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	03/28/2024

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** 48932 Based on closed record review, staff interview, and review of the facilitydocumentation, policies and procedures, the facility failed to protect the rights of 3 residents (#92, #71, and #1) to be free from abuse of another (#117 and #460). The deficient practice could result in residents not protected from further abuse. Findings include: Regarding resident #92 and #117 -Resident #92 was admitted on [DATE] with diagnoses of major depressive disorder, Stage 3 kidney disease, and a history of strokes. The annual MDS (Minimum Data Set) assessment dated [DATE] included a BIMS (Brief Interview for Mental Status) score of 13 indicating the resident was cognitively intact. A review of the electronic health record revealed that on July 19, 2023 resident #117 pulled the hair of resident #92 who then pulled the hair of resident #117. The documentation included that both residents were separated and placed on 15 minute checks; and, resident #117 was moved to a different room. 49199 Based on closed record review, staff interview, and review of the facility documentation, policies and procedures, the facility failed to protect the rights of two residents (#71) to be free from abuse of another. The deficient practice could result in residents not protected from further abuse. Findings include: Regarding resident #71 Resident #71 was admitted to the facility on [DATE] with a diagnosis of dementia. The second Resident involved in the incident has passed away. (continued on next page)

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 03/28/2024
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MDS (Minimum Data Set) assessment revealed a BIMS (Brief Interview for Mental Status) revealed a score of 06 which indicated the resident had severe cognitive impairment. Review of the clinical record revealed that on July 27, 2023 at 5:45 p.m., yelling was heard from the room of resident #71 and his roommate. Per the documentation, when staff entered the room resident #71 was on the floor and his roommate was standing next to him; and that, resident #71 was yelling, holding the wrist and leg of the roommate, and was hitting at the roommate. The documentation also included that staff immediately seperated both residents and resident #71 was moved to a new room the same day of the incident. 49325 Regarding Resident # 1 and # 460: -Resident # 1 was admitted on [DATE] with diagnoses of Alzheimer's Disease, cognitive communication deficit, major depressive disorder, and unspecified psychosis. The care-plan initiated July 25, 2022 revealed interventions that included staff will assign seating away from other residents when agitated during meal times. A review of the quarterly MDS (minimum data set) assessment dated [DATE] revealed a BIMS (brief interview of mental status) score of 2, indicating resident had severe cognitive impairment. A review of the electronic medical records revealed that on August 11, 2023 at 10:50 a.m., resident # 1 entered the dining room and saw resident #460 sitting in her favorite spot. Per the documentation, resident #1 asked resident #460 to move and as resident #460 was getting up, both residents started having a verbal altercation. The documentation also included that as staff were intervening, resident #1 bumped resident #460 with her walker and resident #460 attempted to push the walker back into Resident #1. Per the documentation, staff were physically in between both residents. -Resident # 460 was admitted to the facility on [DATE] with diagnoses that included dementia, post-traumatic stress disorder, and Alzheimer's disease. Review of the MDS assessment dated [DATE] revealed Resident #460 was not assessed for a BIMS score. A review of the facility investigation dated August 18, 2023 revealed that both resident (#1 and #460) were both on a secured behavioral unit when staff reported that resident #1 walked into the dining room and resident #460 was sitting in a chair that resident #1 wanted. The report also included that resident #1 began to push her walker into Resident #460; staff witnessed the incident and immediately intervened and no injuries were noted to either resident. An interview was conducted on March 26, 2024 at 11:54 AM with behavioral health unit manager (BHUM/staff # 52) who stated that staff receive abuse in-service trainings. Staff # 52 initially stated she was not sure of how soon it was reported, although later detailed it should be right away because they have a 2-hour window. Staff # 52 stated that the first thing staff do was to ensure both residents were safe during a physical altercation as resident safety comes first. