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	05/22/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, and review of the facility's policies and procedures, the facility failed to ensure the Ombudsman's office was notified of the discharge of four residents (#150, #211, #215, and #217). The sample size was four. The deficient practice could lead to lack of post-discharge care coordination for residents.Findings Include: - Regarding Resident #217: Resident #217 was admitted on [DATE] with diagnoses that included fracture of the right lower leg, difficulty in walking, and polyneuropathy. Resident #217 was discharged on February 20, 2026. A care plan, initiated on February 8, 2026, revealed a focus for discharge to home with interventions that included coordination with the resident and the resident's family for plan of care and discharge planning. A Social Services Summary progress note, dated for February 9, 2026, revealed that the resident wanted to discharge home with her significant other. A Case Manager progress note, dated for February 17, 2026, revealed that the resident received a Notice of Medicare Non-Coverage (NOMNC) with a discharge date of February 20, 2026. A Case Manager progress note, dated February 18, 2026, revealed the resident submitted an appeal to the NOMNC provided, and the documents were uploaded in the resident chart. A Case Manager progress note, dated for February 20, 2026, revealed the resident lost the appeal and proceeded with planned discharge home. A Discharge Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The assessment also revealed that Resident #217 participated in discharge planning and had a planned discharge. There was no evidence in the resident's progress notes, dated February 2, 2026 through February 20, 2026, indicating that the facility had contacted the Ombudsman of the resident's discharge. Regarding Resident #150: Resident #150 was admitted to the facility on [DATE], with diagnoses that included fracture of the left femur, muscle weakness, major depressive disorder, and chronic kidney disease. (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	05/22/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an admission Minimum Data Set (MDS), dated [DATE], indicated Resident #150 participated in a Brief Interview for Mental Status (BIMS) assessment and scored a 15, indicating he was cognitively intact. Review of an order summary revealed a physician's order, dated May 12, 2026, which indicated the resident was to be transferred to the hospital. Review of a progress note, dated May 12, 2026 at 12:43 P.M. revealed Resident #150 was sent to the hospital, directly from an orthopedic appointment, for surgery. Further review of Resident #150's clinical record revealed no documentation indicating the Ombudsman's office was notified of the resident's transfer to the hospital. Regarding Resident #211: Resident #211 was admitted to the facility on [DATE], with diagnoses that included dementia, Chronic Obstructive Pulmonary Disease (COPD), and cognitive communication deficit. He was discharged on April 19, 2026. Review of a discharge MDS, dated [DATE], revealed that a BIMS assessment was not completed; however, the same MDS indicated the staff assessment of cognitive skills for daily decision-making was noted to be severely impaired. Review of a progress note, dated April 19, 2026 at 1:58 P.M., revealed Resident #211 exhibited an increase in confusion and was reaching out in the air with his hands. The note further revealed that a family member requested that Resident #211 be sent to the hospital due to the increased confusion and medication refusal. Review of a second progress note, dated April 19, 2026 at 7:45 P.M., revealed Resident #211 was sent to the hospital upon a family member's request. Further review of the clinical record revealed no documentation indicating the Ombudsman's office was notified of the resident's discharge to the hospital. Regarding Resident #215: Resident #215 was admitted to the facility on [DATE] with diagnoses that included COPD, interstitial pulmonary disease, suicidal ideations, and major depressive disorder. The resident was discharged on February 12, 2026. Review of a Medicare 5-day MDS, dated [DATE], indicated Resident #215 participated in a BIMS assessment and scored a 04, indicating she had severe cognitive impairment. Review of a physician's order revealed Resident #215 was to be transferred to another facility on February 12, 2026. Review of a progress note, dated February 12, 2026 at 6:31 P.M., revealed Resident #215 was discharged from the facility. (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	05/22/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the clinical record revealed the resident was discharged to another facility; however, there was no documentation indicating the Ombudsman's office was notified of the discharge. An e-mail received on May 21, 2026, at 7:50 P.M. from the facility's Ombudsman confirmed that the facility had not submitted transfer and discharge reports from October 2025 through April 2026, and noted that the transfer/discharge report was submitted to her that evening. An interview was conducted on May 22, 2026 at 10:21 A.M. with Social Services Manager (SSM/Staff #2). Staff #2 shared that her assistant had recently gone out on leave and that, during that time, the task of making notifications of resident transfers and discharges to the Ombudsman's office was not being completed. Staff #2 stated she discovered the error while conducting an audit of Ombudsman notifications the prior month. Staff #2 further stated that upon review of her emails, she found the last notification made to the Ombudsman was in September 2025. Staff #2 stated she contacted the Ombudsman on May 19, 2026, and provided a list of residents who were transferred or discharged in April 2026. Staff #2 acknowledged that residents could be at risk of not being informed of available resources post-discharge if the Ombudsman was not notified of transfers and discharges. An interview was conducted on May 22, 2206 at 10:29 A.M. with the Director of Nursing (DON/Staff #120). Staff #120 stated that transfer and discharge notifications to the Ombudsman's office was not completed from October 2025 until May 19, 2026. Staff #120 further stated that Staff #2 had sent the list of April transfers and discharges on May 19, 2026, and that on May 21, 2026, Staff #2 had sent the transfers and discharges list for October 2025 through March 2026. Staff #120 stated her expectation was that the resident transfer and discharge list was to be sent to the Ombudsman's office on a monthly basis. Staff #120 was not able to identify potential risks to residents if the Ombudsman is not notified of the transfers and discharges. She added that the Ombudsman is at the facility once a month for Resident Council meetings, and that she would be notified in person if there were issues with a resident's transfer or discharge; however, Staff #120 acknowledged that a formal notification to the Ombudsman was required. Review of the facility's policy and procedure titled Criteria for Transfer and Discharge, revised/reviewed in December 2023, revealed the policy required that transfers and discharges be documented in the clinical record; however, the policy contained no language regarding the notification to the Ombudsman's office of resident transfers and discharges.

