

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  06/21/2025
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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review, staff interviews, and policy review, the facility failed to ensure that two residents did not abuse other residents. The deficient practice could result in residents being physically harmed. Findings Include:</p> <p>Past non-compliance was identified for this citation: In November 27, 2023 the facility conducted an in-service regarding behavioral care and charting that included implementation of a 24-hour report to monitor new behaviors, daily clinical meetings with discussion regarding new behaviors. In January 2024, the facility implemented new training in January 2024 training for all nursing staff and certified nursing assistants, using the Crisis Prevention Institute program training for all nursing staff and certified nursing assistants.</p> <p>On March 18, 2025, a nursing meeting was conducted on managing difficult behaviors and de-escalation. to review the changes made to the behavioral units. Following this, on March 22, 2025, all nursing staff and certified nursing assistants received in-service training on understanding dementia and mental illness. On April 2, 2024 the facility continued in-service training on trauma informed care. On June 20, 2024 an in-service was provided regarding behavioral health interventions and care plans. Further in-services on August 16, 2024 included behavior training, interventions, boundaries and de-escalation.</p> <p>The facility provided daily 24-hour reviews audits of progress notes for behaviors and care plan interventions during April 2024 through September 2024. The facility also provided their De-escalation Crisis plan that included steps on to ensure resident safety when a patient is disruptive, agitated, verbally aggressive and not redirectable or potentially a risk for physical aggression.</p> <p>- Regarding Resident #171</p> <p>Resident #171 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, cognitive communication deficit, paranoid schizophrenia, anxiety, and a major depressive disorder.</p> <p>A care plan initiated May 11, 2020 and resolved May 21, 2020 revealed that the resident was prescribed an anti-anxiety medication related to anxiety as evidenced by restlessness. The interventions included to provide a quiet environment.</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 - Few</p>	<p>A behavior care plan dated May 19, 2020 revealed that the resident takes a psychotropic medications related to schizoaffective disorder as evidenced by physical aggression. Non-pharmacological interventions included redirection, provide a quiet environment, and provide reassurance.</p> <p>The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 3 indicating the resident had a severe cognitive impairment.</p> <p>A progress note dated May 3, 2023 stated that the CNA on the floor was walking in the hallway when a resident in a wheelchair slapped resident #171 in the abdomen. The resident yelled out, stop it. The resident did not have any signs of pain and there was no redness noted on the abdomen. The CNA separated them and reported it. The Sheriff's Department was contacted at 3:20 p.m., event number #230502256.</p> <p>The progress note dated May 3, 2023 (late entry) stated that the resident was apparently assaulted earlier by another resident. Another resident slapped him in the abdominal area. The resident denies any pain. There was no evidence of trauma noted on abdominal area. The resident will be monitored closely.</p> <p>A progress note dated May 28, 2023 revealed that an altercation occurred between resident #171 and another resident. The other resident made accusations that resident #171 was being inappropriate. Nursing staff stated that this was not the case and that things have been resolved. The other resident apparently hit him in the genitalia area. Resident #171 does not recall this or was able to explain it. The other resident accused him of touching himself inappropriately.</p> <p>The care plan dated December 1, 2023 revealed that the resident takes an anti-anxiety medication related to an anxiety disorder as evidenced by restlessness and pacing. Interventions included to use non-pharmacological interventions done: back rub, redirection, speak to/approach in a calm manner, reposition, offer snacks/fluid/milk/, assess for pain, provide a quiet environment, encourage to express feelings, take to activities, provide reassurance.</p> <p>-Regarding Resident #50:</p> <p>Resident #50 was admitted to the facility on [DATE] with diagnoses that included alcohol dependence in remission, major depression, anxiety disorder, and disorientation unspecified.</p> <p>A behavior care plan dated March 28, 2021 revealed that the resident has behavioral disturbances which include but not limited to physical aggression, verbal aggression, repetitive questions and statements, pacing, rummaging related to dementia, and poor impulse control. It also included that the resident had a resident to resident altercation on March 28, 2021 and April 16, 2024. The interventions included to allow the resident to walk on the secure patio as able.</p> <p>The MDS dated [DATE] included a brief interview for mental status score of 7 indicating the resident had a severe cognitive impairment.</p> <p>A progress note dated May 12, 2025 revealed that the resident was slapped on his arm and back by another resident while entering the dining room.