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with certified nursing assistant (CNA/staff #138) conducted on March 27, 2024 at 11:44 a.m., the CNA stated that facility incorporates in-service training on abuse; and, the abuse protocol was to notify the nurse as soon as possible and make sure residents were safe. The CNA said that she was familiar with resident #1; but, she was not familiar with resident # 460 or any altercation between the two residents. An interview was conducted on March 27, 2024 at 2:35 p.m. with registered nurse (RN/staff # 49) who stated that if at any time a resident to resident make physical contact, this incident is reported. The RN said that the physical contact does not have to be purposeful to be reportable; and that, comes first. The RN further stated that residents were removed and placed on 15-minute checks whenever physical abuse was suspected. During an interview with the Director of Nursing (DON/Staff # 51) conducted on March 28, 2024 at 11:40 a.m. , the DON stated that during a resident to resident altercation, the residents involved were separated and assessed for any injuries. Further, the DON said that the facility expectations on abuse was that residents were free from abuse. Review of the facility's Policy titled, Abuse: Prevention of and Prohibition Against (revised October 2023) revealed, it is the policy of this facility that each resident has the right to be free from abuse. The facility will provide oversight and monitoring to ensure 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. Policy defines abuse as willful infliction of injury, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Will, as used in this definition of abuse, means the individual must have acted deliberately. Furthermore, policy revealed that physical abuse includes but is not limited to hitting, slapping, pinching, and kicking. The facility will act to protect and prevent abuse and neglect from occurring with the facility by identifying, correcting and intervening in situations in which abuse is more likely to occur.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident’s assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49325 Based on clinical record reviews, staff interviews, the Resident Assessment Instrument (RAI) manual, and facility policies, the facility failed to develop and complete a quarterly Minimum Data Set (MDS) assessment within the required timeframe for one resident (#47). The deficient practice could result in delayed identification of potential risks and care needs of the resident. Findings include: Resident # 47 was admitted on [DATE] with diagnoses of dementia, Parkinson's Disease, and peripheral vascular disease. The admission MDS (Minimum Data Set) revealed that it was completed on November 16, 2023. Review of the clinical record revealed no evidence that a quarterly MDS assessments were completed after November 16, 2023. In an interview with MDS Coordinator (Staff # 91) conducted on March 28, 2024 at 12:50 p.m., The MDS coordinator stated that all residents should have a quarterly MDS Assessment completed to meet facility expectations regardless to what the resident had for an insurance. During the interview, a review of the electronic clinical record was conducted with the MDS coordinator who stated that a quarterly MDS assessment for resident #47 was missing and not done on time. The MDS coordinator stated that when a quarterly MDS Assessment is not completed, it is unknown whether the resident had changes in their status or if facility was able to meet the needs of the resident. The MDS coordinator stated that the resident should have come up on the schedule for an assessment; but it appeared that the schedule for this resident was cleared and did not appear on the scheduler. The MDS coordinator then proceeded to initiate a quarterly MDS dated [DATE] and stated that the quarterly assessment can still be completed but it would not be timely. An interview was conducted on March 28, 2024 at 1:23 p.m. with the Director of Nursing (DON/Staff # 51) who stated that not having a quarterly MDS Assessment completed would not meet facility expectations. During the interview, a review of the electronic record was conducted with the DON who stated that the quarterly MDS assessment for resident #47 was missing and it should have been completed in the month of February to meet facility expectations. Review of the facility's Policy titled, Resident Assessment - Accuracy of Assessment (MDS 3.0), reviewed May 2023, revealed it is the policy of this facility to ensure that the assessment accurately reflect the resident's status. The physical, mental, and psychosocial conditions of the resident determine the appropriate level of involvement of physicians, nurses, rehabilitation therapists, activities professionals, medial social workers, dieticians, and other professionals in assessing the resident and in correcting resident assessments. Involvement of other disciplines is dependent upon resident status and needs. (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Policy titled, Resident Assessment - Assessments, Frequency of, (revised May 2021) revealed, it is the policy of this facility that resident assessments shall be developed and reviewed on a timely basis, based on resident condition and RAI guidelines. The interdisciplinary team will document resident assessments and reviews at least quarterly. Review of the RAI manual dated October 2019 revealed that the primary purpose of the MDS assessment tool is to identify resident care problems that are addressed in an individualized care plan. The Quarterly ARD date is no later than the ARD of the previous OBRA assessment + 92 days and the completion date is no later than the ARD + 14 calendar days.