentation, staff conducted a search but was not able to find the missing money. The facility initial self-report dated October 26, 2022 that at approximately 3:30 p.m., the resident stated that she was missing $75.00 and 4 quarters which she left in a Ross bag in her room when she went went back to the acute hospital on October 22, 2022. The facility 5-day investigation dated November 2, 2022 revealed that the facility concluded that the missing money may have been misplaced because the alleged missing money was left in a Ross bag that may have been placed in the trash can in the resident's room. Per the documentation, the resident's missing money was replaced in full on October 26, 2022. The investigation included interviews conducted with 3 CNAs (certified nursing assistants), 2 of which worked on October 26, 2022 the day the resident came back from the hospital and 1 worked on the day the resident was discharged to the hospital on October 25, 2022. However, the facility did not have any interviews with staff who were on shift or took care of the resident on October 20 and 21, 2026; and, there were no evidence that other residents were interviewed as well. An interview with the social services director (SSD/staff #111) was conducted on March 26, 2026 at 1:13 p.m. The SSD stated that if she receives a report that the resident was missing personal items including money or reports of money stolen, she would go talk to the resident and ask permission if she could try to locate it in the resident's room; and if the missing item cannot be found, the facility will try to replace it. She stated that if it was about missing/stolen money and the money was noted in the resident's inventory list, then it will be replaced. However, if the missing/stolen money was not in the inventory list, she will notify the administrator who will then decide whether the missing/stolen money will be replaced or not. The SSD further stated that replacement of missing/or stolen money was on a case to to case basis as it does not happen all the time. Regarding the allegation of the missing money for resident #139, the SSD stated that she would have to look at the records and see if there was a grievance for this allegation and what the resolution was. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with a registered nurse (RN/staff #138) conducted on March 26, 2026 at 2:43 a.m., the RN stated that any allegations of abuse will be reported immediately to the DON/administrator who then has 2 hours to report the incident to SA. She stated that if she receives a report of allegations of abuse, she will ensure that the resident involved was safe and she will talk to the resident to get as much details of the allegation. The RN said that she will then document that she reported the incident to the DON. The RN also said that if the allegation involved a staff, she will report to the DON who will then tell the alleged staff to stop caring for the resident and will be sent home by the DON or Administrator until the investigation was completed During an interview with the DON (staff #7) conducted on March 28, 2026 at 1:16 p.m., the DON stated that any reports of resident's missing item including missing money is reported to the SSD who will then complete a grievance form. She stated that an investigation will be initiated and the incident will reported to the SA (state Agency). She further stated that the incident will be thoroughly investigated and and the facility's report/investigation will be submitted to the SA within the required timeframe. In a later interview conducted on March 28, 2026 at 2:28 p.m., the DON stated that the facility's investigation needs to be thorough to address and identify what happened. She stated the investigation includes removing the involved staff from schedule, interviews with staff and residents to get answers needed for the investigation. The DON said that interviews are always required on an investigation and not having interviews would result in the investigation not being thorough. In a written statement from the administrator dated March 28, 2026, the Administrator wrote that they were not able to locate the investigation or any documents pertaining to the missing money of Resident #139. An interview with the administrator was conducted on March 28, 2026 at 2:57 p.m. The administrator stated that facility investigation was done thoroughly; and that, investigations includes interviews with staff and with everyone to make sure that everything makes sense. She stated that if interviews were missing in the investigations, then it would be hard to come to a conclusion of what have happened, whether incident happened or not, and the investigation was not thorough. The facility policy on Preventing, Reporting and Investigation Abuse and Neglect included that it is their policy that residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. Facility is committed to protecting residents from abuse by anyone. Abuse prevention program provides guidelines that govern as a minimum identification of occurrences and patterns of potential mistreatment/abuse; protection of residents during abuse investigation; timely and thorough investigations of all reports and allegations of abuse; development of investigative protocols governing reports and allegations of resident ANE, resident-to-resident abuse, exploitation, individual injury; and, reporting and filing of accurate documents relative to incidents of abuse. The policy also included that witness reports will be obtained in writing; and, the individual conducting the investigation, will, as a minimum: Interview the person(s) reporting the incident; Interview any witnesses to the incident; Interview the resident as medically appropriate; Interview staff members (on all shifts) who have had contact with the resident during period of the (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and facility policy review, the facility failed to ensure a baseline care plan was provided to resident/representative for 3 of 25 sampled residents (#168, #171 and #175). The deficient practice could result in residents not receiving the necessary care and services to meet their assessed needs upon admission.Findings include:-Resident #168 was admitted on [DATE] with diagnoses of acute posthemorrhagic anemia, unsteadiness of feet, difficulty of walking, seizures, and COPD (chronic pulmonary obstructive disease). The nursing note dated October 23, 2023 included that resident arrived from the hospital, was alert and oriented x 4 and was able to make needs known. Per the documentation all consents were signed by the resident. The baseline care plan dated October 23, 2023 included that the meeting was attended by the social services and nutrition staff; and did not indicate the resident or resident representative was part of the creation of the baseline care plan. Per the documentation, initial goals of the resident was to get better and was a full code. However, all the items in the initial goals based on admission orders section were not marked and was not signed and dated by the resident or resident representative. Further, the baseline care plan had a completion date of May 2, 2024 (approximately 7 months after the resident's admission date) and that, it was not completed by a specific staff but was documented as system completed. There was no evidence that the baseline care plan summary was provided to the resident and/or the resident representative. The clinical record revealed that the resident was transferred to the hospital on November 2, 2023 per hematologist request. The nursing note dated November 6, 2023 revealed that resident remained discharged at the hospital. -Resident #175 was admitted on [DATE] with diagnoses of acute kidney failure, contusion of left knee and type 2 diabetes mellitus. The nursing note dated January 23, 2024 included that the resident was alert and oriented x 4 and arrived at the facility via stretcher. Per the documentation, resident had edema to left upper extremities, left knee swollen and bruised from the last fall, had MASD (Moisture-Associated Skin Damage) with redness to gluteal cleft back and front, and had Foley catheter in place for failed voiding trial. The baseline care plan was initiated on January 23, 2024. Significant diagnoses included fall with left knee contusion, rhabdomyolysis and dehydration. Discharge plan was to home with support. Initial goals were to use a walker and get well enough to return home. Per the documentation, care plan participants included the resident/resident representative, social services, DON (director of nursing), nutrition and activities staff. It also included