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	01/23/2026

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the interview, review of the clinical record, and review of facility policy and procedure, the facility failed to ensure PASSAR screening and referral were accurate and completed for 6residents (#3, #5, #9, #13, #21, and #55). This deficient practice can result in residents medically related social and emotional needs not being met. The sample size was 8. The census was 56. -Regarding Resident # 9 Resident # 9 was initially admitted to the facility on [DATE], and re-admitted on [DATE], with clinical diagnoses that included borderline personality disorder, post-traumatic stress disorder, chronic pain syndrome, insomnia, recurrent depressive disorders, other specified anxiety disorders, and factitious disorder imposed on self, with predominately physical signs and symptoms. A Pre-admission Screening and Resident Review (PASSR) dated May 1, 2025 from the discharging hospital, completed prior to admission, revealed the resident had no history of Serious Mental Illness (SMI), mental disorders or was prescribed any psychotropic (mental health) medications. The PASSR was marked no regarding 30 day convalescent. However, diagnoses including, borderline personality disorder, post-traumatic stress disorder, recurrent depressive disorders, other specified anxiety disorders, were not included on the PASSR. The clinical record revealed no evidence of a corrected PASRR that included borderline personality disorder, post-traumatic stress disorder, recurrent depressive disorders, other specified anxiety disorder. A care plan dated May 4, 2025 revealed the following areas of focus and discharge goals: Antidepressant medication use: revealed the use of antidepressant medication related to depression as evidenced by self-isolation, and inability to sleep. Anti-anxiety medication use, revealed the resident was to be given antianxiety medications for agitation and restlessness. Substance Use Disorder (SUD) care plan, revealed the resident was to be assisted with access to counseling and support groups to the fullest degree possible. The care plan discharge goals, identified the resident as a PASRR level 1, and included that arrangements were to be made with the required community resources to support independence post-discharge. A care plan focus of Post-Traumatic Stress Disorder (PTSD), initiated on May 6, 2025, revealed the (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff was to assist in the development of more appropriate methods of coping and interacting, and to conduct a psychiatric evaluation if indicated. A Social Services Assessment, dated May 8, 2025, identified the resident had a history of PTSD. An admission Minimum Data Set (MDS), dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating she was cognitively intact. The assessment included active diagnoses of anxiety disorder, depression, PTSD, and borderline personality disorder. The assessment also revealed the resident was taking antianxiety, and antidepressant therapy. A consultant psychiatric progress note, date of service May 13, 2025, revealed the resident was recommended to have Dialectical Behavior Therapy (DBT) upon availability for Borderline personality disorder. In addition, the progress note revealed the resident was admitted to the hospital for not feeling safe, after a roommate verbally threatened the resident at a previous facility. A consultant psychiatric progress note, with date of service May 20, 2025, the resident was seen again, for follow up of antidepressant medication changes during hospitalization, and a desire to return to previous primary care providers. A care plan focus regarding confabulation, and false accusation, initiated May 27, 2025, directed the staff to intervene as necessary to protect the rights and safety of others, and to provide Care in Pairs. A physician order listing, dated June 16, 2025 revealed orders dated May 19, 2025 included Topiramate 100 mg twice a day for borderline disorder, Venlafaxine HCL Extended Release 150 mg a day for depression, Hydroxyzine HCL 50 mg as needed for anxiety every eight hours, and Escitalopram Oxalate 10 mg daily for depression. A consultant psychiatric progress note, dated June 25, 2025, revealed the resident's medical and psychiatric illness would not allow the resident to be seen in an outpatient setting. The progress note also revealed the sole role of the psychiatric consultant was to only provide recommendations to the patient's primary care provider during their skilled stay in regards to the resident's psychiatric and mental health. A significant change in status MDS, dated [DATE], related to hospitalization, revealed no behavioral symptoms, and included active diagnoses of anxiety