STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035147	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Maria Post Acute and Rehabilitation	4310 East Grant Road Tucson, AZ 85712

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 - 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 clinical record review, staff interviews, facility documentation and policy review, the facility failed to protect the rights of one resident (#1) to be free from abuse by another resident (#2). The deficient practice could result in further resident abuse. Findings include: -Resident #1 was admitted on [DATE] with diagnoses of dementia, non-displaced bimalleolar fracture of the lower right leg, alcohol abuse, and type 2 diabetes. The resident's bed assignment in the electronic health record (EHR) revealed that the resident was moved to a different bed in a different unit on September 21, 2024. A 5-day MDS (Minimum Data Set) assessment dated [DATE] revealed a BIMS (Brief Interview for Mental Status) score of 14 indicating the resident had no cognitive impairment. The progress note dated on October 1, 2024 included that resident #1 saw and attempted to slap resident #2 who then stood up from his chair and struck resident #1. Per the documentation, both residents swung at each other several times before resident #1 fell to the ground and sustained a laceration on the right forehead. It also indicated that staff attempted to intervene but were unsuccessful; and, both residents were separated, 911 was called and resident #1 was transported to the hospital for further evaluation. The hospital after visit summary dated October 1, 2024 revealed that resident #1 received sutures for his laceration. -Resident #2 was admitted on [DATE] with diagnoses of cellulitis of the right upper limb, alcohol dependence, and acquired absence of left leg below the knee. The admission MDS assessment dated [DATE] included BIMS score of 15 indicating the resident had no cognitive impairment. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035147	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Maria Post Acute and Rehabilitation	4310 East Grant Road Tucson, AZ 85712

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 - Actual harm Residents Affected - Few	A progress note dated September 20, 2024 included that resident #2 was told by staff to lower the volume of his TV because his roommate (resident #1) reported that it was too loud. Per the documentation, resident #2 told staff that he was going to keep playing the TV at a loud volume until they moved his roommate (resident #1) out of his room. It also included that resident #2 was bothered by a situation that had occurred earlier in the day where his roommate (resident #1) had defecated on the floor of their shared room when on the way to the bathroom. The progress notes dated October 1, 2024 revealed that resident #2 was being escorted by two staff members due to being discharged to another facility. It also included that resident #2 had an altercation with another resident (#1) and that staff had attempted to intervene but were unsuccessful. Per the documentation, resident #2 told staff that he was defending himself because the other resident (#1) attacked him. The documentation also included that after the altercation with another resident (#1) was over, resident #2 was placed in an observation unit until the police department came to arrest him. An interview with central supply (staff #14) was conducted on October 3, 2024 at 1:49 p.m. The central supply staff stated that she and another staff (#8) were going down the main hallway when she saw resident #1 walking towards resident #2. She said that both residents then stopped and resident #1 had attempted to hit resident #2 but had missed. The central supply staff said that at this point, resident #2 stood up from his wheelchair and hit resident #1. She said that she placed her hand on the shoulder of resident #2 shoulder in an attempt to get him to sit down. She stated that once the altercation was over, a behavioral health technician (staff #8) sat with the resident in his room to ensure his safety; and later, she and staff #8 escorted resident #2 directly to another facility which was next door. In an interview with a Behavioral Health Tech. (BHT/staff #8) conducted on October 3, 2024 at 2:02 p.m., the BHT stated that he was going down the hallway and saw resident #1 standing up and was a little bit behind resident #2. The BHT said that resident #1 swung at resident #2 but had missed; and, resident #2 then stood up and punched resident #1. The BHT said that he and another staff (#8) attempted to separate both residents. He stated that after resident #1 fell to the ground, he and staff #8 were able to get resident #2 back into his wheelchair. An interview was conducted on October 3, 2024 at 2:13 p.m. with a Certified Nursing Assistant (CNA/staff #5) who stated that she was on her way into a resident's room when she heard resident #2 talking with other staff about a shower. Staff #5 indicated she then saw resident #1 slapped resident #2 who then stood up and hit resident #1. The CNA stated that she saw two other staff members (#14 and #8) attempted to separate both residents but resident #1 continued to go after resident #2. The CNA further stated that other nurses came to separate the two residents; and, she then went back to providing resident cares. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035147	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Maria Post Acute and Rehabilitation	4310 East Grant Road Tucson, AZ 85712

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 - Actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON/staff #11) conducted on October 3, 2024 at 2:19 p.m., the DON stated that since the incident on October 3, 2024 between residents #1 and #2, the facility had identified areas that could be improved upon such as additional de-escalation training for staff and implementing behavioral contractions. The DON said that the facility could have done a better job with establishing boundaries with new residents upon admission and the behavioral contracts outlines the expectations related to those boundaries. The DON said that both residents #1 and #2 had a history prior to the altercation as there was an issue when resident #1 was admitted on [DATE]. She stated that resident #2 was upset with resident #1 because resident #1 defecated on the floor of their shared room. The DON said that resident #1 was then moved to a different room because he felt threatened by resident #2. The DON said that staff ensures that both residents did not dine together, were not in activities together, and were not in the common areas together. The DON further stated that the two staff (#8 and #14) that escorted resident #2 on October 3, were not familiar with the resident's history with resident #1. The DON said that allowing residents who do not get along with each other cross paths with each other could result in one resident could provoke the other to have a negative reaction and it can cause an altercation to take place. The DON stated that the facility did not have any policy on de-escalation management with residents who are aggressive towards other residents. The facility policy on Resident Rights with last review date of June 2024 included that residents have a right to be free from physical abuse. A review of a policy on Abuse: Prevention of and Prohibition Against with revision date of November 2023, revealed that it is their policy that each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. The policy defined abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical, mental and psychosocial well-being. Willful, as used in this definition of abuse means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.