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48932 Based on clinical record review, staff interviews, observation of current facility practice and review of the facility's policies, the facility failed to ensure controlled medications were provided and accounted for in accordance with professional standards for 4 residents (#52, #358, #27) The deficient practice could result in diversion of resident medication. Findings include: -Resident #52 was admitted to the facility on [DATE] with diagnoses that included cognitive communication deficit, rheumatoid arthritis, morbid obesity, and bipolar disorder. The quarterly Minimum Data Set (MDS), dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident is cognitively intact. The MDS also revealed resident #52 was on a scheduled pain regimen and also received pain medications as needed. Review of the current physician order recap revealed Oxycodone-Acetaminophen (narcotic) 5-325 milligrams (mg) every 8 hours for chronic rheumatoid arthritis. Further review of the clinical record revealed that this order was transcribed onto the MAR (medication administration record); and, the MAR revealed that this medication were documented as administered as ordered. - Resident #358, they were admitted to the facility on [DATE] with diagnoses that included Cervical Disc Disorder with Myelopathy, muscle weakness, and partial paralysis. The resident was discharged from the facility on February 27, 2024. The quarterly Minimum Data Set (MDS), dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated the resident was moderately cognitively impaired. The MDS also revealed resident #358 was on a scheduled pain regimen and also received pain medications as needed. The current physician order recap revealed Hydrocodone-Acetaminophen (narcotic) 5-325 milligrams (mg) every 6 hours as needed (PRN) for pain rated 7 though 10. A review of the February 2024 MAR revealed Hydrocodone-Acetaminophen was not administered as ordered on the evening of February 4, 2024. The controlled drug record for February 2024 revealed that on February 5, 2024 one tab of Hydrocodone-Acetaminophen was wasted at 5:00 a.m. and 5:00 p.m. The 5:00 a.m. entry had a note written as wasted and was signed by a nurse (staff #194). However, the 5:00 p.m. entry was not signed. -Resident #27, they were admitted to the facility on [DATE] with diagnoses that included paraplegia, Post Traumatic Stress Disorder (PTSD), and a personal history of transient ischemic attack. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The annual Minimum Data Set (MDS), dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated the resident was cognitively intact. The MDS also revealed resident #27 did not have a scheduled pain regimen but did receive pain medications as a PRN. Resident #27's medication orders revealed they were prescribed Tramadol HCI 50 mg tablet and were to take two tablets by mouth every six hours as needed for pain rated 5 through 10. February MAR revealed there was no tramadol given to the resident during the evening of February 4, 2024 or in the early morning of February 5, 2024. The same MAR did indicate two tablets of tramadol were administered at 8:10 AM on February 5, 2024 by staff #176. A review of the controlled drug record reveals three tablets of Tramadol was administered on February 4, 2024 at 2:00 AM by staff #194. An interview was conducted with a Licensed Practical Nurse (LPN/Staff #88) on March 27, 2024 at 8:24 AM. Staff #88 explained that when a controlled medication was to be wasted, there must be a second nurse observing the wasting of the medication. Staff #88 also indicated there was always a second nurse available at all times in the building; and that, they often get training throughout the year on controlled medication processes. An interview was conducted with LPN (staff #80) on March 27, 2023 at 8:44 AM. Staff #80 indicated that controlled medication administration should be done according to the resident's orders and if medications were to be wasted, a second nurse was needed to observe the process. Staff #80 also indicated that there was always a second nurse available in the building to waste medications and if a second nurse could not be found, a unit manager can assist. An interview was conducted with the Director of Nursing (DON/staff #51) on March 28, 2024 at 11:17 AM. When asked what the expectation of documenting the administration of controlled medications, staff #51 indicated the resident's orders must be followed and the documentation is done on the paper form and the electronic health record. When asked what the expectation of wasting controlled medications was. Staff #51 indicated that the nurses have a drug buster at the bottom of the medication carts. Medications must be wasted with another nurse present. Then staff #51 or the pharmacist would process the medications and label them accordingly for the United Parcel Service (UPS) pick-up. Staff #51 indicated the risks associated with controlled medications being wasted with one staff is that medications could be taken and abused by staff. A review of the facility policy titled Medication Administration indicated that controlled medications not administered to a resident must be destroyed in the presence of two licensed nurses and the disposal documented on the accountability record, on the line representing that dose. 49325 -Regarding Resident # 118 Resident # 118 was admitted into the facility on [DATE] with diagnoses that included type 2 diabetes mellitus, encephalopathy, and essential hypertension. