

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035070	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/14/2024
NAME OF PROVIDER OR SUPPLIER Casas Adobes Post Acute Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1919 West Medical Street Tucson, AZ 85704	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47911</p> <p>Based on clinical record review, staff interviews, facility documentation, policies and procedures, the facility failed to ensure that five residents (#1, #3, #4, #5, #6) were free from abuse from other residents. The deficient practice could result in other residents being abused.</p> <p>Findings included:</p> <p>Regarding Resident #1 and #2:</p> <p>Resident #1 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder, cognitive communication deficit, atherosclerotic heart disease, syncope, hypertension, and mild neurocognitive disorder.</p> <p>A review of the quarterly MDS (minimum data set) assessment dated [DATE] for resident #1 revealed a BIMS (brief interview of mental status) score of 7, indicating moderate impact on cognition.</p> <p>Resident #2 was admitted on [DATE] with diagnosis including dementia, major depressive disorder recurrent, dysphagia, cognitive communication deficit, chronic obstructive pulmonary disease, hypertensive heart and chronic kidney disease.</p> <p>A review of the quarterly MDS (minimum data set) dated November 21, 2023 for resident #2 revealed a BIMS (brief interview of mental status) score of 3, indicating severely cognitively impaired.</p> <p>A review of the progress notes revealed that on November 13, 2023 at 3:52 P.M. resident #1 and resident #2 were self-propelling their wheelchairs out of the dining area, as staff were assisting other residents, words were exchanged between resident #1 and resident #2. Resident #1 accused resident #2 of running over the foot of resident #1. Resident #1 was then observed by staff hit resident #2 in the arm before staff could reach either resident. Staff were noted to have separated the residents and assisted them back to their respective rooms. Resident records revealed that skin checks were conducted and no areas of redness or injuries were observed. The progress notes further revealed that notifications of the director of nursing, family, case manager, provider, and police had transpired. Residents were placed on 15-minute intervals checks.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the facility investigation dated November 16, 2023 revealed that a resident to resident altercation had occurred on November 13, 2023 between resident #1 and resident #2. The investigative report revealed that resident #1 and resident #2 were self-propelling their respective wheelchairs from the dining room area and that the wheelchair of resident #2 made contact with the foot of resident #1 and then that the hand of resident #1 made contact with the arm of resident #2. The investigation cited that the residents were immediately separated and that no injuries had transpired, notifications were made, laboratory assessments ordered and the residents were placed on 15-minute interval checks.</p> <p>An interview was conducted on February 13, 2024 at 2:35 PM with a certified nursing assistant (CNA, staff #81). Staff #81 stated that staff receive frequent ongoing training regarding abuse and neglect. She further stated that if she were to observe an instance of abuse, whether it involved staff or another resident, she would immediately intervene, ensure the residents safety and report the issue.</p> <p>An interview was conducted on February 14, 2024 at 10:46 AM with behavioral health unit manager (staff #20). Staff #20 stated that unit 500, 600 and 800 are locked units and that determination to place a resident on either unit is contingent on their behaviors, documentation of behaviors, intensity of behaviors and frequency of behaviors to ensure the residents were a good fit for that unit. She stated that based on the aforementioned criteria, both resident #1 and #2 were deemed a good fit. She stated that staff received ongoing training through the facilities online learning portal as well as recent CPI [Crisis Prevention Institute] training on identifying warning signs for potential behaviors and de-escalation of behaviors. She stated that there is at least one behavioral health training for staff on a monthly basis. Staff #20 stated that the units are staffed contingent on the needs of the resident and based on the facility assessment, and that generally equated to 3 CNAs on each unit. Staff #20 stated that abuse could be verbal or physical and that the expectation was that all residents are free from abuse, whether by another resident, by staff, or other persons.