

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 04/12/2024
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** 48932</p> <p>Based on clinical record review, staff and resident interviews, and a review of the facility's policy and procedures, the facility failed to protect the rights of five residents (#1, #4, #2, #5, and #3) to be free from abuse from other residents. The deficient practice could lead to further abuse and residents being placed in an unsafe environment.</p> <p>Findings include:</p> <p>Regarding to resident #4 and resident #5</p> <p>-Resident #5 was admitted on [DATE] with diagnoses of dementia, cognitive communication deficit, and heart disease.</p> <p>The quarterly MDS (Minimum Data Set) assessment dated [DATE] revealed a BIMs (Brief Interview for Mental Status) score of 8 indicating the resident had moderate cognitive impairment. The assessment also included that the resident had been experiencing verbal behavioral symptoms towards others, rejection of care, and wandering within the 1 - 3 days of the assessment.</p> <p>The progress note dated August 17, 2023 revealed a staff was with resident #5 who was laying on their left side next to their wheelchair; and that, the wheelchair was also on its side. Per the documentation, another resident (#4) was yelling in the hallway and reported that resident #5 ran over the foot of the other resident (#4) so resident #5 threw him (referring to resident #4) down. The note also included that resident #5 complained of pain in the left hand and hip.</p> <p>A review of the x-ray result done on August 18, 2023 revealed there was no fracture or soft tissue trauma of the left hip, left hand, humerus, radius, ulna or the forearm.</p> <p>-Resident #4 was admitted on [DATE] with diagnoses of dementia, muscle weakness, and cognitive communication deficit.</p> <p>A review of the care plan revised on August 16, 2023 included a focus area of behavioral disturbances. The goal was that resident #4 understand their verbally abusive behavior. Interventions included providing positive feedback for good behavior, anticipating the needs, and to intervene when resident showed signs of being agitated.</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
---	-------	-----------

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 04/12/2024
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>A progress note dated August 17, 2023 revealed that staff heard resident yelling in the hallway. The documentation included that resident #4 accused resident #5 of running over his (referring to resident #4) foot with the wheelchair; and that, resident #4 threw resident #5 onto the floor. The documentation also included that resident #4 was placed on 1:1 staff supervision until the resident was transferred to the ED (emergency department).</p> <p>The progress note dated August 17, 2023 included resident #4 required a higher level of transfer due to his aggression; and that, resident was transported to the hospital.</p> <p>The discharge MDS assessment dated [DATE] revealed resident #4 had physical and verbal behaviors including rejection of care and wandering; and that, BIMs score was not completed for resident #4.</p> <p>An interview with certified nursing assistant (CNA/staff #8) was conducted on April 12, 2024 at 10:03 a.m. The CNA stated she saw the incident between residents #4 and #5. She stated that resident #4 went into the room of resident #5; and, she saw resident #4 lifting the wheelchair with resident #5 in it resulting in resident #5 falling to the floor. The CNA stated that resident #4 was a big and strong guy so he was able to lift the chair. Further, the CNA stated that after witnessing the incident, she separated both residents from each other and the nurse came to help out.</p> <p>Regarding resident #2 and #3</p> <p>-Resident #2 was admitted to the facility on [DATE] with diagnoses of dementia, psychosis, and anxiety disorder.</p> <p>The quarterly MDS assessment dated [DATE] revealed a BIMs score of 8 indicating the resident had moderate cognitive impairment. The assessment included resident #2 had no behavioral symptoms.</p> <p>A review of a progress note dated September 22, 2023 at 4:04 p.m., revealed staff witnessed resident #2 grab resident #3 from behind and hit resident #3 on his left cheek. Per the documentation, resident #2 and resident #3 were separated and 1:1 staff was placed with resident #2 until he was moved to another unit. It also included that resident #3 had a scratch on the cheek.</p> <p>The care plan updated on September 22, 2023 revealed interventions to include 1:1 staffing until resident placed in a separate unit. Prior to the altercation, the following interventions were in place: approach resident in a calm manner, discuss resident's behavior with resident if appropriate, provide positive interactions, and administer medications as ordered.</p> <p>-Resident # 3 was admitted on [DATE] with diagnoses of cognitive communication deficit, metabolic encephalopathy (neurological disorder caused by chemical imbalance), and muscle weakness.</p> <p>The progress note dated October 10, 2023, revealed resident #3 was entering the dining room and bumped his wheelchair with another resident (#1) who then hit resident #3 on the head. The documentation included that there were no injuries noted and both residents were separated from each other and 15-minute checks were implemented.</p> <p>(continued on next page)</p>		