disorder, depression, PTSD, and borderline personality disorder. The assessment also revealed the resident was taking antianxiety, antidepressant, and anticonvulsant therapies. A Social Services Assessment, dated August 7, 2025, revealed the resident had a history of trauma. A consultant psychiatric progress note, dated August 19, 2025, revealed that the situational nature of the resident's depression related to facility concerns and room changes suggests that medication adjustments alone may have limited benefit. A PASSR dated September 24, 2025, completed prior to re-admission, revealed The PASRR revealed the admission met the criteria for 30day convalescent care. The PASRR was marked no regarding the history of Serious Mental Illness (SMI), mental disorders or was prescribed any psychotropic (mental health) medications, despite active diagnoses that included anxiety disorder, depression, PTSD, and (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	borderline personality disorder, and physician orders for antianxiety, antidepressant medications. Review of the Social Services Assessment, dated September 24, 2025, revealed the resident had a history of trauma. Review of the pre-admission History and Physical, dated September 29, 2025, revealed the resident had a history of anxiety states, depression with anxiety, borderline personality disorder, and a history of prescription drug abuse. Review of the PASSR, dated October 8, 2025, completed prior to re admission, revealed the resident met the criteria for 30-day Convalescent Care, and no regarding mental illness. Review of the psychiatric progress note, dated October 14, 2025, revealed the resident continued to experience anxiety when alone and expressed concerns about potentially getting a roommate again. Review of the Social Services Assessment, dated October 15, 2025, revealed a history of trauma that was identified from the prior assessment. Review of the significant change in status MDS, dated [DATE], revealed the resident presented no behavioral symptoms. The assessment included the resident had active diagnoses of anxiety, depression, PTSD, psychotic disorder (other than schizophrenia), borderline personality disorder, and factitious disorder. The assessment also revealed the resident was taking antidepressant therapy. Review of the psychiatric progress note, dated November 18, 2025, revealed the client continued to experience significant loneliness, along with frustration about her limited social support. The progress note documentation also revealed the resident experienced nightmares, sleep disturbances, and had a recent hospitalization related trauma (October 8, 2025). The progress note revealed the provider suggested the resident needed to reach out to the insurance provider, to find a therapist, who specialized in Borderline Personality Disorder. The clinical revealed no evidence that a Level I PASRR was completed after the 30-day convalescent period, ending November 8, 2025. Review of facility documentation, revealed that a PASRR Level I was created January 22, 2026 at 9:38 p.m. A Social Services Manager job description, for Staff # 104, dated November 11, 2024, revealed the primary purpose of the job position was to plan, organize, develop, and direct the overall operation of the Social Service Department to assure that the medically related emotional and social needs of the resident are met/maintained on an individual basis. An interview was conducted on January 21, 2026, at approximately 2:33 p.m. with the Director of Social Services (DSS/Staff #104). After review of the clinical record, and the PASSR paper binder, the DSS stated that the PASSRs on record for Resident #9 were completed by the referring facilities, and stated that the PASSR after 30 days of initial admission was not completed. She also stated that review of the current PASSRs in the resident's record did not accurately reflect the behavioral health diagnoses of anxiety, depression, PTSD, and borderline personality disorder. In addition, the director stated that she would have included the medications related to behavioral health in the assessment, and that receiving care from behavioral health, did not exclude the resident from PASSR Level I (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and attention. A Late Entry NP / PA Progress Note dated February 24, 2025, revealed Resident #13 re-admitted to the facility after hospitalization status post fall at home, with diagnoses that included depression, bipolar disorder, anxiety, and polysubstance abuse. A psychiatric evaluation note dated February 25, 2025, revealed Resident #13 had recent inpatient hospitalization in January 2025 due to suicidal ideation. The documentation revealed Resident #13 had diagnoses of bipolar disorder, unspecified, major