that a copy of the initial care plan was provided to resident/representative on January 23, 2024 at 7:00 p.m. However, the resident/resident representative signature and date section was not signed and dated by either the resident or the resident representative. Further review of the baseline care plan revealed that completion date was July 27, 2024 (approximately 6 months from the date of admission) and was not completed by a specific staff but was documented as system completed. Review of the clinical record revealed that resident was transferred to the hospital on January 28, 2024 because of a low blood sugar. -Resident #171 was admitted on [DATE] with diagnoses of acute & chronic respiratory failure with hypoxia, pneumonia due to pseudomonas, dysphagia, attention to tracheostomy and attention to gastrostomy The nursing note dated April 15, 2025 included that the resident was admitted with a complex medical history including acute and chronic respiratory failure with both hypoxia and hypercapnia, pneumonia due to Pseudomonas, tracheostomy dependence, PEG tube for enteral feeding, dysphagia, ventilator dependence, paraplegia,hypothyroidism, conversion disorder with seizures, paroxysmal atrial fibrillation, generalized anxiety disorder, polyneuropathy, gastroesophageal reflux disease (GERD), delayed physiological development, and a history of COVID-19. The baseline care plan was initiated on April 15, 2025. Significant Diagnoses included acute and chronic respiratory failure, hypoxia, with history of Peg tube and Trach with use of ventilator, developmental delay, Schizophrenia, seizure (continued on next page)

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 03/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foothills Rehabilitation Center	2250 North Craycroft Road Tucson, AZ 85712

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	disorder and quadriplegia. Care Plan participants included resident/resident representative, social services and an RN (registered nurse). It also included that the facility spoke with the public fiduciary and consents were faxed to them. Discharge plan was to remain in the facility at this time and may re-evaluate discharge plan if condition changes or resident chooses to initiate discharge plan. Further, the documentation included that hopes to discharge the resident to a group home. Initial goals of the resident was for physical and occupational therapy and to transition to self independence. The documentation also included that the resident alert and oriented x 1, had a pressure call light and a copy of the initial care plan was provided to resident/representative on April 15, 2025. However, the resident/resident representative signature and date section was not signed and dated by either the resident or the resident representative. There was no evidence found that the copy of the baseline care plan was provided to the resident representative i.e., the public fiduciary. Further review of the baseline care plan revealed that completion date was October 31, 2025 (approximately 6 months from the date of admission) and was not completed by a specific staff but was documented as system completed. The nursing note dated April 15, 2025 included that the resident's public fiduciary was notified of the resident's admission and the staff will fax medication consents to them. The documentation did not include that the baseline care plan such as interim interventions/approaches in place to meet the resident's immediate needs. The social service note dated April 17, 2025 included that social services met had a 48-hour meeting with the resident's public fiduciary who planned for resident's return to the medical group home. The documentation did not include the baseline care plan with interventions/approaches in place to meet resident's needs were discussed with the public fiduciary. In an interview with a nurse manager (staff #19) conducted on March 28, 2026 at 8:46 a.m., the nurse manager stated that when residents are admitted , the receiving nurse starts with a baseline care plan observations and documents the assessment in the clinical record. She stated that the nurse leadership team then conducts a secondary review of the entries and ensure that they are completed and the information were accurate. She stated that there was always a risk if the baseline care plan was not completed timely or accurately; however, resident safety was a priority and the care plan helps to ensure that. An interview was conducted with a licensed practical nurse (LPN/staff #51) on March 28, 2026 at 10:08 a.m. The LPN stated that when there was a new admission, she receives the admission packet about information regarding the resident. She said that when the resident arrives at the facility, she will then conduct head-to-toe assessment and identify the needs of the resident. The LPN said that baseline care plan is initiated with the needs based on the assessment conducted on admissions; and, interventions to address these identified need are put in place. In another interview with the nurse manager (staff #19) conducted on March 28, 2026 at 10:27 a.m., the nurse manager stated that before admission, she reviews the admission packet related to resident's medications, diagnosis codes and would verify with the provider the resident's medications, contact pharmacy to ensure that medications were available for the resident when the resident gets admitted . She stated that a piece of paper containing this information with important notes is provided to the nurse in the unit where the resident will be admitted . She then opens the observations in their electronic record which included assessments for fall, Braden scales, baseline care planning, and any assessment that the nurse had to complete for the admission. She said that baseline care plan is then completed by the nurse within 14 days of the resident admission. She does not know why baseline care plan will be documented as system completed. During an interview with the Director of Nursing (DON/staff #7) conducted on March 28, 2026 at 1:16 p.m., the DON stated that baseline care plan is created in conjunction with the comprehensive care plan; and that, the baseline care plan needs to completed within 48 hours or resident's admission. She said that the social services staff would then meet with the resident within 48 hours of admission and will ask the resident if they wanted copy of the baseline care plan. She stated that the social service staff will then document in the electronic record whether or not the resident or representative received a copy or not. In a later interview with the DON conducted on March 28, 2026 at approximately 3:00 p.m., the (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	DON stated that she checked the clinical record of residents #168, #171 and #175 and found no documentation that the resident or representative was provided with a copy of baseline care plan. Review of the facility's policy on Care Plans included that an individualized comprehensive person centered care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. The resident is informed of his or her rights to participate in his or her treatment, and provided advance notice of care planning conferences. If the participation of the resident and his/her resident representative in developing the resident's care plan is determined to not be practicable, an explanation is documented in the resident's medical record. The explanation should include what steps were taken to include the resident or representative in the process.