STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035068	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pueblo Springs Rehabilitation Center	5545 East Lee Street Tucson, AZ 85712

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, facility documentation, resident and staff interviews, and policy review, the facility failed to ensure that one resident (#284) was free from physical abuse from other residents (resident #15). The deficient practice could result in further incidents of resident to resident abuse. Findings include: -Resident #284 was admitted to the facility on [DATE], with diagnosis that include quadriplegia, urinary tract infections, diabetes mellitus type 2, weakness, hypertension, pressure ulcers, spinal stenosis, anxiety, insomnia, and myocardial infarction. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 99 which indicated the resident had severe cognitive impairment. A behavioral care-plan initiated December 26, 2024 revealed the resident is at risk for impaired cognitive function / dementia with noted intervention to use simple directive sentences, and provide cues as necessary, and to stop and return if agitated. This further indicates resident vulnerability due to impaired cognition. Review of information received from the SA complaint tracking system revealed that January 24, 2024, at 1:09 p.m. a facility reported incident was received that revealed on January 24, 2024 at 12:30 p.m. The administrator was informed that there was an incident that occurred between resident #284 and another resident in the main hall near the guest bathrooms. Resident #284 stated the other resident pushed him in the shoulder, and that staff had immediately separated the residents. A review of progress notes for resident #284 dated January 24, 2024 at 12:30 p.m. stated resident #284 was sitting in the hallway in a wheelchair with feet positioned flat on the floor. Resident sitting in wheelchair with feet positioned flat on the floor. Another resident was ambulating with therapy staff and accused resident #284 of trying to trip him as his feet were pointed outwards. Residents exchanged words and the other resident pushed him in the shoulder. Residents were immediately separated. The note concludes that the resident was assessed and no injury was noted, as well as notifications being made to family, the provider, and the ombudsman. (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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with a Licensed Nursing Assistant (LNA/staff #20) on June 5, 2025 at 7:35 a.m. The LNA stated that abuse is verbal, physical, mental, refusing to assist residents, and not answering lights. The LNA also stated that when abuse occurs in a resident to resident situation the first thing is to intervene, make sure they are safe, report it forward, and make sure they stay safe until someone assists. The LNA stated that the expectation is that abuse is not allowed to occur, and that the risk of abuse is trauma to the residents. The LNA concluded that she was not aware of any staff to resident abuse. An interview was conducted with resident #284 on June 5, 2025 at 11:44 a.m. The resident stated that he was punched by the other resident by the smoking area in the upper arm. The resident stated that he was lucky I didn't hit him back and that he thinks he got in his way. The resident concluded that the facility moved the other resident away from him and he didn't see the other resident after that. An interview with the Director of Nursing (DON/staff #50) was conducted on June 6, 2025 at 11:44 a.m. The DON stated that Abuse has many definitions. Physical abuse is like slapping someone, physically touching someone they don't want to be touched. The DON stated that the administrator is the abuse coordinator, and that if a staff member suspected abuse they would notify her or the administrator, and she would notify the administrator since she hasn't been in the facility for that long, and that the staff just know the administrator better. The DON stated that when abuse is suspected, they notify the police and make a report. The DON stated that the police usually don't show up but they do it to get a case number. The DON stated that when abuse occurs they usually switch the residents to different areas of the building, and if something really bad happens they would transfer to different facility. During the interview the DON accessed the clinical record for resident #284 and stated that the staff assessed for redness and injury, and the provider was notified related to the incident. The DON also stated that the notes were different from the report as it stated that it was pushed vs hit. The DON concluded with this incident that it did not meet her expectations. A review of facility policy titled Reporting alleged violations of abuse, neglect, exploitation or mistreatment revised October of 2023 revealed that it is the policy of this facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, exploitation and mistreatment. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. Residents must not be subjected to abuse by anyone, including but not limited to facility staff, other residents, consultants or volunteers, staff, of other agencies serving the resident, resident representatives, families, friends, and other individuals.