STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035070	A. Building B. Wing	04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casas Adobes Post Acute Rehab Center	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, staff and resident interviews, review of facility documentation, and review of facility's policy and procedures, the facility failed to protect the resident's right to be free from physical abuse by another resident for two of the four sampled residents (#2 and #3). The deficient practice could result in placing residents at risk for physical harm, injury and psychological distress.Findings Include: Regarding Resident #2: Resident #2 was admitted on [DATE], with a diagnosis that included metabolic encephalopathy, vascular dementia, major depressive disorder, anxiety disorder, cerebral infarction, hearing loss, and respiratory failure.A quarterly Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 03, indicating he was severely cognitively impaired.A care plan revised on March 2, 2026 identified behavioral disturbances including yelling/screaming, using abusive language, threatening behaviors, physical aggression, pushing, punching, exit seeking, delusional thoughts, paranoia, spitting food, refusing care related to dementia/ a cerebrovascular accident. Interventions included March 02, 2026, Labs and Urinalysis ordered, psych provider to visit this week and placement in a separate unit in a secured hall for behaviors. Monitoring for psychosocial needs. A nursing note dated March 02, 2026, at 12:59 PM revealed that at approximately12:45 PM, Resident #2 was in the dining room, in a self-propelling wheelchair when Resident #2 bumped Resident #3's chair. The note revealed Resident #3 turned and asked Resident #2 what he was doing. Resident #2 then opened his hand and made contact with Resident #3 on the side of the face. Resident #3 reported that Resident #2 startled him and responded by making contact with Resident #2's right side of the face with an open hand as well. Resident #2 was wearing glasses at the time of the incident. Both residents were separated immediately, and skin checks were completed for both residents. A Sitter was placed for Resident #2, and both residents were placed on 15-minute checks. Both residents were moved to different units. Family was notified of Resident #2, the Department of Health Services, Adult Protective Services, the provider was notified, and law enforcement. A weekly skin evaluation dated March 2, 2026, revealed a skin tear on the right elbow. An IDT (Interdisciplinary Team) note dated March 3, 2026, at 10:13 AM, revealed IDT team met to review an incident on March 02, 2026, of an altercation with another resident. An interview was conducted on April 14, 2026, at 1:53 PM with Resident #2, who was unable to follow through, resulting in an unsuccessful interview. Regarding Resident #3: Resident #3 was admitted on [DATE], with a diagnosis that included adjustment disorder, bipolar disorder, anxiety disorder, schizoaffective disorder, and epilepsy. A quarterly Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating Resident #3 was cognitively intact. A care plan revised on March 02, 2026 identified behavioral disturbances including poor impulse control, verbally aggressive to staff, 2 of 2 Traumatic Brain Injury (TBI), impulse control. Interventions included for March 02, 2026: Labs, urinalysis, and a psych provider consult were placed. Monitor for an increase in anxiety and psychosocial needs. Assess and anticipate the resident's needs: food, thirst. toileting needs, comfort level, body positioning, and pain. Document observed behavior and attempted interventions. Give as many choices as possible about care and activities. Modify (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035070	A. Building B. Wing	04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casas Adobes Post Acute Rehab Center	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	environment: Adjust room temperature to a comfortable level, reduce noise, dim lights, place familiar objects in the room, keep the door closed, etc.) Monitor/document/report to the medical doctor of danger to self and others. Place a checklist of frequently needed items to remind [NAME] and staff to review prior to staff exiting the room. Psychiatric/Psychogeriatric consult as indicated. When becomes agitated: Guide away from the source of distress; Engage calmly in conversation; If the response is aggressive, staff should walk calmly away, and approach later. A nursing note dated March 02, 2026, at 5:07 PM documented resident #3 had resident to resident altercation with resident #2. An IDT note dated March 3, 2026, at 10:20 AM, revealed the IDT team met to review the incident on March 02, 2026, of an altercation with another resident. Resident #3 resides in a secured Behavioral unit. Diagnosis: Adjustment disorder, Bipolar, Anxiety, Schizoaffective disorder, and Traumatic brain injury. All notes and event reviewed in detail. Both residents were immediately separated. The Resident #2 was placed on one-on-one and relocated to another unit. Resident #3 was placed on 15min checks for 24 hours. Labs, urinalysis, and a psych follow-up were ordered. Resident #3 was able to recall the event and is very apologetic. It was caused by impulse, and he is working hard on that. There were no events that occurred since admission. Resident #3 will be continually monitored for all the psychosocial needs. In the IDT meeting, the Director of Nursing (DON), Assistant Director of Nursing (ADON), Charge Nurse, Activities Director, and Case Managers were present. A review of the skin Evaluation dated March 02, 2026, revealed no new skin noted. An interview was conducted on April 14, 2026, at 1:21 PM with Licensed Practical Nurse (LPN/Staff #1), who stated that she had witnessed part of a resident-to-resident altercation between Resident #2 and Resident #3. She stated this happened when she was charting on the computer. When she looked away from the computer, she witnessed Resident #3 striking out at Resident #2 in the dining room, and then she immediately got up and took Resident #2 away into a separate room and made sure he was okay. She did a skin check on Resident #2, where she found a mark over his eyebrows on the right side. She cleaned it up and put steri-strips on that injury. Staff #1 stated that when she checked Resident #3, she did not find any injuries. An interview was conducted on April 14, 2026, at 1:59 PM with Resident #3, who stated that somebody hit him in the face, and then he back-handed him and slapped him automatically. He further stated he did not mean to hit the other resident and stated he feels safe at the facility. An interview was conducted on April 14, 2026, at 2:08 PM with Certified Nursing Assistant (CNA/ staff #2), who stated that she had heard that Resident #2 and Resident #3 were involved in an altercation with each other, and she heard that both Residents were in the dining room, where Resident #2 was moving his wheelchair back and forth, and he bumped into Resident #3's wheelchair. This is when Resident #3 struck Resident #2. She stated that the activities personnel and the nurse separated them immediately. An interview was conducted on April 14, 2026, at 3:18 PM with the Activities Aide (Staff #3), who stated that there was a resident-to-resident altercation between Resident #2 and Resident #3. He stated that he witnessed Resident #2 accidentally bumped into Resident #3's wheelchair and they both made contact, then Resident #3 slapped Resident #2's face, and this happened while he was passing out snacks in the dining room. He further stated that Resident #2 probably hit Resident #3, which he did not observe, but that was what Resident #3 stated. The activities aide stated that after the incident, they were immediately separated from the situation and sent to different rooms. An interview was conducted on April 14, 2026, at approximately 3:25 PM, with the DON (Staff #5), who stated that there was a physical altercation between Resident #2 and Resident #3 in the dining room. She stated that Resident #3 was leaving the dining room when he bumped into Resident #2's wheelchair, which bumped into his chair. Resident #3 turned around, raised his voice, and Resident #3 made contact with Resident #2's face. Resident #2 was wearing glasses, and the glasses bumped into his eyes after Resident #3 made contact with his face, leaving him with a skin tear on his right eyebrow. She stated that physical abuse occurred, which did not meet her expectations or the facility's expectations. A Policy titled Abuse: Prevention of and Prohibition Against was revised in April 2025, revealing that each resident has the right to be free from abuse, neglect, misappropriation of resident property, exploitation, and mistreatment.