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews and review of policies and procedures, the facility failed to ensure that food was labeled and stored in accordance with professional food safety standards. The deficient practices could result in food-borne illnesses.Findings include:An initial kitchen observation was conducted on March 24, 2026 at 8:20 AM with the Dietary Manager (staff #108). There was an open 2-pound package of Hormel deli smoked ham inside a Ziploc bag with no open date on either the original packaging or the Ziploc bag; and, a box of mushrooms labeled with a production date of March 9, 2026 was found in the kitchen refrigerator. The mushrooms in the box were dark brown in color and were 'mushy'. The Dietary Manager stated that the mushrooms were browning and should be going in the trash. A observation of the kitchen freezer was also conducted with the dietary manager (staff #108) on March 24, 2026 at 8:30 AM. In the freezer was an open 64-ounce bag of Frozen Harvest mixed vegetables with no open or use-by date. There was also an open unlabeled and undated bag of cream colored, meat-like textured pieces, which were identified by the Dietary Manager as boneless skinless chicken pieces. The Dietary Manager stated that an open date and label should always be documented on the packaging once the original package has been opened; and that, if the date was not documented, staff would not know when the food item was opened and/or if the food item was still good to use.In an observation of the dry storage area conducted with the dietary manager (staff #108) on March 24, 2026 at 8:35 AM, there were 2 cans of Fancy Pinto Beans, 1 can of 100% canned pumpkin and 2 cans of harvest diced peached that were dented in different areas of the can including the on the seems and the body of the cans and were found in the canned storage section. These cans were not stored in the dented section but rather on the ready for use racks. The Dietary Manager immediately removed all 5 dented cans and stated that these should have not been stored with the for use canned items because of the potential risk could include food-[NAME] illness.During an interview conducted with the Dietary Manager on March 26, 2026 at 7:44 AM, the dietary manager stated that the expectation was that all food items are labeled and dated when stored. She stated that if items were not labeled and dated the risk would be that staff would not know when the items went out of 'code'. She also stated that the walk-in refrigerators was not conducive to fresh-produce because they are too cold and too moist; and, her expectation was that produce was used based on rotation-first in, first out. The dietary manager further stated that she checks produce rotation twice a week and that dietary staff were also expected to check, but sometimes they put it off until later and forget to do it. Further, she stated that there was no risk regarding the mushrooms as they were taken out and would be replaced. Regarding the dented cans, the dietary manager said that her expectation was for staff to recognize this upon delivery; and that, no dented cans should be going on the 'rack' but should instead be stored with the dented cans on the shelf. The facility policy on Proper Labeling/Dating Procedures included that everything in the freezer, thaw box, reach in refrigerators and dry storage needs an open date. Loose bags of vegetables, blueberries, pie shells, etc., must have today's date. Any loose items need to be in a container with an open date.Review of the facility policy on Food Storage included that food items should be stored, thawed and prepared in accordance with good sanitary practice. Dented or bulging cans should be placed on damaged goods shelf and returned for credit.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the clinical record review, observations, interviews, facility documentation, and policy, the facility failed to ensure infection control practices were followed regarding Enhanced Barrier Precautions (EBP) for 3 residents (#82, #42, and #10) The universe is 25. This deficient practice can result in contamination and spread of infection.Findings include:-Resident #82 was admitted to the facility on [DATE] with diagnoses of MRSA (Methicillin resistant Staphylococcus aureus) infection, rash and other nonspecific skin eruption, Zoster without complications and disorder of skin and subcutaneous tissue. The care plan dated March 2, 2026 included resident was at risk for dehydration related to MRSA bacteremia. The nursing note dated March 21, 2026 revealed admission diagnosis of MRSA infection. The wound note dated March 24, 3036 included that the resident had a wound to the breast related to acute generalized exanthematous pustulosis. The facesheet in the clinical record that resident was on EBP related to PICC (Peripherally Inserted Central Catheter), wounds and recent MDRO infections However, during an observation was conducted on March 24,2026 at 1:04 PM, there was no sign posted outside of the resident's room regarding resident being on EBP and any instructions regarding what PPE (personal protective equipment) to wear when providing care. In another observation conducted on March 25, 2026 at 11:45 AM, the outside of the resident's room continued to have no signs posted related to resident being on EBP -Resident #48 was admitted on [DATE] with diagnoses of open wound to the left and right lower leg and Methicillin resistant Staphylococcus aureus infection as the cause of diseases. The admission MDS (minimal data set) assessment dated [DATE] included a a BIMS (Brief Interview for Mental Status) score of 15 indicating that the resident was cognitively intact. Active diagnoses included open wound to the right lower leg, Methicillin resistant Staphylococcus aureus infection. The assessment coded the resident had an infection of the foot. The skilled observation note dated March 22, 2026 revealed an admission diagnoses of open wound to the right and left left lower leg and Methicillin resistant Staphylococcus aureus infection as the cause of diseases. Per the documentation, the resident was alert and oriented to person, place, time and situation; and that, the resident had no adverse reactions to IV (intravenous) antibiotic. Review of the clinical record revealed that Resident #48 was on EBP for open wounds. During an observation conducted on March 26, 2026 at 11:57 AM, there was no sign regarding resident being on EBP posted outside of the resident's room and any instructions regarding what PPE (personal protective equipment) to wear when providing care. -Resident #10 was admitted on [DATE] with diagnoses of type 2 diabetes mellitus with diabetic neuropathy, cystectomy and irradiation cystitis without hematuria. The 5-day MDS assessment dated [DATE] revealed the resident had a BIMS score of 15 indicating the resident was cognitively intact. Active diagnoses included BPH (benign prosthetic hyperplasia, neurogenic bladder and obstructive uropathy. The assessment also included that Resident #10 was coded for ostomy. Review of the clinical record revealed the resident was on EBP for urostomy. However, during an observation conducted on March 25, 2026 at 4:17 PM, there was no sign regarding resident being on EBP posted outside of the resident's room and any instructions regarding what PPE (personal protective equipment) to wear when providing care. An interview was conducted on March 25, 2026 at 4:27 PM with Wound Nurse (Staff #36) who stated EBP signs are used for residents with open wounds, catheters and MDRO. Staff #36 stated EBP signs are used to let staff when enhanced barrier precautions are needed. She stated that without signage in front of the applicable rooms, there is a risk for exposing residents to infections, or introducing other bacteria. Staff # 36 stated signage is essential to communicate with staff, when EBP is required, especially staff who do not have access to clinical records. Staff #36 reviewed resident #82 and confirmed that the resident is on EBP but does not have a sign in front of the door. An interview was conducted on March 25, 2026 at 4:22 PM with Respiratory Therapist (RT/staff #113) who stated that EBP signs were used when residents have diagnosis such as MRSA; and that, EBP signs let staff (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	know to wear a gown, mask and wash hands before entering and after leaving the room for direct care. Further, the RT stated that not having EBP signs posted on the resident's room posed a risk for the spread of infection, and passing infections to other residents. In an interview with the registered nurse (RN/staff #90) conducted on March 25, 2026 at 4:37 PM, the RN stated that EBP signs were used for residents who have an IV, foley and wounds; and that, if there were no signs posted when a resident was on EBP was not a good practice it could be dangerous for both staff and resident and could result in the spread of the infection. An interview was conducted with Licensed Practical Nurse (LPN/staff #129) on March 26, 2026 at 10:28 AM. The LPN stated that EBP were used for resident on IV treatment and had open wounds; and that, when a resident was on EBP there would be a sign posted on their door. The LPN also said that EBP signs were posted to make visitors, such as family members, aware of what to do when entering the room of a resident on EBP; and, if the EBP was not followed, there is a risk for spread of bacteria or infection. During an interview with the with the Director of Nursing (DON/Staff #7) conducted on March 27, 2026 at 11:54 AM, the DON stated that the resident's status related to EBP and/or TBP (transmission-based precautions) was communicated with a banner on the facesheet of clinical records; and, there would be signs about this posted on the resident's room door. She stated that it does not meet her expectation if there were no signs outside the resident's door and the resident was on EBP. The DON further stated that an EBP sign explains to staff/visitor when to wear PPE (Personal Protective Equipment) which was a barrier of infection between patients and employees; and, when PPE was not worn when needed it imposes a risk of infections. The facility's policy titled Isolation- categories of transmission-based precautions revised April 2012 revealed examples of infections requiring Contact Precautions include, but are not limited to: Infections with multi-drug resistant organisms, Heavily draining wounds with non-contained drainage. Signs used to alert staff of contact precautions. The policy further noted that the facility will implement a system to alert staff to the type of precautions the resident requires. It was documented that this facility utilizes the following system for identification of Contact Precautions for staff and visitors: Sign posted on resident room/door See Nurse Before Entering Room. The facility will also ensure that the resident's care plan and care specialist communication system indicates the type of precautions implemented for the resident.