</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 - Few</p>	<p>An interdisciplinary team meeting note dated May 15, 2023 stated that the team met to review an incident on May 12, 2023 of physical altercation with another resident. Resident #50 resides on a secured dementia with behaviors unit. He has a diagnoses of schizoaffective disorder, dementia with behavioral disturbances. Resident #50 walked up next to another resident while trying to enter the dining room and she hit him on his arm and then once on his back. No injuries were noted. The two residents were separated. The aggressor was placed on fifteen-minute checks for twenty-four hours, labs and urine to rule out infection.</p> <p>-Regarding Resident #172:</p> <p>Resident #172 was admitted to the facility on [DATE] and discharged [DATE]. The diagnoses included Alzheimer's disease, cognitive communication deficit, behavioral disturbance, psychotic disturbance, and bipolar disorder.</p> <p>The MDS dated [DATE] included a brief interview for mental status score of 1 indicating the resident had a severe cognitive impairment. It also included that the resident exhibited physical and verbal behaviors 1 to 3 days during the look-back period.</p> <p>The progress note dated May 3, 2023 revealed that the writer was informed by the certified nursing assistant (CNA) that the resident was in the hallway when another resident walked by and then resident #172 slapped the resident in the abdomen. The other resident yelled out stop it. The CNA separated them and reported it. The Sheriff's Office was contacted at 3:20 p.m. and the event number was #230502256. The resident was placed on fifteen-minute checks, a psych evaluation was done and a medication was adjusted.</p> <p>Review of the clinical record revealed that resident #172 was put on fifteen-minute checks on May 2, 2023 and May 3, 2023 due to behavioral concerns.</p> <p>The care plan dated May 4, 2023 revealed that the resident had behavioral symptoms which include but not limited to hitting, kicking, pinching, screaming, yelling, impulsiveness, verbal aggression, refusal of care related to bipolar diagnosis, dementia, and poor impulse control. Interventions included to assess and anticipate resident's needs: food, thirst, toileting needs, comfort level, body positioning, pain, etc. It also included that when the resident becomes agitated, guide away from source of distress; engage calmly in conversation; if response is aggressive, staff should walk calmly away, and approach later.</p> <p>The interdisciplinary team (IDT) meeting note dated May 4, 2023 revealed that the team reviewed the incident that occurred on May 2, 2023 of a physical altercation with another resident. Resident #172 resides on a secured dementia with behaviors unit with a diagnosis of dementia with behavioral disturbances. A resident walked up next to resident #172 while in the hallway, and she hit him on his abdomen. No injuries were noted and the two residents were separated. Resident #172 was placed on fifteen-minute checks for twenty-four hours and a psych evaluation with a medication change was completed.</p> <p>The progress note dated May 4, 2023 revealed that the resident was alert and able to verbalize her needs, was up in her wheelchair most of the shift, and eating meals in the dining area. The resident was wandering intrusively on the unit going in and out of other rooms and getting clothes from closets. The resident gets very agitated when redirected and yells and hits staff.</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 - Few</p>	<p>A progress note dated May 5, 2023 revealed that the resident was alert and up in her wheelchair wandering intrusively most of the day, grabbing at clothes from other rooms, very hard to redirect, yells and hits at staff, swinging her hands and throwing stuff.</p> <p>A progress note dated May 12, 2023 revealed that a staff reported the resident who was in her wheelchair slapped another male resident two times on his arm and one time on his back, while she was trying to go inside the dining room. The residents were immediately separated, and this resident was placed on fifteen-minute checks. The incident was reported to the police, case number #230512267.</p> <p>Review of the clinical record revealed that resident #172 was put on fifteen-minute checks on May 12, 2023 and May 13, 2023 due to behavioral concerns.</p> <p>An IDT meeting note dated May 15, 2023 stated that the team reviewed on May 12, 2023 of a physical altercation with another resident. Resident #172 resides on a secured dementia with behaviors unit with a diagnosis of dementia with behavioral disturbances. A resident walked up next to resident #172 while she was trying to enter the dining room, and she hit him on his arm and then once on his back. There were no injuries noted. The two residents were separated. Resident #172 was placed on fifteen-minute checks for 24 hours, labs and urine to rule out infection.</p> <p>A progress note dated May 28, 2023 stated that the resident has been wandering into other residents rooms this shift and taking clothes, personal belongings. The resident has also attempted to hit other residents in the dining room and was redirected multiple times.