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	05/22/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, interviews, and review of the facility's policies, the facility failed to ensure 1 of 35 residents (Resident #1) received oxygen therapy in accordance with a current physician's order. The deficient practice placed Resident #1 at risk for unmonitored and potentially unnecessary medical treatment.Findings include:Resident #1 was admitted to the facility on [DATE] with diagnoses including acute respiratory failure with hypoxia, type 2 diabetes mellitus with diabetic chronic kidney disease, and chronic pulmonary edema.Review of the admission Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 11 which indicated Resident #1 had moderate cognitive impairment. The same MDS indicated that Resident #1 was not experiencing shortness of breath but was on oxygen therapy.A physician's order, dated April 28, 2026, indicated Resident #1 was to have continuous oxygen at 2 liters per minute (lpm) via nasal cannula (NC). The order was subsequently discontinued on May 16, 2026 at 1:37 P.M. A secondary review of all current physician's orders confirmed no active orders for oxygen therapy was on file.On May 20, 2026, at 8:54 A.M., Resident #1 was observed in her bed with a NC in place and connected to an oxygen concentrator set at 2 lpm.A second observation of Resident #1 on May 20, 2026 at 1:32 P.M., confirmed Resident #1 remained in bed with her NC in place at 2 lpm. During this observation, Resident #1 stated that the oxygen helps her breathe better.An interview was conducted with a Certified Nursing Assistant (Staff #132/CNA) on May 20, 2026 at 1:54 P.M. Staff #132 shared that Resident #1 uses oxygen at 2 lpm and had used oxygen since admission.An interview was conducted with a Registered Nurse (Staff #301/RN) on May 20, 2026 at 1:59 P.M. Staff #301 shared that he was unaware of the facility's policy requiring a physician's order for a resident's oxygen use. He acknowledged that based on his experience, residents would typically need physician's orders to use supplemental oxygen. When asked if Resident #1 used oxygen, Staff #301 reviewed her clinical chart and shared that she did not use oxygen because there was no order for it. At 2:05 PM. Staff #301 and surveyor entered Resident #1's room and directly observed her using oxygen via a NC. Staff #301 then reviewed the clinical record a second time and confirmed there was no current order for oxygen use. He further stated he was unfamiliar with the facility's protocol regarding oxygen administration. An interview was conducted with a Licensed Practical Nurse Supervisor (Staff #103/LPN) on May 20, 2026 at 2:10 P.M. Staff #103 stated that residents are required to have physician's orders for oxygen use. Upon being taken to Resident #1's room, Staff #103 observed the resident using oxygen via a NC and stated that resident should have orders for its use. After reviewing Resident #1's clinical record, Staff #103 confirmed the resident did not have active orders for oxygen and stated it was not the facility's process to administer oxygen without current orders. Staff #103 added that Resident #1 did have orders for oxygen use; however, it was discontinued on May 16, 2026. Staff #103 stated that a resident receiving oxygen without a physician's order presents a risk of hypoxia. An interview was conducted with the Director of Nursing (Staff #120/DON) on May 20, 2026 at 2:22 P.M. Staff #120 stated that residents are required to have current physician's orders for oxygen use, as oxygen is considered a medication. While reviewing Resident #1's clinical record, Staff #120 noted that a new oxygen order had been entered that day at 2:22 P.M. by RN/Staff #233. Staff #120 confirmed the prior oxygen order had been discontinued on May 16, 2026, and stated she was not able to locate a progress documenting the clinical rationale for the discontinuation. Staff #120 further stated that she did not know whether a resident receiving oxygen without a current physician's order would result in an adverse reaction. An interview was conducted with Staff #233 on May 20, 2026 at 2:38 P.M. Staff #233 shared that she had entered the new oxygen orders for Resident #1 upon learning the resident was receiving oxygen without a current order. Staff #233 explained that Resident #1 was issued a Notice of Medicare Non-Coverage (NOMNC) and the therapy team had assessed the resident as no longer needing the oxygen, resulting in the discontinuation of the order. Staff #233 further explained (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	05/22/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 should have ceased oxygen use when the order was discontinued and noted the resident was scheduled for discharge from the facility on May 22, 2026.Review of the facility's policy and procedure titled Oxygen Administration, last reviewed in April 2026, indicated that oxygen therapy is to be administered as ordered by the physician.