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, interviews, and review of the facility's policies and procedures, the facility failed to ensure one resident's (#120) advance directive was accurately documented and implemented in accordance with the resident's expressed preference. The universe was 25. The deficient practice could result in the resident's wishes and preferences related to life-sustaining treatment not followed and honored. Findings include:Resident #120 was admitted to the facility on [DATE], discharged on [DATE], and returned to the facility on [DATE]. His diagnoses included Chronic Obstructive Pulmonary Disease (COPD), Morbidity, and Acute Kidney failure, unspecified.Review of the Change in Condition (CIC) Minimum Data Set (MDS), dated [DATE], revealed Resident #120 completed a Brief Interview for Mental Status (BIMS) and scored a 13 which indicated he was cognitively intact.Review of Resident #120's Care Plan revealed it was last reviewed/revised on [DATE]. The Care Plan identified Resident #120's code status as Full Code and noted that the code status would be re-addressed on a quarterly basis or as needed. It also noted that in the event of a cardiac or respiratory arrest, staff are to perform resuscitation measures per facility guidelines.Review of the Physician's orders revealed an order, dated [DATE] indicating Resident #120's Code Status was DNR.Review of Resident #120's Progress Notes, in the clinical chart, revealed an entry, dated [DATE] at 7:51 A.M. The entry noted that Resident #120 was full code. The Progress Note entry was e-signed by the Nurse Practitioner (NP/Staff #201).Further review of the Progress Notes revealed a second entry, dated [DATE] at 8:45 A.M., which noted Resident #120's Code Status as full code. The Progress Note entry was e-signed by NP/Staff #205.Review of Resident #120's clinical record revealed a red DNR warning next to his picture on his profile.A review of the Residents' Code Book at the Nurses' station was conducted on [DATE] at 10:48 A.M. There was no Advance Directive or DNR sheet for Resident #120 in the Code Book.An interview was conducted with Resident #120 on [DATE] at 10:53 A.M. Resident #120 shared that he wanted life saving measures to be taken to save him if necessary and that he did not want to be a DNR.An interview was conducted on [DATE] at 11:02 A.M. with Certified Nursing Assistant (CNA/Staff #69). Staff #69 explained that the Nurses' station has a DNR/DNI (Do Not Intubate) book for each of the units. She further shared that she has not needed to use the book during her shift to determine a resident's code status. However, Staff #69 did share that she did not memorize her residents' code status so she would immediately ask her unit Nurse to find out a resident's code status. Staff #69 further shared that she is certified in Cardiopulmonary Resuscitation (CPR) and she was able to perform this on residents, if necessary.An interview was conducted with CNA/Staff #165 on [DATE] at 11:10 A.M. Staff #165 shared that she would provide CPR to all residents regardless of their code status. She further shared that she did not know how to find out a resident's code status but it was important, to her, to give everyone CPR so they all can have a chance to live.An interview was conducted on [DATE] at 11:17 A.M. with Licensed Practical Nurse (LPN/Staff #120). Staff #120 explained that if a resident was in distress and needed CPR to be performed, the CNAs are certified to perform this. Staff #120 shared that Residents' code status are in their Electronic Health Record (EHR) as well as the Daily Report Sheet which identifies the resident's code status, how they take their medications, the Doctor's name, and any special instructions. She provided an undated Daily Report Sheet and it was observed that Resident #120's code status was listed as DNR. Staff #120 also shared that she mostly works in her current unit and has most of her resident's code status memorized but if there was an emergency situation, she would still look at the Daily Report Sheet and also check the EHR in case something changed. She further shared that there is also a folder containing Residents' code status. However, she added that the information regarding the code status, that is in the folder, is copied and given to emergency personnel when residents are (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transported to the hospital. Staff #120 explained that Resident #120 was on Hospice until several weeks ago and she was aware that he was thinking of changing his code status to full code but she believed he was still a DNR. She added that she did not know if his code status had changed. Staff #120 reviewed the code status book and shared that she did not see a code status form for Resident #120. She stated that the form should be in the book especially if Resident #120 was a DNR, however if they were full code then they did not need a code status form. An interview was conducted on [DATE] at 12:10 P.M. with the Director of Nursing (DON/Staff #7). Staff #7 confirmed that CNAs are able to provide CPR to residents if necessary. She further shared that all CNAs at the facility are certified in CPR. Staff #7 shared that when a person is admitted to the facility, they are asked what their preferences are related to their Code Status. She further shared that residents are able to change their code status at any time as it is their choice. If a resident were to tell a CNA that they wanted to change their code status, then the CNA needs to tell a Nurse. Staff #7 added that the code status for that resident should be made right away because if they change their mind and something were to happen to the resident, the correct code status needs to be in place. When asked what the code status for Resident #120 was, Staff #7 indicated that he was a DNR. When asked if that information was listed on the care plan for the resident, she reviewed the EHR and shared that the code status was listed as Full Code. She further shared that the information was not accurate. Staff #7 was also asked to review the most recent Progress Note written by the NP. After reviewing the Progress Note, Staff #7 shared that it was noted the resident was Full Code. Staff #7 explained that this was an error because the documentation did not match each other. She further explained that Resident #120 is alert and oriented and is able to make his own decisions. She also shared that this was a risk to the resident because there was a potential for staff to not provide CPR because he is not listed as Full Code which is against his wishes.Review of the facility's policy and procedure, titled Advance Directives, explained that the code status for Residents will be displayed prominently in the medical record/EHR. It also indicated that the care plan for each resident will reflect their treatment preferences including their advance directive. The policy and procedure further indicated that the Interdisciplinary Team will routinely review the residents' advance directives with the resident and/or their representative to ensure their wishes have not changed.