</p> <p>A progress note dated May 29, 2023 revealed that the nurse was charting at the nurse's station and heard yelling and immediately went to the dining room. She noted that resident #172 was in her wheelchair and yelled at the resident in room [ROOM NUMBER] A standing in front of her scratching his thing. Resident #172 yelled at the other resident stop touching yourself, reached over and slapped him in the genitalia.</p> <p>The five-day investigation dated May 8, 2023 revealed that on May 2, 2023 a certified nursing assistant (CNA/staff #300) was in the hallway monitoring residents and saw resident #172 slap resident #171 in the abdomen. She heard resident #171 yell and growl and immediately went to separate them. (CNA/staff #63) also witnessed resident #172 slapping resident #171 in the abdomen and went to help separate the residents. She stated that both residents were put on fifteen-minute checks. It also included that both residents have wandering behaviors.</p> <p>The five-day investigation dated May 19, 2023 revealed that on May 12, 2023 a resident to resident altercation occurred between resident #172 and resident #50. The investigation included a statement from (CNA/staff #160) who stated that she was helping in the hall and was asked by another worker to come into the dining room assist. When she walked into the dining room, another staff member was separating resident #50 from resident #172. CNA #160 helped to remove resident #50 from the room and called for the nurse for assistance. A second statement from a licensed practical nurse (ADON/LPN/staff #228) revealed that she was called into the dining area and a staff member reported that resident #172 hit resident #50. She helped to separate the residents and assessed them for injuries. No injuries were noted and both residents were placed on fifteen-minute checks. Based on the facility investigation and speaking with staff, it was a witnessed behavior that occurred on a dementia hall known to have wandering and demented residents.</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 - Few</p>	<p>The five-day investigation dated June 1, 2023 revealed that on May 28, 2023 residents #171 and #172 were in the dining room. Resident #171 was scratching his inner thigh while being fully clothed. Resident #172 told resident #171 to stop and hit him in the genital area. Both residents were separated immediately and assessed for injury and no injuries noted for either party.</p> <p>An interview was conducted on June 19, 2025 at 1:59 p.m. with the Director of Nursing (DON/staff #51), who stated that when she does a five-day investigation, interviews any staff and/or residents who witnessed the incident or heard anything. She acknowledged that the five-day investigation sent into the state agency only included interviews from (CNA/staff #160) and (LPN/staff #228). She reviewed documentation in a brown box and pulled out the Facility Investigation Report for Resident Abuse, Neglect, Misappropriation of Property, and Exploitation of Residents in Long-Term Care Facilities dated May 12, 2023 with the statement of Hospitality Aide (HA/staff #303). She reviewed the interview and stated that staff #303 witnessed the resident to resident altercation between resident #172 and resident #50. She also stated that she considered the altercation a form of abuse.</p> <p>An interview was conducted on June 19, 2025 at 12:38 p.m. with the staffing coordinator/certified nursing assistant (CNA/staff #160), who stated that she has received training on abuse and one resident can abuse another resident. She stated that staff have to keep their eyes open and be aware of the surroundings at all times. She stated that the staff on the secured units rotate watching the public areas (dining room and hallway) and the nurse will also help to monitor the residents in the dining room when she is in the dining room. She stated that there are generally more than one staff in the public areas whether it be an activities person, nurse or a CNA. She stated that she was working the day that resident #172 hit resident #50 and thinks she was standing in the doorway of the dining room, but didn't remember which staff was between the two residents. She stated that there have been a couple of incidents when she had to intervene and get between resident #172 and other residents. She stated that resident #172 has hit and grabbed other residents. She stated that one time resident #172 put her nails into another resident and thinks it was resident #50.</p> <p>An interview was conducted on June 19, 2025 at 1:06 p.m. with a licensed practical nurse (LPN/staff #228), who stated that she has received training on abuse and when a resident grabs or hits another resident it is abuse. She thinks that resident #172 reached out and slapped resident #50 and this was abuse. Resident #172 does reach out and slap people when they walk by in the dining room and hits the staff. She stated that there are always staff in the dining room and if the activity staff see something, the staff should report it to the licensed staff. She can see the residents from her office, but acknowledged that she might not be able to get to the residents from her office before they hit each other. She also stated that there should be a staff that monitors the hallway as well.