</p> <p>Regarding Resident #3 and #9:</p> <p>Resident #3 was admitted to the facility on [DATE] with diagnoses that included dementia, psychotic disturbance, mood disturbance, anxiety disorder, alcohol induced psychotic disorder with hallucinations, Wernicke's encephalopathy, cognitive communication deficit, unsteadiness and dysphagia.</p> <p>A review of the quarterly MDS for resident #3 assessment dated [DATE], revealed a BIMS score of 14, indicating cognitively intact.</p> <p>Resident #9 was admitted on [DATE] with diagnoses that included respiratory failure, hemiplegia, hemiparesis, symbolic dysfunction, epilepsy, major depressive disorder-recurrent, traumatic brain injury and schizophrenia.</p> <p>A review of the annual MDS for resident #9 revealed a BIMS score of 15, indicating cognitively intact.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the progress notes dated November 21, 2023 at 3:56 P.M. revealed that staff #37, a restorative nurse assistant, reported an incident between 2 residents. It was noted that resident #9 was in his wheelchair blocking the doorway and not allowing his roommate to exit the room. Resident #9 was noted to have kicked out with his foot and made contact with the abdomen of resident #3. It was noted that the 2 residents were immediately separated, vitals were obtained, skin assessments completed, no noted injuries reported and that resident #3 denied having any injuries as a result of the incident. It was further noted that 15-minute visual checks were implemented, notifications occurred, and laboratory assessments were ordered.</p> <p>A review of the facility investigative report revealed that a resident to resident altercation had occurred on November 21, 2023 between resident #3 and resident #9. The report revealed that resident #3 was participating in therapy with staff #37. It was noted that resident #9 was blocking the way for resident #3. Resident #3 and staff 37 asked resident #9 for room to pass and resident #9 stated no. The foot of resident #9 then made contact with the stomach of resident #3. It was further noted that both residents were immediately separated, skin checks conducted, no injuries were noted, appropriate notifications transpired, residents were placed on 15-minute skin checks, resident #9 was moved to a different room on a different hall, laboratory assessments were ordered and follow-up visits were conducted by the operations manager (staff #133).</p> <p>An interview was conducted on February 13, 2024 at 9:35 A.M. with resident #3. Resident #3 stated that he was trying to leave the room to meet his therapist and had asked resident #9 to move. He stated that resident #9 did not move and instead kicked him. He said that there were no injuries and that the facility had acted promptly and conducted a head to toe skin assessment and moved resident #9 to another hall. He stated that there have been no further incidents.</p> <p>An interview was conducted on February 14, 2024 at 3:18 P.M. with staff #37. Staff #37 stated that that resident #3 was at the door of his room wanting to go out, but resident #9 was blocking the door and would not move. She stated that as a CNA was trying to get a walker out of the way, resident #9 kicked resident #3 in the abdomen. She stated that staff separated the residents and moved the residents into separate rooms. She stated that this has been the first time that resident # 9 had ever physically acted out against another resident. She stated in any instance of physical abuse, staff intervene, insure that the residents are safe and free of injury, place the aggressor away from other residents, notify all appropriate parties and proceed with written statements of the incident. She stated that the expectation is to prevent all types of abuse; however resident #3 did suffer abuse by resident #9.</p> <p>Regarding Resident #4 and #5:</p> <p>Resident #4 was admitted to the facility on [DATE] with diagnoses that included dementia with agitation, muscle weakness and cognitive communication deficit.</p> <p>A review of the admission MDS assessment dated [DATE] revealed a BIMS score of 9, indicating moderate cognitive impairment.</p> <p>Resident #5 was admitted on [DATE] with diagnosis that included dementia, cognitive communication deficit, dysphagia, unsteadiness, muscle weakness, chronic kidney disease, anxiety disorder, major depressive disorder-recurrent, paranoid personality disorder, Parkinson's disease, and persistent mood disorder.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the 5-day MDS assessment dated [DATE] revealed a BIMS score of 14, indicating cognitively intact.