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident interviews, staff interviews, and a review of policies and procedures, the facility failed to ensure a safe homelike environment for residents. This deficient practice had the potential for resident injury and psychosocial harm. Findings include:Resident #39 was admitted on [DATE] with diagnosis including anemia, hypertension, diabetes mellitis, and depressionThe 5-day MDS (minimum data set) with an assessment reference date of December 29, 2025 revealed that the resident had a BIMS score of 15, indicating that the resident was cognitively intact.A review of the facilities work-orders from January 2026 through March 26, 2026 revealed a total of 16 work orders for the entire time span. There was no evidence of a work-order for either the baseboards or the hole in the wall for the 200-hall.An observation was conducted on March 24, 2026 at 9:27 AM past the entrance doors of the 200-hall secured unit. To both sides of the hall, missing sections of baseboards were observed. On the right- hand side past the entrance door, approximately 2.5 feet of roughly 4-inch baseboard was missing entirely and on the left-hand side, approximately 1.5 feet of baseboard was missing. On the left side where the baseboard resumed, the existing baseboard was partially bent forward extending into the hall approximately an inch.An observation was conducted on March 26, 2026 at 9:55 AM, in the dinning/ communal area of the 200- hall. On the back side of the room to the left side of the nurse's station, a visible hole measuring approximately 3 inches (height) by 2.5 inches (width) was observed. The portion of the hole that was not visible was partially covered by a plain beige blank outlet plate cover which was observed to be broken in half. No visible wiring was observed. The bottom end of the broken plate cover revealed jagged edges.An interview was conducted on March 26, 2026 at 9:25 AM with resident #39 who stated that chipping baseboard in her room by the bed had not been an issue, as it was minor, but she didn't like how the baseboards in the hall looked and that it did not make feel ?homey'.An interview was conducted on March 26, 2026 at 9:41 AM with staff #51, LPN (licensed practical nurse). Staff #51 stated that resident in the facility should feel like they are at home. They should have things like their favorite blanket, things they are familiar with, their own belongings and should have the ability to arrange things, within in reason, in their own rooms. Staff #51 stated that the appearance, walls, floors, and ceilings also factored into ?home-like' environment. Staff #51 further stated that cracks in the walls and floors could constitute safety issues and would need to be fixed immediately. She stated that peeling baseboards might have chemical adhesives that could be ?toxic' and should be fixed immediately. She stated that generally if maintenance is notified they respond right away. She stated that she normally works a different hall and is not aware of any maintenance issues that have not been addressed, but stated that if there were issues the risk to the resident, of not addressing the issue, could include depression and not feeling like they belong.An interview was conducted on March 26, 2026 at 9:52 AM with staff #17, CNA (certified nursing assistant). Staff #17 stated that to her, a homelike environment meant that things should be like home and conforming to resident's likes. Staff #17 stated that peeling or entirely missing baseboards in the 200-hall did not look good and would make residents feel as if the building was not being taken care of.An interview was conducted on March 26, 2026 at 9:59 AM with staff #50, LPN. Staff #50 stated that a home-like environment includes a resident's room furnishing and their ability to come out of their room into communal areas. She stated that she did not like the appearance of missing or peeling baseboards. Staff #50 stated that staff have the ability to report issues to the maintenance depart but was not aware of any issues that were currently being worked on in the 200-hall. Staff #50 was directed to the hole in the wall by the nurse's station and stated that she was not aware that it was there. She stated that she observed the outlet plate to be broken and jagged on the bottom edge, with the hole measuring approximately 2 x 4 inches. She stated that the risk to residents could include residents attempting to put their hand in the hole and potentially cutting (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Foothills Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2250 North Craycroft Road Tucson, AZ 85712	

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	themselves on the jagged edges of the plate cover.An interview was conducted on March 26, 2026 at 10:24 AM with staff #48, Maintenance Director. Staff #48 stated that the facility generally receives 20 plus work orders daily and the department would prioritize anything with potential resident safety concerns and that there are completed right away. Staff #48 stated that they are in the process of renovating some of the rooms and that some had already been entirely renovated. Staff #48 further stated that he had started renovations approximately 6 months ago on the 200-hall, but that they still had a lot left. He stated that outstanding work orders for the 200 hall included repairs to the main door and hallway painting. He stated that in the 200-hall dining area, just some painting and improvements were needed. When asked about the baseboards, he stated that he was aware and that they would be fixed. When asked about the hole in the wall, staff #48 stated that he was aware that there was a partial plate cover over a hole by the nurse's station on the 200-hall which needed to be replaced. Staff #48 stated that that this issue would qualify as a high priority issue because of the broken plate and because it was a 'lock-down' unit. Staff #48 stated that the issue was reported verbally to him on March 15, 2026. He stated that it should have been fixed by now and that the risk included someone getting cut. When asked he further stated that the 200-hall, currently, does not constitute a home-like environment and stated that additional risks to residents could include resident's feeling bad about their current living situation.An interview was conducted on March 26, 2026 at 11:58 AM with staff #116, Administrator. Staff #116 stated that a homelike environment includes a resident feeling comfortable in their room/ facility and can include having their belongings, hygiene supplies being afforded privacy and even having one plant if they are not on the respiratory unit. If a resident voices concern regarding home-like environment then they are placed on high-priority to ensure that they do feel comfortable in their setting. Staff #116 stated that holes in walls are fixed the minute maintenance finds out about them, but stated that maintenance does need to be made aware of them by staff or residents. Staff #116 stated that one of the challenges that had been encountered was staff not providing written work orders to the maintenance department. The administrator further stated that a hole in the wall with a partial plate cover and jagged edges could potentially cause a skin tear for a resident and that no one likes to see holes in the wall.A review of the facility policy titled Quality of Life-Homelike Environment with a revised date of February 2014 revealed that it's focus was to provide the residents with a safe, clean, comfortable homelike environment.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, facility policy review and the Resident Assessment Instrument, the facility failed to ensure the assessment for one sampled Resident #45. The universe was 25. The deficient practice could result in residents not meeting their needs according to the comprehensive assessment. Findings include:Resident #45 was admitted to the facility on [DATE] with diagnoses that included presence of cardiac pacemaker, morbid (severe) obesity, type 2 diabetes mellitus with other skin complications, type 2 diabetes mellitus with diabetic polyneuropathy and chronic respiratory failure with hypoxia.The face sheet in the electronic medical records revealed Resident #45 was identified as a white female.Review of the admission Minimum Data Set (MDS) assessment dated [DATE] included Resident #45 had a BIMS (Brief Interview for Mental Status) score of 14 which indicated resident was cognitively intact. Section A101 included Resident #45 was white.However, the Prehospital Medical Care Directive dated March 13, 2025 and signed by Resident #45 revealed that the resident's race was documented as black.Despite inconsistencies with documentation related to the resident's race, the continuity of care document with a creation date of March 26, 2026 continued to reveal the resident's race was