</p> <p>An interview was conducted on June 20, 2025 at 8:46 a.m. via the phone with the Assistant Director of Nursing (ADON/staff #6), who stated that she has received training on abuse and resident to resident abuse can occur. She stated that resident #172 spent a lot of time in the dining room. She stated that she has never witnessed resident to resident abuse at the facility. The surveyor read staff # written statement regarding resident #172 hitting resident #171 in the genitals on May 28, 2023. Staff # acknowledged that if she wrote a statement for the five-day investigation, the statement was true.</p> <p>Attempted to contact (CNA/staff #300) on June 20, 2025 at 12:51 p.m. but the phone number was inaccurate.</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 - Few</p>	<p>Attempted to contact (CNA/staff #63) on June 20, 2025 at 12:56 and could not leave a message due to the voicemail box not being set up.</p> <p>-Regarding Resident #170</p> <p>Resident #170 was admitted to the facility on [DATE] with diagnoses that included unspecified dementia, schizophrenia, major depression, and anxiety disorder.</p> <p>The minimum data set (MDS) dated [DATE] included that the resident was not able to repeat three words back, was not able to state the current year, month, or day of the week.</p> <p>The care plan revealed that the resident is an elopement risk/wanderer related to disorientation to place, impaired safety awareness. The resident wanders aimlessly. Interventions included to document wandering behavior and attempted interventions.</p> <p>The progress note dated March 9, 2023 revealed that the resident had an encounter with another resident. She is fine and does not have any injuries. Nursing does not know what happened. She was slapped by another resident on the right side of her face. Right side of face was reddened.</p> <p>A nursing note dated March 9, 2023 stated that staff reported at approximately 1:30 p.m. that a male resident slapped this resident (victim) on the right side of her face in the aggressor's room. The residents were separated immediately, and the aggressor was put on fifteen-minute checks and moved to the 600 unit at 2:00 p.m. The resident was comforted, and skin check was done, right side of face reddened. Sheriff's Department was notified, case #230309188.</p> <p>The order summary included an order dated March 9, 2023, Change of Condition for monitoring mood and behaviors every shift for status post altercation with peer for three days. No injuries noted.</p> <p>Review of the Medication Administration Record (MAR) dated March 2023 revealed that the resident was being monitored for a change of condition (COC) for mood and behaviors every shift for status post altercation with peer for three days dated March 9, 2023. COC was monitored from March 9, 2023 through March 12, 2023. On March 11 and 12, 2023, the resident exhibited behavioral symptoms.</p> <p>-Regarding Resident #148:</p> <p>Resident #148 was admitted to the facility on [DATE] with diagnoses that included vascular dementia, cognitive communication disorder, and anxiety.</p> <p>The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 9 indicating the resident had a moderate cognitive impairment.</p> <p>The care plan dated April 28, 2022 revealed that the resident has behavioral disturbances with include but not limited to yelling, screaming, using abusive language, threatening behaviors, physical aggression, pushing, punching, exit seeking, delusional thoughts, paranoia related to dementia/cerebral vascular accident (CVA). Altercations occurred on: -November 8, 2022-March 9, 2023-July 27, 2023-September 22, 2023-May 2, 2024Interventions included to assist to develop more appropriate methods of coping and interacting. Encourage to express feelings appropriately.</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 - Few</p>	<p>A progress note dated March 9, 2023 revealed that staff reported at approximately 1: 30 p.m. that this resident slapped another female resident in his room. The residents were separated immediately, and this resident was put on fifteen-minute checks. The Sheriff's Department was notified, case number #230309188. This resident was moved to the 600 unit at 2:30 p.m.</p> <p>A progress note dated March 10, 2023 revealed that change of condition for monitoring mood and behaviors every shift for status post altercation with peer for three days.</p> <p>Review of the five-day investigation dated March 16, 2023 revealed that a licensed nursing assistant (LNA/staff #302) was in the soiled utility room and heard resident #148 yelling. She ran towards the room and heard a slap. Another CNA was already in the room and she assisted her with separating the residents and removed resident #170 from resident 148's room. (LNA/staff #301) was assisting another resident in the hall and heard resident #148 yelling at someone. As she approached the residents, she witnessed resident #148 slap resident #170 across the face. She immediately separated the residents and called for assistance. Another LNA was there and helped to remove resident #170 from resident #148's room.</p> <p>An interview was conducted on June 18, 2025 at 10:30 a.m. with a licensed practical nurse (LPN/staff #7), who stated that interviews are always conducted when an incident occurs. She stated that it is her expectation that abuse should not occur and there is a risk of physical or emotional injury.</p> <p>An interview was conducted on June 19, 2025 at 8:32 a.m. with the Director of Nursing (DON/staff #51), who stated that all staff receive training on abuse. She stated that all their residents have behaviors, so resident to resident altercations can occur. She stated that the behaviors for each resident would be his/her behavioral care plan and staff have access to the care plans. She stated that the public areas (dining room and hallway) on the secured units must be monitored so staff are aware of what is going on with the residents. She stated that when the staff are monitoring the public areas, she expects the residents to be within the line of sight of the staff. She stated that staff are monitoring to make sure residents do not wander into other residents rooms.</p> <p>(continued on next page)</p>		