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 04/12/2024
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>A nursing note dated October 14, 2023 at 3:08 p.m., revealed that a staff witnessed resident #3 make contact with the left lower jaw of resident #1. The documentation included immediate interventions were put into place such as a check for injury, 15-minute checks, and both residents were separated. The note also included that facility leadership, family and the sheriff department were notified.</p> <p>The clinical record revealed that in the days prior to the October 14, 2023 incident, resident #3 had been experiencing an increased inability to sleep, feeling more tired as usual, restlessness, and delusions; and that, resident #3 was administered medication to help them sleep.</p> <p>A review of the care plan updated on October 16, 2023 included a focus of behavioral disturbances. The goal was that the resident not harming himself or others. Interventions included providing verbal and physical cues to minimize their anxiety and agitation; and redirection and removing the resident them from the current environment when there were signs of agitation.</p> <p>The discharge MDS, dated [DATE] indicated resident #3 had a BIMs of 15 which indicated the resident was cognitively intact. The same discharge MDS assessment also indicated resident #3 had not exhibited behavioral symptoms.</p> <p>An interview with resident #2 was conducted on April 11, 2024 at 1:34 p.m. Resident #2 was sitting upright on his bed; and stated that he felt safe in the facility. The resident also said that staff come to see him every morning to give him the pills that he needs.</p> <p>In an interview with CNA (staff #3) conducted on April 11, 2024 at 2:25 p.m., the CNA said that she was working in the unit when the altercation between resident #2 and #3 took place; and that, she remembered hearing yelling as she was walking down the hall. The CNA stated that she saw resident #2 punch resident #3; and, she separated the two residents and called out for help. Further the CNA said that the behavioral manager had come into the dining room and helped defuse the situation.</p> <p>Regarding resident #1 and #3</p> <p>Resident #1 was admitted on [DATE] with diagnoses of chronic obstructive pulmonary disease (COPD), dementia, and a history of strokes.</p> <p>The quarterly MDS assessment dated [DATE] revealed a BIMS score of 2 indicating the resident had severe cognitive impairment. The assessment also included that resident had exhibited no behavioral symptoms.</p> <p>A review of the nursing note dated October 14, 2023 at 11:05 a.m., included that another resident (#3) was witnessed making contact with the lower left jaw of resident #1. The documentation also included that immediate interventions were put into place such as a check for injury, 15-minute checks, and both residents were separated; and that, facility leadership, family, sheriff department were notified.</p> <p>The weekly skin evaluation dated October 14, 2023 revealed that there were no injuries noted and that the resident did not complain of pain or discomfort in the jaw area.</p> <p>(continued on next page)</p>		

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 04/12/2024
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>The interdisciplinary team (IDT) meeting note dated October 16, 2023 included that resident #1 had a verbal altercation with resident #3; and that, this resulted in resident #1 being hit on her left lower side of the face. The IDT note also included that the aggressor was resident #3; and that, laboratory test was ordered, a psychiatrist referral was placed and a referral was sent to secure alternate placement in another facility for resident #3.</p> <p>An interview with licensed practical nurse (LPN/staff #5) was conducted on April 11, 2024 at 2:13 p.m. The LPN stated that she mostly worked in the behavioral unit so she was familiar with the residents in those units. The LPN said that staff in the behavior unit monitor the residents and when staff notice a trigger occur, staff will attempt to remove the trigger or redirect the residents to another area of the unit. The LPN said that if a resident to resident altercation happens, staff will remove the residents from the environment and evaluate the situation then report the incident to the unit managers. Further, the LPN said that facility management often talked with staff about abuse and the behavioral team will get extra training due to the residents they work with.</p> <p>Another interview was conducted on April 11, 2024 at 2:25 p.m. with the CNA (staff #3) who stated that she was trained on abuse upon hire and she completes an online training class every year. Further she stated that she had to report any suspicion of abuse to her supervisor immediately even though staff had 2 hours to report it.</p> <p>In an interview with another LPN (staff #6) conducted on April 12, 2024 at 9:45 a.m., the LPN said that she was the unit manager for the behavioral health unit; and that, since she became the unit manager, she had increased staff training on de-escalation. The LPN said that she had been more involved in the screening process for incoming residents to determine where they would be a fit within the behavioral health units; and, this included the process of phasing out residents with dementia who wander. Further, the LPN said that she was also putting more emphasis on the activities program for residents within the unit and she had hired 1 activities staff per unit to create activities specifically for each of those units.</p> <p>During an interview conducted with the assistant administrator (staff #7) conducted on April 12, 2024 at 11:13 a.m., staff #7 stated that the staff training on Abuse was a topic of conversation at the monthly staff meetings, nurse meetings, behavioral health training meetings and each time there was a case of abuse in addition to their annual training. She stated that the expectation was that suspected abuse were reported to the abuse coordinator right away even when the guidelines stated that it must be reported within 2 hours. Staff #7 also said that the facility mitigated the risks of abuse in the behavioral health unit by thoroughly vetting the needs of incoming residents and looking how to cohort with others; and, the facility also has a full-time behavioral health case manager who reviews the residents' care plans and triggers. Further, staff #7 stated that each behavioral health unit has a specific level of care that they serve; and the facility had implemented a behavioral activity program that had been extremely helpful with keeping the residents busy and engaged.</p> <p>A review of the facility's policy titled, Abuse: Prevention of and Prohibition Against with a review date of October 2023, states Residents also have the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The policy also continues to state under the Prevention section, The Facility will act to protect and prevent abuse and neglect from occurring within the Facility by: Identifying, assessing, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect .</p>		