white.During an interview with resident #45 conducted on March 25, 2026 at 2:12 p.m., Resident #45 identified herself as a black/African American female.An interview was conducted on March 26, 2026 at 10:42 a.m. with the MDS coordinator (staff #107) who stated that upon resident's admission, the interdisciplinary team (IDT) assess the residents related to all aspects of resident care. She said the MDS staff then reviews the diagnoses codes, medications, and functional ability; and, there was a 7 day look back to conduct a review and to look for any discrepancies. The MDS coordinator stated that the MDS assessment was specific for each facility; and, she pulls the information from the documentation that was added by the admissions nurse including the resident's demographics. She said that MDS assessment accuracy was important; and, Resident #45 was black. A review of the clinical record was conducted with the MDS coordinator who stated that the resident's demographics/race in the MDS assessment should have been coded as black/African American.In an interview with the Director of Nursing (DON) conducted on March 26, 2026 2026 at 3:38 p.m., the DON stated that MDS information needs to be accurate because it is used to ensure the facility accurately provides care for the residents. A review of the clinical record was conducted with the DON who stated that the clinical record identified Resident #45 as a white female. She stated that this inaccurate because Resident #45 was black/African American.The facility policy titled Resident Assessments with a revision date of March 2025 included that all persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information.The RAI manual included that the RAI process, which includes the Federally mandated MDS, is the basis for an accurate assessment of nursing home residents. The goal of the Overview to the Item-by-Item Guide to the MDS is to facilitate the accurate coding of the MDS resident assessment and to provide assessors with the rationale and resources to optimize resident care and outcomes. Standardizing self-reported data collection for race allows for the equal comparison of data across multiple healthcare settings and is an important step in improving quality of care and health outcomes.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, the facility documentation and policy review, the facility failed to ensure the care plan was revised to reflect the assessed need for a two-person assist with bathing for one resident's (#167). The universe was 25. The deficient practice led to staff providing care with only one person assist which resulted in the resident sustaining an injury and being hospitalized .Resident #167 was admitted to the facility on [DATE] with diagnoses that included persistent vegetative state, chronic respiratory failure with hypoxia, traumatic subarachnoid hemorrhage without loss of consciousness, and Crohn's disease.Review of the admission Minimum Data Set (MDS), dated [DATE], did not assess Resident #167's cognitive status. The same MDS also noted that Resident #167's functional status for bathing was total dependence and required 1-person physical assist.The care plan indicated dated December 6, 2022 revealed the resident required total assist for all Activities of Daily Living (ADLs) which included bathing. The Quarterly MDS assessment dated [DATE], indicated that a staff assessment for mental status was completed. It was noted that Resident #167's cognitive skills for daily decision making was severely impaired. The MDS also revealed that Resident #167's functional status for bathing was total dependence and required 2-person physical assist.A Monthly Summary form, dated August 29, 2023, indicated the resident was totally dependent for bathing and required one-person physical assist. The quarterly MDS assessment dated [DATE], indicated that staff assessed Resident #167's cognitive skills for daily decision making as severely impaired. It was also noted that his functional status for bathing was total dependence and required 2-persons physical assist.The Monthly Summary forms, dated October 5 and November 23, 2023, indicated Resident #167 was total dependence for bathing and required two+ persons physical assist.The progress note dated November 29, 2023, at 11:26 A.M. created by Registered Nurse (RN/Staff #138) noted that Resident #167 was restless and had pushed the rail on the gurney while a Certified Nurse Assistant (CNA) had turned to throw away a razor. It also noted that the resident had fallen from the gurney and sustained an abrasion to the left side of his head and a hematoma on the right side of his head. It further noted that bleeding was noted in his mouth but staff was unable to determine the cause of the bleeding. The documentation also included that Resident #167 was sent to the emergency room per the physician's order for evaluation.The progress note dated November 30, 2023 at 1:10 P.M revealed the Interdisciplinary Team (IDT) reviewed the incident and indicated that the resident was a high risk for falls due to his medical conditions.The ADLs care plan was revised on December 20, 2023 by the Director of Nursing (DON/Staff #7) to include requiring 2-person assist with showers. It was noted that the start date for the updated intervention was December 11, 2023. There was no evidence that the care plan was revised to include 2-person assist for bathing was identified prior to December 20, 2023.Review of the facility's 5-day investigation report, for the alleged incident, revealed there was one CNA present with Resident #167 when he fell during a shower on November 29, 2023. It also noted that the CNA was following the resident's care plan. An interview was conducted on March 28, 2026 at 8:23 A.M. with the MDS/Care Plan Coordinator/Licensed Practical Nurse (Staff #59). Staff #59 explained that the MDS is created upon admission and is updated if there is a change in condition or if a quarterly review is due. She further explained that once the MDS assessment is completed, the comprehensive care plan is triggered with information obtained from the MDS assessments. She added that she and another MDS staff person also create and update the care plans after completion of the MDS. Staff #59 reviewed Resident #167's June 2, 2023 MDS assessment and shared that he was total dependence for bathing and required 2-person assist. Staff #59 reviewed Resident #167's September 2, 2023 MDS assessment and shared that he was total dependence for bathing and required 2-person assist as well. Staff #59 also reviewed Resident #167's comprehensive care plan and shared that it was noted (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	he was a total assist for all ADLs however, it did not specifically say that he was a 2-person assist for bathing. She further shared that she did not know why the care plan did not reflect that the resident was a 2-person assist for bathing.An interview was conducted on March 28, 2026 at 8:41 A.M. with the Director of Nursing (DON/Staff #7). Staff #7 shared that once a resident's needs are assessed, the MDS is reviewed and then the care plan is developed from the information obtained in the MDS. She further shared that the MDS nurse will do the assessments and the care plan development and/or updates. Staff #7 reviewed the June 2, 2023 MDS for Resident #167 and shared that he was total dependence and a 2-person assist for bathing. She also reviewed the September 2, 2023 MDS for Resident #167 and shared that he was total dependence and required 2-person assist for bathing at that time as well. When reviewing the care plan for Resident #167, she shared that it identified that Resident #167 was a 2-person assist with showers starting December 11, 2023. She further shared that there was no information, regarding bathing with 2-person assist, in the care plan prior to December 11, 2023. Staff #7 explained that the care plan should have reflected that the resident was a 2-person assist prior to that date and confirmed that the care plan did not match the information in Resident #167's MDS. Staff #7 explained that if a resident's required supports was not identified on the care plan, there would be a risk of injury to the resident.Review of the facility's policy and procedure titled ?Care Plans - Comprehensive' (last reviewed October 2025) indicated the comprehensive care plan is to be developed to address each resident's medical, nursing, mental, and psychosocial needs. The policy further specified the care plan is to be based on a thorough assessment, including the MDS, and must be developed within seven days of completion of the MDS to reflect the resident's current assessed needs.