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 reviews, facility documentation, staff interviews, and policy review, the facility failed to implement written policies and procedures that prevent the misappropriation of the property of one resident (Resident #299). The deficient practice can result in the lack of prevention for future occurrences. Findings include: Resident #299 was admitted to the facility on [DATE] with the diagnosis of cellulitis of the left lower limb. The resident was then discharged on January 31, 2023. A review of an MDS (Minimum Data Set) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) had not been completed and a staff assessment had been completed. Indicating that the resident's cognitive function was assessed and documented by staff, either because the BIMS interview with the resident was not completed or not feasible. A record request was submitted on June 5, 2025 at 12:45PM to review the inventory sheet of Resident #299. At 12:52PM on June 5, 2025, Administrator (Staff #55) had stated that the facility does not have an inventory sheet for the Resident #299. Staff #55 stated that they are unsure what had happened on the day of admission for Resident #299 and stated that an inventory sheet was not completed for the resident. An interview was conducted on June 6, 2025 at 9:03AM with a CNA (Certified Nursing Assistant/Staff #49) where Staff #49 stated that when the facility receives a new admission, they are expected to meet and greet the resident, gather their inventory to create a detailed inventory sheet, they will also obtain their vitals, provide assistance to get comfortable and acclimated to the facility, and provide education to the resident regarding the facility's day to day opportunities and services. Staff #49 also stated that during the admission process, an admission packet would be completed and that the packet includes an inventory list. Staff #49 also stated that the expectation with the inventory list is that it is to be filled out within the first two hours, that not completing the inventory list immediately can have the risk of making the facility liable and question of whether the items were present at admission or not. An interview was conducted on June 6, 2025 at 9:17AM with a LPN (Licensed Practical Nurse/Staff #24) where Staff #24 stated that the admission process includes the completion of an inventory sheet that is expected to be completed within 24 hours of admission. Staff #24 also stated that the inventory sheet serves as an opportunity for a resident to provide staff with the value of their inventory, including valuable items, so that in the event that an item would go missing, the facility will have the opportunity to repay the resident with the value of the item. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Admission/Discharge/Transfer, Inventory of Personal Affects, revealed that the facility will take reasonable steps to protect the personal property of the residents. The policy also revealed that when a resident is admitted to the facility, an inventory of the resident's personal effects shall be done by a staff member of the facility. The inventory should record all of personal clothing, valuable articles, etc. that are brought into the facility with the resident and retained by the resident. The policy also stated that once the inventory process is completed, the indicated form will be signed by the resident and responsible party, as well as the staff member, and that a copy of the sheet should be given to the resident.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, interviews, and observations the facility failed to ensure a Preadmission Screening and Resident Review (PASRR) was updated to accurately reflect changes in the condition of resident #88. The deficient practice can result in a resident not receiving recommended services to promote and attain the highest level of well-being. Resident #88, was re-admitted to the facility on [DATE] with diagnoses that include alcoholic cirrhosis of the liver, major depressive disorder-recurrent, insomnia, and history of a myocardial infarction. An order for Mirtazapine 7.5 mg by mouth at bedtime for depression was discontinued on September 19, 2023. Review of a progress note dated March 4, 2024 revealed the resident had an altercation with another resident, and had to be separated for safety. Review of progress notes dated March 4, 2024 - March 6, 2024 revealed Change of Condition documentation for altercation with another resident. The Ineffective Coping related to Alcohol abuse, care plan-initiated May 10, 2024 revealed an intervention to offer professional support and referral for mental health and/or substance center. A progress note dated September 30, 2024 revealed the resident was able to communicate effectively and make his needs known. In addition, he exhibited no adverse, negative behaviors at this time. An order for Trazodone HCL 50 mg was initiated on October 1, 2024, give 1 tablet by mouth at bedtime for depression as evidenced by inability to stay/fall asleep. The quarterly Minimum Data Set, dated [DATE] revealed a Brief Interview Mental Status score of 14, indicating the resident had intact cognition. The Behavioral Symptoms were coded as 0 for physical and verbal symptoms during the 7-day look back period. A progress note dated April 27, 2025 revealed the staff had suspicion of alcohol intoxication. In addition, the writer describes the resident as being verbally aggressive. Also, the resident was observed going into another resident's room to use their restroom. The facility documented contacting the provider to relay these findings. A progress note dated May 23, 2025 revealed the resident was encouraged to find different way to handle a dispute without yelling and using foul language. A progress note dated June 4, 2025 provided a summation that the resident has irritability and verbal aggression. The provider ordered to continue medications as prescribed and to follow up with behavioral health per resident preference. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility documentation dated June 4, 2025 revealed that an internal investigation was to be conducted, because the resident was identified as an alleged perpetrator in a resident to resident altercation the weekend prior. Review of facility documentation revealed that an internal 5-day investigation began on June 4, 2025 in which the resident was identified as an alleged perpetrator in a resident to resident altercation. The CNA Response History dated June 5, 2025 for Behavior Symptoms, revealed no entries over the 30 day look back period. The clinical record does not support the facility's Interdisciplinary Team (IDT) attempt to review PASARR recommendations. An interview was conducted with the resident on June 5, 2025 at 11:01 a.m., who admitted to getting into a couple of disagreements as of late at the facility. The resident revealed the incidents are never anything to serious that he cannot handle. The resident revealed feeling safe at the facility. An interview with Licensed Practical Nurse (LPN/Staff# 24) conducted on June 6, 2025 at 9:08 a.m., revealed if concerns about a resident's mental well-being arise, those concerns are reported to the doctor, Director of Nursing, social services, and if it warrants, the crisis team. An interview was conducted with the admissions director (Staff # 8) on June 6, 2025 at approximately 10 a. m. The director identified a purpose of the PASSR is to ensure residents receive the appropriate level of care for each resident. The director further stated that the PASSR is performed pre-admission, and is also repeated after 30 days of residency. The director explained that the importance of a Level 2 PASSR referral is to ensure the resident receives the correct level of care, and to ensure the staff are adequately trained to meet the level of care that may be needed. During review of the clinical record, the director identified September 18, 2023 as the most current PASSR for the resident. The director also identified the following inconsistences with the current PASSR: -Substance related disorder was not selected, despite resident having a substance related disorder. - Issues with interpersonal behaviors and adaptation to change was not selected, despite the resident being involved in several adverse behavioral incidents at the facility. -Mirtazapine 7.5 mg daily is listed as an active medication, despite it being discontinued on September 19, 2023. The director stated that the current PASSR does not accurately reflect the status of the resident, should be updated to remedy, as the current version does not meet facility expectation. An interview with the DON (Staff #50) on June 6 , 2025 at approximately 11:45 a.m., revealed the facility expectation is to keep the resident's PASSR accurate and current. The DON revealed the importance of the PASSR is to make sure the residents are receiving the right care for their level of need. After review of the clinical record, the DON was unable to find documentation supporting accuracy of the current PASSR. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Behavioral Health policy provides residents with the necessary behavioral health care and services. The policy also defines Substance use disorder as recurrent use of alcohol and/or drugs that causes clinically and functionally significant impairment. Procedurally, the facility's Interdisciplinary Team (IDT) will review PASARR recommendations. The facility's Change of Condition policy with the review date of July 2024, revealed that it is the policy of this facility that all changes in resident condition will be communicated to the physician. In addition, the licensed nurse responsible for the Resident will continue assessment and documentation. The facility's Documentation and Charting policy, with the revision date of July, 2023 revealed that the facility is to provide an account of the progress of the resident's care. The PASARR policy, with the revision of May, 2025 refers to the state's AHCCS Pre-admission Screening and Resident Review (PASAR) policy. The Arizona Health Care Cost Containment System (AHCCCS) with the effective date of May 15, 2023 revealed that PASRR Level 1 Screenings are used to determine whether the individual has a diagnosis or other presenting evidence that suggests the potential for Mental Illness (MI) and/or Intellectual Disability (ID). In addition, Nursing Facilities (NF) are required to request Resident Reviews for individuals experiencing a Significant Change in condition.

