

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 06/14/2024
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 - Few</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** 47341</p> <p>Based on resident and staff interviews, clinical record review, and facility policy, the facility failed to failed to prevent resident to resident abuse with resident #55 being the aggressor and #44 being the victim. The deficient practice could result in further abuse of residents at the facility.</p> <p>Findings include:</p> <p>Resident #55, the aggressor, was admitted to the facility on [DATE] and discharged on [DATE] with diagnoses that included bipolar disorder, major depressive disorder, and dementia. At the time of incident, prescribed psychotropic medications included Aripiprazole, Citalopram, Depakote, hydroxyzine, and Donepezil and memantine for dementia. Resident #55 had an order to monitor for psychosis as evidence by physical aggression and verbal threats dating back to 11/03/2022. Change in condition protocols were ordered due to an altercation with a peer on 03/01/2023, on 04/03/2023, and again later on 4/18/2024.</p> <p>In the Quarterly Minimum Data Set (MDS) assessment from 02/09/2023, Resident #55 scored a 01 in a Brief Interview of Mental Status which suggested severe cognitive impairment. The MDS also revealed that the resident had wandered on a daily basis in the assessment period.</p> <p>In the care plan originally initiated on 11/03/2022, Resident #55 had goals for a potential psychosocial well-being problem related to her Dementia, depression, and bipolar diagnoses. Interventions included if conflict arises, remove residents to a calm safe environment and allow to vent/share feelings. Also documented in the care plan, for psychotropic medications use for physical aggression and labile mood. Interventions included taking psychotropic medications as ordered, monitoring for effectiveness, and adjusting dosages as clinically appropriate.</p> <p>Progress notes documented the following history of resident having altercations with other residents:</p> <p>-03/01/2023: Resident went into another resident's room and hit him on his back while he was shaving. When staff entered room, Resident #55 had a hand raised as if to strike him again.</p> <p>-03/20/2023: Resident #55 it a hit roommate on the chest with the back of their hand while in the hallway.</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 06/14/2024
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 - Few</p>	<p>-04/04/2023: Resident #55 walked up to another resident and pushed the resident to the floor. Labs and Urinalysis was ordered.</p> <p>-4/14/2023: Resident #55 had two episodes of aggression. One where they pushed a staff member from behind. The second was where they were posturing at another resident in the dining room during dinner. There was no physical contact.</p> <p>-4/18/2023: Interdisciplinary Team (IDT) met to review incident on 4/17/23 of physical altercation with another Resident #55 was seen shaking a fist at another resident. The other resident reported Resident #55 had hit her on her back.</p> <p>A note timestamped 4/18/2023 05:18pm documented a medication regimen review which revealed Resident #55 may have been having exacerbated symptoms from Depakote. The day started on Depakote was a day physical aggression was seen. As dose was increased to help alleviate her aggression and labile mood, aggression slowly increased. After staffing with the psychiatric provider, Depakote was discontinued and her Aripiprazole dose increased.</p> <p>A discharge summary from 4/20/23 showed that resident was ultimately transferred to a behavioral care home as documented in a nursing progress note dated 04/18/2023.</p> <p>Regarding Resident #44, the victim:</p> <p>Resident #44 admitted to the facility on [DATE] and discharged [DATE] with diagnoses that included dementia and major depressive disorder.</p> <p>In the quarterly MDS assessment from 03/19/2023, Resident #44 scored a 05 on BIMS which suggested severe cognitive impairment. The MDS also revealed that the resident had not behaviors other than wandering during the assessment period.</p> <p>During an interview on 6/14/2024 at 4:45p with Licensed Practical Nurse (LPN), Staff #21, stated that to prevent resident to resident altercations the staff will try to do activities and keep residents busy. If they see the signs of agitation they can redirect with food and fluids for example for ask if they need pain medication. They will try to keep the resident happy before anything happens. If they are becoming agitated keep them a safe distance from other patients. They will also call the doctor and have the psychiatric provider take a look at their medications. She stated she was unsure if the facility does one on ones for residents. She said it is a good option, but she has not seen it here. It is not possible in her nursing opinion to prevent all resident to resident interactions. The patient could be having delusions, PTSD (posttraumatic stress disorder), or any number of other reasons including boredom. It is about anticipating their needs.</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 06/14/2024
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 - Few</p>	<p>In an interview on 6/14/2024 at 4:50pm with the Director of Nursing (DON), Staff #31, along with Operations Manager Staff #51, visiting DON Staff #41, and Clinical Resource Staff #61, the facility discussed the history of Resident #55's altercations with other residents. For the incident in question on 04/03/2024, the DON stated that typically in a resident to resident altercation, staff will remove the aggressor and focus on the aggressor. She stated that Resident #55 was not always the aggressor. On 4/3 after the incident, she was moved from the 500 to 800 unit. 800 is the high acuity behavioral unit and 500 unit is for dementia with behaviors. Both units are secured. A review of the electronic chart with the above-mentioned staff members revealed 5 incidents in 2023 when Resident #55 was the aggressor prior to her discharge. The dates are 4/17, 4/14, 4/3, 3/20, 3/1. The DON stated that after the incident on 3/1, the resident was placed on 15-minute checks; on 3/20/2024 she moved rooms and was placed on 15 minutes checks; after 4/3/2024 she was moved to high acuity unit from wandering dementia unit with behaviors. For residents that have repeated altercations with other resident, if they are stable and can be safe, then the facility can try to do medical clearance, have a psychiatric provider assessment, and different techniques to keep them in the least restrictive environment possible. If needed, they will do 1:1 staff. If it is needed for an extended period of time, then they are sent to a level I facility. On 4/18/24, they had a 1:1 for Resident #55.</p> <p>The DON stated that in August of 2023 the unit was transferred from dementia to wandering with behaviors. Wandering residents were placed on a different unit which decreased resident to resident altercations. Since January of 2024, they have placed a staff member in the hall and dining rooms. The psychiatric team is always involved whenever there is an altercation. They are on site 5 days a week. Psychiatric evaluations are done every time and then they will do a medication review, urinalysis, and labs if indicated. Behavior health counselors are on site every day, and will talk with the aggressor to adjust and provide counsel, and then the victim to make sure they are doing okay post incident.</p> <p>The facility has also since implemented a new activity program. It is 7 days a week and includes low and high sensory activities on the behavioral units. The DON stated she feels confident since implementing new training in January that they are taking care of residents. The incidence of resident altercations have gone way down. She said she had no concerns about Resident #55 and how her case was handled after review of the chart.</p> <p>Facility policy titled Reporting Alleged Violations of Abuse, Neglect, Exploitation or Mistreatment last revised on 10/2023 states it is the policy of this facility that each resident has the right to be free from abuse . Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, [and] other residents. Abuse is defined as willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm pain, or mental anguish .Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.</p>		