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The MDS indicated that the resident experienced verbal behavioral symptoms directed at others (e.g., threatening others, screaming at others, and cursing at others).The resident's care plan dated 7/10/2024 revealed potential for problems related to psychosocial well-being regarding a recent incident in the building, grief related to the death of his brother, risk of re-traumatization due to post-traumatic stress disorder (PTSD) related to military service, behavioral disturbances with 5 altercations occurring on 5/2/2024, 9/22/2023, 7/27/2023, 3/9/2023 and 11/8/2022. Interventions to address these problems included emotional support, calm reassurance, 15-minute checks, move to high acuity unit, psychiatric evaluation, and medication administration as ordered. A room move consent was identified, showing the resident was moved from room [ROOM NUMBER]-A to room [ROOM NUMBER]-14 A, and received 15-minute checks by facility staff. A review of the electronic health record confirms these checks were conducted and recorded in the tasks section of the electronic health record.A psychiatric evaluation was conducted on 5/23/24 that noted continuing hallucinations that led the resident to be verbally aggressive. No progress notes related to the incident were identified in the electronic health record. - Resident # 2 Resident # 125 was admitted on [DATE] with a diagnosis of unspecified dementia, unspecified severity with agitation, brief psychotic disorder, and other generalized epilepsy and epileptic syndromes, intractable without status epilepticus. He was discharged from the facility on 4/17/2025.The quarterly MDS dated [DATE] revealed a BIMS score of 03, indicating severe cognitive impairment. The PHQ-2 revealed a score of 00, indicating no mood disturbance. Behavioral symptoms identified in the MDS included the presence of delusions, physical symptoms directed towards others, rejection/refusal of care, and wandering.The resident's care plan initiated on 1/04/2024 indicated that the resident was placed in a secured behavioral health unit and that he was at risk for cognitive function/dementia or impaired thought processes, behavioral disturbances which included delusions, exit seeking, physical aggression, medication and treatment refusals, paranoid delusions and verbal aggression related to traumatic brain injury (TBI) and dementia.No progress notes related to the incident were identified in the electronic health record.Emergency Department triage notes from the hospital, dated 5/3/2024 at 01:33 A.M., revealed the resident presented with a chief complaint that while at the care facility, he was punched in the face and fell on a chair, hitting his left anterior ribs. Reported symptoms included pain with breathing. Resident # 125 was noted to have bruises to the left anterior ribs and left eye. Emergency department physician notes revealed that the resident apparently got into a fist fight with another resident. The resident was noted to have a bandage on the left cheek, but when removed, no abrasion or laceration was present. The physician's notes indicated that resident # 125's step-daughter and medical power of attorney was contacted and confirmed that the resident's current cognitive status is that of oriented to self only, which was his baseline.Diagnostic evaluation at the hospital included a CT scan of the head/brain and maxillofacial areas that revealed no acute findings. The resident returned to the facility, and the electronic health record identified that neurological checks were completed from 5/2/2024 to 5/5/2024.A review of the facility's 5-day investigative report dated 5/9/2024 indicated that Resident # 148 and Resident # 125 were in the dining room for an activity on 5/2/2024 when Resident # 148 became verbally escalated and an altercation occurred, Resident # 148 and Resident #125 were immediately separated, and care was provided to both residents. The report indicated that neither resident recalls the incident. The report indicated that the facility provided skin checks for both residents. The facility notified physicians and emergency contacts/decision makers for both residents, and Resident #125 was transported to the hospital for evaluation and treatment. Additional interventions following the altercation revealed that Resident # 148 was moved to an alternate behavioral health unit, had a psychiatric evaluation initiated, and received medication adjustments. The facility provided staff education on de-escalation techniques.A request for the incident report related to the altercation was addressed by the facility providing an additional copy of the facility's 5-day investigative report dated 5/9/2024. An interview was conducted on 6/18/2025 at 10:25 A M with staff</p>		