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Care Plan initiated on January 26, 2024, concerning diabetes mellitus, revealed will receive diabetes medication as ordered by doctor. Review of the physician order with a start date of January 19, 2024 revealed an order for Lantus Subcutaneous Solution 100 Unit/Milliliter (Insulin Glargine) Inject 25 unit subcutaneously one time a day for Diabetes Mellitus hold if fasting blood sugar less than 110. Review of Medication Administration Records (MAR) February 2024 revealed that this medication was administered outside of the physician ordered parameters (hold if fasting blood sugar less than 110) on the following dates: -February 18 fasting blood sugar (FBS) 106 -February 21 FBS 106 - February 25, FBS 105 - March 4, FBS 106 -March 6, FBS 106 -March 17, FBS 109 -March 18, FBS 105 - March 25, FBS 109 The clinical record revealed no evidence why this was administered outside of the physician ordered parameters; and that, the physician was notified. An interview was conducted on March 28, 2024 at 03:12 PM with Registered Nurse (RN/Staff # 189) who stated medications are administered based on physician orders. Staff # 189 stated that high risk medications have parameters and if administered outside of parameters the nurse should communicate this to the doctor. Staff # 189 stated if the provider doesn't want us to administer glargine, if fasting blood sugar is less than 110, that is what the provider requested and we should be administering within ordered parameters. Staff # 189 stated with any medication given outside of the parameters there are risks. Staff # 189 stated administering Insulin Glargine outside of parameters may cause sugar levels to tank and drop too low. An interview was conducted on March 28, 2024 at 3:30 PM with the Director of Nursing (DON/Staff # 51) who stated following physician order is expected during med pass. Staff # 51 reviewed the medication administration records and progress notes regarding Insulin Glargine administration, and confirmed that there was a total of 8 administration of the medication outside of parameters. Staff # 51 stated if insulin is given outside of parameter when it is not required it may cause residents to experience lightheadedness, dizziness, and become diaphoretic. Staff # 51 stated that the administration of Insulin Glargine outside of parameters did not meet facility's expectations. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's Policy titled, Physician Orders (revised May 2023) revealed, it is the policy of this facility to accurately implement orders in addition to medication orders (treatment, procedures) only upon the order of a person duly licensed and authorized to do so in accordance with the resident's plan of care. It is the policy of this facility that drugs shall be administered only upon the order of a person duly licensed and authorized to prescribe such drugs. No drugs and biological orders shall be written, dated, and signed by the person lawfully authorized to give such an order. Review of the facility's Policy titled, Medication Administration - Oral (revised May 2022) revealed, it is the policy of this facility to accurately prepare, administer and document oral medications. Any irregularity in pouring or administering must be reported to the doctor. If there is any question in regard to dosage, the person in doubt should not give the drug until obtaining information which clarifies drug dosage. Review of the facility's Policy titled, Controlled Medications (revised June 2023) revealed, the Director of Nursing Services and the consultant pharmacist maintain the facility's compliance with federal and state laws and regulations in the handling of controlled medications. A controlled medication accountability record is prepared when receiving or checking in a Schedule II, III, IV, or V medication. When a controlled medication is administered, the licensed nurse administering the medication immediately enters all of the following information on the accountability record: date and time of administration, amount administered, signature of the nurse administering the dose, completed after the medication is actually administered. When a dose of controlled medication is removed from the container for administration but refused by the resident or not given for any reason, it is not placed back in the container. It must be destroyed in the presence of two licensed nurses and the disposal documented on the accountability record. At each shift change, a physical inventory of all controlled medications is conducted by two licensed nurses and is documented on an audit record. Any discrepancy in controlled substance medication counts is reported to the Director or Nursing Services immediately.