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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 observation, interviews, review of records, and review of facility policy and procedure, the facility failed to ensure that staff follows appropriate infection control practices. The deficient practice could result in a spread of preventable illness to residents and staff. Findings included: Resident #56 was admitted to the facility on [DATE] with the diagnosis of quadriplegia, unspecified. A care plan focus initiated on October 14, 2024 revealed that the resident has a suprapubic catheter and that staff is to use enhanced barrier precautions when providing services. Another care plan focus initiated on October 14, 2024 revealed that the resident has a diabetic ulcer and that staff is to use enhanced barrier precautions when providing services. On June 4, 2025 there was an observation at 11:22AM where an LPN (Licensed Practical Nurse/Staff #73) where Staff #73 walked out of the room of Resident #56 with their gloves still on, and holding some type of device in their hand, and had put the device back into the medication cart. The room was also observed to have an Enhanced Barrier Precaution sign. An interview was then conducted with Staff #73 on June 4, 2025 at 11:26AM, where Staff #73 stated that the expectations with those on transmission-based precautions is to ensure a gown, a mask, and gloves are outside a resident's room or a hall if there are more than one resident with a signage that declares the usage of enhanced barrier precautions. Staff #73 also stated that if there is the need to utilize any protective equipment such as gloves, gowns, masks, or a face shield, is to be disposed within a resident's room prior to exiting the room. Staff #73 also stated that hand hygiene is to be completed before and after entering a resident's room, and, before and after proceeding resident care. In regards to Resident #56, Staff #73 stated that the resident has an enhanced barrier precaution sign due to having a suprapubic catheter and as well as open wounds that he is currently receiving treatment for. Staff #73 also stated that utilizing personal protective equipment such as gowns and a mask is only required for dressing changes and direct care to the catheter. Staff #73 also stated that they were just going into the room of Resident #73 to obtain his blood sugar levels before lunch and that the expectation is that staff only need to wear gloves when obtaining blood sugar levels, even when there is an enhanced barrier precaution sign located near the door of a resident. Another interview was conducted on June 4, 2025 at 12:43PM with a CNA (Certified Nursing Assistant/Staff #66), where Staff #66 stated that the facility's protocol for a resident on enhanced barrier precautions is to ensure gloves and gowns are worn when providing care. Staff #66 also stated that if there is a concern for airborne or contact precautions, then the expectation is to ensure a mask is also utilized. Staff #66 also stated that all protective equipment is to be taken off and disposed in the resident's room, prior to exit, by taking of the gown first, and then the gloves. Staff #66 also stated that hand hygiene is to also be completed before and after providing patient care, whether it was to provide the resident with a blanket, with their meal tray, or to take their vitals, hand hygiene is expected at all times, and, as well as, disinfecting any equipment that was used. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Another interview was conducted on June 4, 2025 at 2:51PM with the Infection Preventionist and Wound Care Nurse (Staff #83), where Staff #83 stated that the protocol for a resident on enhanced barrier precautions, staff is expected to utilize the personal protective equipment that can be located in front of or near the door of a resident that has been identified for enhanced barrier precautions. Staff #83 also stated that she does play a role with that identification of resident's that have been put on enhanced barrier precautions with ensuring the proper precautions are listed and in visual of the resident's door, and as well as communicating any changes to a resident's care with staff. Staff #83 also stated that resident's that may be ordered or have these medical conditions that include having a wound; a catheter; a peripherally inserted central catheter (PICC) line; a feeding tube; antibiotics; an intravenous (IV) line; and obtaining blood sugars; and to also use handwashing hygiene when completing any of the tasks mentioned. In regards to the observation on June 4, 2025 at 11:22AM, Staff #83 stated that if a nurse is administering medications, if the medication can go into a cup for the resident, then they would not need to utilize a gown, however, if a nurse is administering medications through an IV, through an injection, a patch, or to check a resident's blood sugars, that would require staff to utilize a gown when administering such medications to a resident under enhanced barrier precautions. An interview on June 6, 2025 at 11:22AM with the DON (Director of Nursing/Staff #50) was conducted where Staff #50 stated that the facility's expectations regarding enhanced barrier precautions is that facility staff and as well as guests is to follow any signage that may be located in front of a resident's room, and to utilize personal protective equipment such as gloves and gowns when completing tasks such as re-positioning a resident; assisting with personal hygiene; and as well as any other patient care. Staff #50 also stated that if the facility's expectations are not followed, that can put staff and the residents at risk for the spread of infections. In regards to the observation on June 4, 2025 At 11:22AM, Staff #50 stated that when administering medications to a resident in a room with a sign that indicates the usage of enhanced barrier precautions certain routes and medications will require a staff member to utilize proper protective equipment. If a staff member were to obtain the blood sugar levels of a resident with such signage, then staff is expected to utilize gloves and a gown due to being exposed to a bodily fluid such as blood. A facility policy titled, Infection Control Prevention and Control Program Standard and Transmission based Precautions, revealed that proper personal protective equipment is to be used when providing care exposes a staff member to blood and bodily fluids.