depressive disorder, recurrent, chronic post-traumatic stress disorder, generalized anxiety disorder, and cannabis abuse. A care plan focus initiated February 25, 2025, revealed Resident #13 used anticonvulsant medication for bipolar disorder as evidence by labile moods. An intervention included for behavioral health / psychiatric services as needed. An admission MDS assessment dated [DATE], revealed Resident #13 had a BIMS score of 15, indicating intact cognition. Section I revealed Resident #13 had active diagnoses of PTSD, bipolar disorder, and generalized anxiety disorder. Section N revealed Resident #13 was receiving anti-anxiety, antidepressant, and anti-convulsant medication. A PASARR Level I Screening Tool dated February March 20, 2025, revealed the PASARR Level 1 review was due to conclusion of a time limit approval. The documentation revealed the resident did not meet admission criteria for 30-day convalescent care, nor did the resident meet criteria for respite admission for up to 30 days. Section B revealed Resident #13 had bipolar disorder and anxiety disorder. The document revealed the resident did not have depression (mild or situational), nor did the resident have a substance related disorder. Additionally, the documentation included that the resident did not have inpatient psychiatric hospitalization currently or within the past two years, and the resident did not have suicide attempt or ideation currently or within the past two years. Section D revealed that no referral was necessary for any Level II PASARR screening. The clinical record revealed no evidence of a PASARR Level II referral. -Regarding Resident #5: Resident #5 was admitted to the facility September 27, 2022, with diagnoses of type 2 diabetes mellitus, depression, and heart failure. Review of Resident #5's medical diagnoses list revealed an added diagnosis of bipolar disorder, dated March 10, 2023. A Nursing Note dated March 11, 2023, revealed Resident #5 was showing signs of altered mental status, screaming at someone to stop talking while covering his ears in hall, and yelling at certified nursing assistant (CNA) and the nurse, and that the resident insisted on being placed into a bed in the room despite no bed being in the area. The documentation revealed that the staff explained to the resident that there was no bed in that area, and the resident was adamant that there was. The note revealed the provider was notified, who ordered a psychiatric consult. A quarterly MDS assessment dated [DATE], revealed Resident #5 had an active diagnosis of depression. However, despite bipolar disorder being added to the resident's medical diagnoses list in the (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that receiving care from behavioral health did not exclude the resident from PASSR Level I screening. Staff # 104 stated that it was the responsibility of their facility to make sure PASSR documentation was accurate and complete in order to ensure the resident would receive the behavioral health services needed. The Director of Social Services stated that if the PASARR screening and referral process was inaccurate or not completed, then a resident may not receive the services that they need. Regarding audits, Staff # 104 stated that the facility's assigned PASRR resource conducts random reviews approximately every three months, if missing dates or incomplete documentation are identified, the facility is notified to make corrections. She reported that these reviews are infrequent and occur at random intervals. Staff # 104 stated that she was uncertain regarding how often PASRR screenings must be updated, and how to track residents who may require both mental illness and intellectual disability Level II evaluations. The Director of Social Services stated that she recognized the importance of ensuring that any specialized services identified through Level II evaluations are incorporated into the resident's care plan. The Director of Social services stated that she initially felt confident in her PASRR processes; however, in retrospect, she believed that formal training, routine audits, and regular performance evaluations would have helped identify knowledge gaps earlier and improve compliance. Staff # 104 revealed that a performance feedback meeting scheduled for December 2025 was postponed and that she had not received a formal performance evaluation since being hired in 2024. The Director of Social Services stated that accurate PASRR completion is critical to resident safety and quality of care and revealed that insufficient training and oversight could result in inaccurate PASRR documentation, potentially leading to residents not receiving necessary services o