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F 0689

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 42319

Based on observation, staff and resident interviews, and facility policy, the facility failed to ensure that one resident (#124) was free from accident hazards. The deficient practice could result in resident not taking their needed medications as prescribed and other residents gaining access to and taking the medications.

Findings include:

Resident #124 was admitted on [DATE] with diagnoses of dementia, bipolar disorder, and cognitive communication deficit.

Review of this resident's care plan included that the resident was admitted to a secured behavior health unit for psychosis, mood disorder and dementia. This care plan also included that this resident has poor safety awareness.

A physician's order dated 2/7/24 included glipizide (hypoglycemic) Oral Tablet 10 mg (milligrams) give 2 tablets by mouth in the morning for Diabetes Mellitus II.

A physician's order dated 3/5/234 included seroquel (antipsychotic) Give 50 mg by mouth two times a day for bipolar disorder as evidenced by auditory hallucinations

A physician's order dated 11/16/23 included depakote sprinkles delayed release 125 mg (antiseizure) give 250 mg by mouth every 8 hours for Bipolar disorder as evidenced by labile mood

A physician's order dated 10/17/23 included metformin (anti-diabetic) 1000 mg give 1 tablet by mouth two times a day for Diabetes Mellitus II.

However, review of the physician's orders did not include an order for self-administration.

An observation was conducted on 3/25/24 at 9:49 A.M. of resident #124's bedside table which included a cup which contained: 2 tablets marked APO glp 10 (glipizide), 1 tablet marked white round 337 (Quetiapine Fumarate), 2 capsules which were blue and white marked 125 (Divalproex), and a white oval tablet marked g12 (Metformin).

An interview was conducted on 3/28/24 at 9:45 A.M. with a Licensed Practical Nurse (LPN/staff #180) who said that when administering medications, you look at computer verify meds, check resident name, the 5 rights, and then you watch them take their meds. This nurse said it is not ok to leave a cup of pills at the bedside.

An interview was conducted on 03/28/24 at 1:31 P.M. with a Certified Nursing Assistant (CNA/staff #172) who said that the nurses usually stay with this resident when she takes her pills but that she has found pills on the resident's bedside table before.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 03/28/24 at 1:35 P.M. with an LPN (staff #108) who said that this resident was not ok to take meds on her own but that she's pretty good about it. She said that nurses should make sure she takes her medication. An interview was conducted on 03/28/24 at 4:15 P.M. with the Director of Nursing (DON/staff #51) who said that her expectation for medication administration was that staff would confirm the right resident, the right medication and the other rights, offer the medication to the patient and then watch the patient and document the administration or refusal. She said that medications left on the bedside table do not meet her expectation and that the facility had identified that issue and had started a QAPI which included assessing patients that wanted to be self administering and to let those patients who could not know that they could not leave the medications at bedside. This DON included that the nurses were educated as well. A policy titled Medication Administration - Oral, revised 5/22, revealed that it is the policy of this facility to accurately prepare, administer and document oral medications. This policy included that the person administering medication must remain with the resident until all medication has been swallowed.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47911 Based on clinical record review, interviews, and facility policy, the facility failed to ensure one resident (#84) received safe monitoring of vital signs, to include weights. The deficient practice could result in the potential for complications and the resident not receiving appropriate care and treatment. Findings include: Resident #84 was admitted on [DATE] with diagnosis including end stage renal disease, type 2 diabetes, epilepsy, and major depressive disorder. A review of the MDS (minimum data set) dated March 09, 2024 revealed a BIMS (brief interview of mental status) score of 15, suggesting that the resident was cognitively intact. A review of the physician orders revealed an order dated March 21, 2024 noting that vitals and weights are to be taken before and after dialysis. Entries under the vitals section of the electronic health record revealed a weight loss of 41 pounds between the dates of March 13, 2024 and March 19, 2024. A subsequent weight gain of 20.4 pounds was noted for the time ranging from March 19, 2024 through March 27, 2024. An IDT (interdisciplinary team) notation on March 19, 2024 revealed an entry by staff #195 (dietetic technician, registered). The entry noted that there was significant weight loss in a one-week period and suggested a re-weigh for the resident; however, facility documentation did not reveal evidence of the resident having been re-weighed. An interview was conducted on March 27, 2024 at 11:02 AM with staff #80 LPN (licensed practical nurse). Staff #80 stated that as part of the assessment process for a resident on dialysis, vitals are taken, which include the resident's weight. She stated that when there is an issue with weights, either a dramatic weight gain or loss then the nurse manager would be notified. She stated that a weight change of 10 pounds or more would be cause for notification. An interview was conducted on March 27, 2023 at 11:05 AM with staff #153 CNA (certified nursing assistant). Staff #153 stated that CNA's are responsible for conducting the vitals. She stated that if she was monitoring a dialysis resident and observed any changes in weight that she would let the nurse know immediately. An interview was conducted on March 27, 2024 at 11:29 AM with staff #196 Nurse Manager. Staff #196 stated that weights are discussed on a weekly and emergent basis. She stated that if weight fluctuations were observed she would let the physician and the family know and review possible causes for the change in weight. She stated that Nurse Manager was in charge on tracking resident weights. An interview was conducted on March 27, 2024 at 11:51 AM with staff #174 LPN. Staff #174 stated that she felt a weight change of 5 pounds could be concerning and would alert the nurse manager of any chnage of 5 or more pounds. (continued on next page)