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, review of the facility's policy and procedures, the facility failed to ensure one resident (#167) was free from unavoidable accidents. The universe was 25. The deficient practice resulted in a resident sustaining a major injury.-Resident #167 was admitted to the facility on [DATE] with diagnoses that included persistent vegetative state, chronic respiratory failure with hypoxia, traumatic subarachnoid hemorrhage without loss of consciousness, and Crohn's disease.Review of the admission Minimum Data Set (MDS), dated [DATE], did not assess Resident #167's cognitive status. The same MDS also noted that Resident #167's functional status for bathing was total dependence and required 1-person physical assist.The care plan indicated dated December 6, 2022 revealed the resident required total assist for all Activities of Daily Living (ADLs) which included bathing; and, was at risk for falling related to weakness. The goal was that the resident will remain free from injury. Interventions included frequent checks by staff while in bed and to observe frequently and place in supervised area when out of bed.The Quarterly MDS assessment dated [DATE], indicated that a staff assessment for mental status was completed. It was noted that Resident #167's cognitive skills for daily decision making was severely impaired. The MDS also revealed that Resident #167's functional status for bathing was total dependence and required 2-person physical assist. The assessment also included that the resident had 1 fall with injury since admission or prior assessment.The care plan dated July 20, 2023 included that the resident had behavioral symptom of placing self on the floor. Intervention included to assess whether the behavior endangers the resident and/or others; maintain a calm environment and approach to the resident; redirect as necessary and notify provider if behaviors interfere with orsignificantly impact residents care; and, provide consistent staff as much as possible.A Monthly Summary form, dated August 29, 2023, indicated the resident was totally dependent for bathing and required one-person physical assist. The quarterly MDS assessment dated [DATE], indicated that staff assessed Resident #167's cognitive skills for daily decision making as severely impaired. It was also noted that his functional status for bathing was total dependence and required 2-persons physical assist. The assessment also included that the resident had 2 falls with no injury and 2 falls with injury since admission or prior assessment.The Monthly Summary form, dated October 5, 2023, indicated Resident #167 was total dependence for bathing and required two+ persons physical assist.The nursing progress note dated November 19, 2023 revealed resident was alert and oriented x2 and required maximum assistance with ADLsThe Monthly Summary form dated November 23, 2023, indicated Resident #167 was total dependence for bathing and required two+ persons physical assist.The nursing note dated November 23, 2023 included that the resident was alert, non-verbal, responded to simple commands and at times can track staff with eyes, was totally dependent for all ADLs was often very restless in bed and can be found sideways in bed. According to the documentation, resident had bilateral floor mats for safety.The progress note dated November 29, 2023, at 11:26 A.M. created by Registered Nurse (RN/Staff #138) noted that Resident #167 was restless and had pushed the rail on the gurney while a Certified Nurse Assistant (CNA) had turned to throw away a razor. It also noted that the resident had fallen from the gurney and sustained an abrasion to the left side of his head and a hematoma on the right side of his head. It further noted that bleeding was noted in his mouth but staff was unable to determine the cause of the bleeding. The documentation also included that Resident #167 was sent to the emergency room per the physician's order for evaluation.The physician note dated November 29, 2023 included that the resident had a fall and head injury; and, to transfer the resident to acute care hospital.The progress note dated November 30, 2023 at 1:10 P.M revealed the Interdisciplinary Team (IDT) reviewed the incident and indicated that it was crucial to note that the resident was at a high risk for falls due to his history of falling, subdural hemorrhage, schizoaffective disorder, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	encephalopathy, persistent vegetative state (PVS), Crohn's disease, slowness and poor responsiveness, as well as muscle wasting. Interventions in place included, but were not limited to, sending the resident to the emergency room for a CT scan. The documentation also included that it was imperative to re-evaluate the resident upon his return from the hospital. The social service note dated December 1, 2023 included that social service spoke with a case manager and discussed the resident's fall and that the resident went to the hospital and had surgery for brain bleed. The fall care plan was revised on December 8, 2023 to include that the resident had an actual fall in the shower on November 29, 2023.The ADLs care plan was revised on December 20, 2023 by the Director of Nursing (DON/Staff #7) to include requiring 2-person assist with showers. It was noted that the start date for the updated intervention was December 11, 2023. There was no evidence that the care plan was revised to include 2-person assist for bathing was identified prior to December 20, 2023.Review of the facility's 5-day investigation report, for the alleged incident, revealed there was one CNA present with Resident #167 when he fell during a shower on November 29, 2023. It also noted that the CNA was following the resident's care plan. Review of the facility's incident reports for Resident #167 revealed an undated [NAME] fall form that indicated he fell from the gurney and was sent to the hospital for evaluation and treatment.A telephonic interview was conducted with CNA (staff #1) on March 28, 2026 at 7:37 A.M. The CNA stated that she know if the resident was a 2-person assist if there was a green sticker next to their name on the name card outside of their room. Staff #1 said she remembered Resident #167 and she was with Resident #167 in the shower room and showers was just completed when Resident #167 jerked and crossed his legs which then went over the railing on the gurney that resulted in resident falling. The CNA stated that she then opened the shower room door and yelled for help from the nurses; and that, Resident #167 went to the hospital after the fall. The CNA further stated that she was by herself with Resident #167 in the shower room because at the time of the fall, Resident #167 was a 1-person assist. She said that after the fall, the resident then became a 2-person assist.In an interview with another CNA (staff #13) conducted on March 28, 2026 at 8:22 a.m., she stated that if the resident was a fall risk, the resident are place on fall preventive measures such as low bed and mats on the floor. She stated that every time she checks on the resident, she would check that these interventions are implemented. The CNA said that if the resident continues to fall despite the interventions, she will check the residents more frequently.An interview was conducted on March 28, 2026 at 8:41 A.M. with DON/Staff #7 who said that if the resident's care plan indicated that the resident was a 2-person assist and only 1-person assist was done and resulted in resident falling, then it would be neglect. She also said that not updating the care plan to reflect that the resident was a 2-person assist was also neglect because the MDS did not link to the care plan so it was not adequately implemented. She further stated that this could lead to residents sustaining an injury because something happened to them due to not getting the proper care. During the interview a review of the clinical record was conducted by the DON who stated that the MDS assessment dated [DATE] coded that Resident #167 was totally dependent and required 2-person assist for bathing; however, the DON stated that Resident #167 was identified to require a 2-person assist with showers only starting December 11, 2023. She further stated that there was no information, regarding bathing with 2-person assist, in the care plan prior to December 11, 2023. The DON further stated that the care plan should have reflected that the resident was a 2-person assist prior to December 11, 2023; and, she said that the resident's the care plan did not match the information in Resident #167's MDS.An interview was conducted on March 