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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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</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  06/21/2025
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record reviews, facility documentation, interviews, and facility policies, the facility failed to ensure that medications were administered as ordered by the physician for one resident (#10). The deficient practice could result medication errors and uncontrolled pain for the residents. Findings include: On March 28, 2024 the facility implemented a Quality Improvement Plan (QIP) regarding medications administered outside of parameters. The plan included inservice/education with the nursing team on medication administration, and weekly random review of the medication administration record to verify pain medications are administered per physician orders. The QIP was reviewed by the CQI committee on June 20, 2024, August 23, 2024, November 5, 2024, January 20, 2025, and May 25, 2025. On January 16, 2024, all nursing staff received in-service training regarding medication administration per parameters, pain documentation. Another in-service was conducted on March 5, 2025 regarding narcotics. Following this, on March 29, 2024 an in-service was conducted regarding medication count, narcotic waste and medication errors. Further in-services were provided to nursing staff regarding medication parameters on April 18, 2024. On May 16, 2024 an in-service was provided to nursing regarding pain medications, pain scales and again on June 20, 2024 regarding pain scales and parameters. The facility provided a daily/weekly/monthly compliance audit dated May 2024 regarding medication administration. A monthly nursing meeting conducted on August 24, 2024 for nursing staff was conducted regarding parameters and completing follow-up notes. Further nursing staff in-services were conducted January 6, 2025 for narcotics forms, and on March 20, 2025 regarding medication parameters. -Regarding Resident #10 Resident #10 was admitted on [DATE] with diagnosis including hypertension, spinal stenosis, polymyalgia rheumatica, cognitive communication deficit and muscle weakness. The resident was discharged from the facility on May 19, 2024. A review of the admission MDS (minimum data set) dated March 12, 2024 revealed a BIMS (brief interview of mental status) score of 13, indicating that the resident was cognitively intact. The MDS further revealed the resident was on antidepressant, anticoagulant, opioid, and antiplatelet medications as well as injections. A review of the physician orders revealed an order for oxycodone HCl oral tablet 5 milligrams, 1 tablet by mouth every 4 hours as needed for pain level 5-10. An order for tramadol HCl oral tablet 50 milligrams, 1 tablet by mouth every 8 hours as needed for pain level 1-4. A review of the MAR (medication administration record) revealed that tramadol HCl 50 milligrams for pain level of 7 on the following dates in 2025: April 6, April 7, April 15 and April 20. Tramadol HCl 50 milligrams was administered twice for a pain level of 8 on April 11 and April 18, 2025; however, the orders indicated that tramadol is to administered for pain level of 1-4. A review of the care plan initiated on April 5, 2024 revealed that the resident had both acute and chronic pain due to chronic neck and back pain. The intervention included that pain relief should be anticipated and that there should be an immediate response to any complaint of pain. Additionally, the care plan noted to follow the pain scale as ordered. An interview was conducted on June 18, 2025 at 11:17 A.M. with certified nursing assistant (CNA/ Staff #132). Staff #132 stated that if she sees or is advised of a resident being in pain, she would ask where the pain is and attempt to make the resident more comfortable. Staff #132 stated if a resident is non-verbal she would look for signs such as grimaces, guarding or over body language that is different from their baseline. She stated that in addition to identifying, locating and assisting with non-pharmaceutical approaches, she would alert the nurse. An interview was conducted on June 18, 2025 at 11:20 A.M. with licensed practical nurse (LPN/Staff #152). Staff #152 stated that if a resident were to present with pain, she would ask where the pain was, how long it had been going on, what it felt like, and what the pain rating was. She stated that she would look in the record to see what orders were in place, administer medication according to the orders, follow-up within an hour and document the effectiveness of the medication. She stated that she would always start with the medication as ordered but if it was not effective, she would reach out to the doctor to see what course of action they wanted to take. The LPN stated that if the pain level exceeded the medication administered and administered outside of parameters then this would not be following physician's orders and the risk to the resident would be that their pain would not be controlled and it may impact the mental well-being of the resident. An interview was conducted on June 18, 2025 at 12:09 P. M. with LPN, staff #377. The LPN stated that he only worked at the facility for about 10 weeks. He stated that if a resident had reported pain, he would assess the pain level, see what's on record and administer the medication and document it in the record. Staff #377 stated that the resident has a right to refuse a</p>		