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 15Number of residents cited: 2Universe: 56Based on review of records, staff interviews and review of policy and procedures, the facility failed to ensure that timely care and services, including physician notification and a physician order for oxygen, were provided upon a change of condition for one resident (#50). The deficient practice could lead to a medical decline and/or physical harm of a resident.Findings include:Resident #50 was admitted to the facility November 14, 2025, with diagnoses of type 2 diabetes mellitus, chronic pain syndrome, spinal stenosis, malignant neoplasm of overlapping sites of right female breast, and pressure ulcer of sacral region, stage 4.A care plan focus initiated November 18, 2025, revealed Resident #50 had an alteration in gastro-intestinal status due to colostomy, with an intervention to monitor vital signs as ordered and record, and to notify provider of significant abnormalities.Despite the care plan intervention to monitor vital signs as ordered and record, review of the clinical record revealed no evidence of a physician order for monitoring vital signs.An admission minimum data set (MDS) assessment dated [DATE], revealed Resident #50 had a brief interview for mental status (BIMS) score of 15, indicating intact cognition. Section O revealed the resident had not received oxygen therapy on admission or while a resident within the last 14 days.Review of an oxygen (O2) saturation vitals log revealed the following entries for January 2026:January 3: 95.0% on room air (RA)January 4: 94.0% on RAJanuary 10: 94.0% on RAJanuary 11: 94.0% on RAJanuary 17: 94.0% on RA A hospice note dated January 19, 2026, revealed that Resident #50 appeared lethargic and continued to have cough and increased secretions. The note revealed oxygen saturation at 87% on RA, and that the nurse attempted to apply oxygen via nasal cannula, however the oxygen concentrator was missing water, so staff was notified to fill the water, and then oxygen was applied to Resident #50 on 2L. However, Physician orders dated November 14, 2025 through January 20, 2026, revealed no evidence o orders for administration of oxygen.Review of the Medication / Treatment Administration Record (MAR/TAR) for January 2026, revealed Resident #50's blood pressure, temperature, pulse, and respirations were recorded on the MAR/TAR every day shift and night shift. However, there was no evidence on the MAR/TAR of monitoring or recording oxygen saturation, until January 21, 2026.A review of the electronic medical record as of January 21, 2026, at 9:40 a.m. revealed no evidence of oxygen saturation monitored and documented for Resident #50 from January 17, 2026 until January 21, 2026. Additionally, there was no evidence in the electronic medical record of uploaded hospice notes for the hospice nurse visits on January 19 or January 21, 2026.A physician order dated January 21, 2026, at 2:41 p.m. included for oxygen at 2L via nasal cannula for diagnosis of hypoxia. The order was discontinued at 6:06 p.m.Another physician order dated January 21, 2026, at 6:06 p.m. included for oxygen at 2L via nasal cannula for diagnosis of supplemental end of life care.A Nursing note dated January 21, 2026, at 6:06 p.m. revealed Resident #50 was placed on oxygen via nasal cannula by hospice, and that the oxygen was ordered for comfort measures.A care plan focus initiated January 21, 2026, revealed Resident #50 had oxygen therapy due to ineffective gas exchange, with a goal to have no signs or symptoms of poor oxygen absorption through the review date. Interventions included to monitor for signs and symptoms of respiratory distress and report to physician as needed, including respirations, pulse oximetry, increased heart rate (tachycardia), restlessness, diaphoresis, headaches, lethargy, confusion, atelectasis, hemoptysis, cough, pleuritic pain, accessory muscle usage, and skin color.A formal request was submitted to the facility on January 22, 2026, at 2:40 p.m. for all hospice records from start of care to present for Resident #50.Review of a Hospice Recert Summary Report dated January 22, 2026, revealed the following documentation which included hospice coordination (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	notes, vital signs log, and physician orders:January 6, 2026: Resident #50 stated she was feeling good today and verbalized that she wanted to get up for lunch.January 13, 2026: Upon arrival, Resident #50 opened her eyes only briefly during the visit and was lethargic and nonverbal, and that Resident #50 may be declining. The documentation included oxygen saturation was 93% on RA.January 15, 2026: Resident #50 was difficult to awaken and lethargic, and stated she did not feel good. The note included that oxygen saturation was at 90% on room air and oxygen was ordered for Resident #50. The note also revealed that