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	03/28/2024

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on March 27, 2024 at 12:00 PM with staff #49 Nurse Manger. Staff #49 stated that fluctuations in weight will always be there with dialysis patients, and stated that staff will weigh residents prior to dialysis and even though they are weighed at the dialysis center, staff would weigh the resident again upon return to the facility. She stated that if there were any abnormalities in weight, the provider would be notified. She stated that she had been the point person for tracking the weights but stated that now the dieticians are tracking weights. She reviewed the residents record and stated that the recent weights may have a documentation error. She stated that the resident should have been re-weighed based on the dramatic change in weight, but had not been. Staff #49 stated that anything over a 5-pound weight change should be actively monitored. An interview was conducted on March 28, 2024 at 10:21 AM with staff #166 DTR (dietetic technician, registered). She stated that there had recently been a transition from an external entity to internal monitoring of resident weights. She stated that monthly monitoring is conducted, but that weights are reviewed on a daily basis for all residents on dialysis. If there is a concern regarding a resident's weight, she stated that she would ask staff to re-weigh the resident. She stated that at times it is feasible to see up to a 30-pound change in weight for a dialysis resident, she stated, however, these should still be investigated. She reviewed the residents record and stated that a change in weight as noted, should be followed up on regardless, but had not been. She stated that the expectation would be to follow-up and monitor any weight changes of 5 pounds or more. She stated that the risk of not monitoring a resident's change in weight could impact the resident's health. An interview was conducted on March 28, 2024 at 10:52 AM with staff #51 DON (director of nursing). Staff #51 stated that vitals and weights are taken prior to dialysis and documented on a flow sheet. She stated that weight changes may be contingent on each individual resident and their overall condition. She stated that the expectation would be for any recommendation to reweigh a resident, due to potential weight fluctuations, would communicated, documented and monitored. She stated that facility will be working on a more robust process to include reviewing the IDT (interdisciplinary team) notes with the new medical director. She stated that her expectations are that residents are re-weighed if there is a greater than 5% weight change. She stated that the risk to the resident could include fluid overload, shortness of breath and the need for further evaluation. A review of the policy entitled weight, with a review date of 2023 revealed that the intent of the policy was to obtain an accurate weight as part of the resident's assessment. A review of the nutrition policy reviewed on July, 2023 revealed that any resident's weight that varies from the previous reporting period by 5% in 30 days would be evaluated by the interdisciplinary team to determine the cause of the weight loss/ gain, what interventions would be required and the need for further recommendations and / or referral. However, the record revealed that the weight loss had been identified by the IDT and the recommendation noted that the resident should be re-weighed, which did not transpire per review of the electronic health record and staff interviews.