28, 2026 at 9:16 A.M. with the Administrator (Staff #116) who said that the resident's June 2 and September 2, 2023 MDS assessments showed that Resident #167 was totally dependent for bathing and required 2-person support which mean that 2 people were to help Resident #167 when providing showers/bathing. The administrator said that based on her interview with which she conducted in November 2023, a CNA took Resident #167 to the shower on a gurney; and, the CNA reported that jerked or seized and fell off the gurney. The administrator said that the fall took place in the shower; and that, there was only one (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA providing bathing assistance to Resident #167 at the time of the incident; but, the administrator said that based on the MDS assessment, Resident #167 was supposed to have two people helping him. Further, the administrator said that this did not meet her expectations and the risk of not providing adequate supports, identified in the MDS assessments, can cause harm to the residents.An interview with CNA (Staff #156) was conducted on March 28, 2026 at 11:04 A.M. Staff #156 revealed that neglect occurs when staff fail to meet residents' needs. Staff #156 shared she receives abuse and neglect training during monthly in-services and annual in-depth sessions. When asked whether providing a 1-person assist to a resident assessed as requiring a 2-person assist for bathing, resulting in a fall, would constitute neglect, she confirmed that it would, as the resident did not receive the required level of assistance. An interview was conducted on March 28, 2026 at 11:13 A.M. with Licensed Practical Nurse (LPN/Staff #120) who stated that neglect occurs when pain medications were given without a proper pain assessment or when cares were not being provided to the resident. She said providing a 1-person assist to a resident assessed to require a 2-person assist for bathing and resulting in a fall, would constitute neglect. She said that the resident is a 2-person assist because the resident moves a lot; and, if a resident was a 2-person assist, then there must be 2 people helping the resident. The LPN further stated that neglecting the residents could result in injury, skin damage, residents could be emotionally affected and they could lose their trust in staff to keep them safe.A review of the facility's policy and procedure titled Accidents and Incidents - Investigating and Reporting indicated it was last revised in November 2023. The policy and procedure indicated that all accidents or incidents that take place on the premises will be investigated and reported to the Director of Nursing and Administrator.The facility policy on Fall Risk Assessment included that the nursing staff, in conjunction with the Attending Provider, Consultant Pharmacist, therapy staff, and others, will seek to identify and document resident risk factors for falls.

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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 observation, interviews, review of clinical record, and facility policy and procedure review, the facility failed to ensure medications were not left at bedside for one of 26 sampled residents (#102). The universe was 124. The deficient practice could result in resident taking the medication outside of the physician ordered parameters resulting in complications such as overdose, negative medication interactions and other residents having unrestricted access to medications.Findings include: Resident #102 was admitted on [DATE] with diagnoses disorganized schizophrenia, age-related osteoporosis, dependence on supplemental oxygen, peripheral vascular disease, obstructive sleep apnea, chronic bronchitis, hereditary and idiopathic neuropathy, and depression. The quarterly MDS (minimum data set) dated March 4, 2026 revealed a BIMS (brief interview of mental status) score of 14, indicating that the resident was cognitively intact. The review of the MDS further revealed no potential indicators of psychosis or behaviors.A review of the physician orders revealed an order for antifungal powder to be applied to the groin area on both sides and to the breast folds. The documented order start date was December 1, 2025 and an initial end date was documented as 'open-ended' and later changed to March 24, 2026.Review of the clinical record revealed no evidence that the resident was assessed and was determined to be safe to self-administer medications.An observation was conducted on March 24, 2026 at 10:30 AM in the room of resident #102. There were two 3-ounce bottles of Thera antifungal powder with an active ingredient of miconazole nitrate 2% on the resident's night table; and that, one bottle was empty and the other bottle was half-empty.An interview was conducted on March 24, 2026 at 10:59 AM with a registered nurse (RN/Staff #143) who stated that a medication was given to the resident and can be administered by mouth, via injection, cream, patches, lotions and powders. The RN stated that residents were not allowed to have medications at the bedside unless there was a current order in place and the resident was care-planned for it. Staff #143 stated the risk for having a medication at bedside could include overdose and another resident coming in and taking the medication.An interview was conducted on March 24, 2026 at 11:04 AM with certified nursing assistant (CNA/Staff #17) who stated that a medication was something prescribed by a doctor but could also include over the counter medications. She stated that tablets can be medications as well as injectables and powders; and that, residents were not allowed to have medications at bedside. Staff #17 stated that she checks for medication in the resident's room each time she provides treatment and if she found medications in the room she would inform the nurse. During the interview, an observation was conducted with the CNA who entered the room of resident #102, saw the 2 bottles of antifungal powder, and then brought the bottles to the RN (staff #20) who then stated that these were medications and that the resident should not have with them at bedside. Staff #20 reviewed the resident's EHR (electronic health record) and stated that there was an order for the antifungal powder but no order for self-administration of the medication. She further stated that there was also no evidence of an assessment for self-administration in the record or that it was care-planned, which she stated it should have been.An interview was conducted on March 26, 2026 at 7:30 AM with the director of nursing (DON/staff #7) who stated that a medication can come in different forms such as tablet, cream, powder or drops; and, it could be administered orally, topically or via injection. She stated that it was important to assess if the resident can self-administer medications appropriately; and, part of the assessment includes a teaching component to ensure resident safety. The DON further stated that an order was required for medication self-administration, a progress note documenting that the resident was able to self-administer medications in the correct manner and, a care plan entry. Regarding resident #102, the DON said that resident #102 reside in the long-term care hall of the facility which also had residents with behaviors. She said that miconazole (continued on next page)

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 03/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foothills Rehabilitation Center	2250 North Craycroft Road 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nitrate was a medication. A review of the clinical record was conducted with the DON who stated that an order for the miconazole medication was in place but there was no order for resident to self-administer it. She also said that the clinical record did not have any self-administration assessment conducted for Resident #102; and that, the resident was not care planned for medication self-administration. The DON stated that not having an assessment or an order for self-administration could pose risk to include misuse or overdose.A review of the facility policy titled Self-Administration of Medications with a revision date of December 2012 revealed that as part of the evaluation of a resident being able to self-administer medications, staff and the practitioner would assess each resident's mental and physical abilities to determine if a resident is capable of self-administering medications. The policy further documented that post assessment, the findings would be documented and that medications must be stored in a safe and secure place, which is not accessible by other residents.