</p> <p>A review of the facilities investigative report revealed that on November 26, 2023, resident #4 and resident #5 were in the dining room in the secured unit, when a nurse heard a noise. It was noted that the nurse observed resident #5 making contact, via his foot, with the wheelchair of resident #4. It was further noted that the nursing assistant escorted both residents to their respective rooms and initiated 15-min interval checks. The report revealed that post separation, skin checks were conducted and revealed an abrasion to the arm of resident #4, notifications were completed, resident #5 had an adjustment to his medications as well as a psychological evaluation. The report further revealed that neither resident recalled the incident.</p> <p>An interview was conducted on February 14, 2024 at 10:25 A.M. licensed practical nurse (LPN, staff #143). Staff #143 stated that she had not observed the verbal altercation between the two residents, but had heard yelling coming from the dining room and went to investigate. She stated that when she arrived in the dining room, she observed resident #5 kicking the wheelchair of resident #4. She stated that she pulled the chair of resident #4 away. She stated that she had separated the two residents and recalled that each had minor injuries. She stated that she thought resident #4 had an injury to his forearm and the resident #5 had an injury to his thumb. She stated that she could not recall if the incident occurred right after lunch or right after dinner and stated that there were either 2 or 3 CNA's (certified nursing assistants) present that day, which is normal for the facility. A review of the punch detail revealed 3 CNA's present on November 26, 2024. She further stated that the expectation is that in spite of it being a behavioral unit, abuse should not occur.</p> <p>Regarding Resident #6 and #7:</p> <p>Resident #6 was admitted to the facility on [DATE] with diagnoses that included schizophrenia, anoxic brain damage, major depressive disorder recurrent, chronic kidney disease, epilepsy, and type 2 diabetes.</p> <p>A review of the quarterly MDS assessment dated [DATE] revealed a BIMS score of 0, indicating severely cognitively impaired.</p> <p>Resident #7 was admitted on [DATE] with diagnosis including metabolic encephalopathy, pneumonia, sepsis, acute respiratory failure with hypoxia, type 2 diabetes, cognitive communication deficit, dysphagia, and dementia.</p> <p>A review of the 5-day MDS dated [DATE] revealed a BIMS score of 01, indicating severely cognitively impaired.</p> <p>A review of the facility's investigative report revealed that on January 31, 2024, resident #7 was observed experiencing increased disorientation, staff intervened and attempted to direct resident #7 out of the dining room to provide de-escalation and re-orientation. It was noted as resident #7 passed resident #6 in the hall. Resident #7 made a hand gesture contacting the upper arm of resident #6. The report further revealed that skin checks were conducted-revealing no injuries, notifications were completed, resident #7 was placed on 1:1 for the remainder of his stay, additional behavioral supports were enlisted from the operations manager and the behavioral health manager.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview was conducted on February 14, 2024 with behavioral health unit manager (LPN, staff #20). She stated that she did not witness the incident but arrived in the dining room right after it had occurred. She stated that resident #7 was noted to become restless and staff were in the process of moving him out of the dining room, when they passed by resident #6. Resident #7 hit resident #6 during the encounter. She stated that that act of hitting resident #6 was deliberate and not accidental She stated that staff were trained to utilize soft, calm approaches and coaxing when trying to remove a resident from an area if they observe a potential concern. She stated that if the resident is in the dining area, they may move the resident to another table or remove them from the dining area entirely. She stated that staff are trained, that if a resident refused to be moved, to call for assistance, keep the resident engaged and try to move the other residents around them. She stated that to her recollection, neither resident incurred any injuries from the encounter and that the appropriate follow-up had been conducted, which included an update to resident #7's care plan. She voiced no staffing concerns for the locked units and stated that her expectation was that residents are free from abuse.</p> <p>Review of the facility policy with a review date of January 2022 revealed that the resident has a right to be free from abuse, neglect, misappropriation of resident property and exploitation. The policy defined abuse as a willful infliction of injury. The policy further revealed that the facility will provide oversight and monitoring to ensure that its staff, who are agents of the facility, deliver care and services in a way that promotes and respects the rights of the residents to be free from abuse, neglect, misappropriation of resident property and exploitation.</p>		