Resident #50 was added to decline list. Despite the documentation that oxygen was ordered for Resident #50, there was no evidence of a physician order for oxygen either in the hospice records or the facility's medical record on January 15, 2026.A physician order dated January 15, 2026, included for emergent as needed (PRN) nursing visit due to change in decline status.January 19, 2026: Resident #50 appeared lethargic and continued to have cough and increased secretions. The note revealed oxygen saturation at 87% on RA, and that the nurse attempted to apply oxygen via nasal cannula, however the oxygen concentrator was missing water, so staff was notified to fill the water, and then oxygen was applied to Resident #50 on 2L. There was no evidence of a physician order for oxygen on January 19, 2026.A physician order dated January 20, 2026, included for licensed practical nurse (LPN) visit to be done January 22, 2026, instead of registered nurse (RN), and for registered nurse case manager (RNCM) to visit resident twice a week.A physician order dated January 21, 2026 included to give oxygen via nasal cannula at 2L, may titrate between 2-4L to maintain oxygen saturation above 90%. Despite the hospice documentation on January 19, 2026, that Resident #50 was hypoxic with oxygen saturation of 87%, there was no evidence in the clinical record or hospice documentation that a physician was notified of a change of condition or that change of condition monitoring was ordered. Additionally, there was no evidence of a physician order for oxygen until January 21, 2026.An observation was conducted on January 20, 2026, at 10:00 a.m. of Resident #50 laying in the bed in her room. Resident #50 had an oxygen concentrator next to her bed, which was turned on and set to 2L. The nasal cannula was not on the resident, and was draped over the top of the concentrator. The resident opened her eyes and stated she was very tired, and then closed her eyes, and was unable to answer further questions.Another observation was conducted on January 21, 2026, at 9:35 a.m. of Resident #50 laying in the bed in her room, with the oxygen concentrator turned on and set to 2L. The resident was wearing the nasal cannula in her nose. The resident was unable to open her eyes for more than a few seconds and could not answer questions.An interview was conducted on January 21, 2026, at 1:52 p.m. with a licensed practical nurse (LPN / Staff #45), who stated that Resident #50 was on hospice services and that she would know to look for any hospice orders or hospice care plans in the resident's hospice binder at the nurses' station. Staff #45 then looked for Resident #50's hospice binder at the nurses' station, then stated Resident #50 did not have a hospice binder. Additionally, Staff #45 stated that a hospice nurse was just in the facility two days prior on January 19, 2026, and that anything that hospice ordered would be included in the orders in the electronic medical record (EMR). Staff #45 then reviewed Resident #50's clinical record and stated that there was no physician order for oxygen therapy, and no care plan for oxygen therapy. Resident #50 was then observed together in the resident's room with Staff #45, and Staff #45 stated that the resident was on oxygen and the dose was 2L, and that she believed a hospice staff who was just there earlier this morning had applied it.An interview was conducted on January 22, 2026, at 1:22 p.m. with the Assistant Director of Nursing (ADON / Staff #25) who stated that if a resident who previously was not on oxygen therapy had a change of condition to now require oxygen, then the provider should be notified right away and the resident would have a physician order for change of condition monitoring. Additionally, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staff #25 stated that if a resident was on oxygen therapy, then there would need to be a physician order, and that the expectation for notifying the physician and receiving the order for oxygen should be done right away but at least by the end of the shift. Additionally, Staff #25 stated that there would be a specific care plan for oxygen as well. Staff #25 stated that if a resident was on oxygen therapy, then oxygen saturation would be monitored every shift to ensure the resident was maintaining oxygen saturation within normal limits. Staff #25 stated that if a resident were administered oxygen and did not need it, then it could be harmful, as it may cause the resident to then rely on the oxygen. Staff #25 stated if a resident on oxygen did not have oxygen saturation monitored, then the resident could be hypoxic and staff would not know. The clinical record for Resident #50 was reviewed together and Staff #25 stated that the first oxygen order for Resident #50 was placed on January 21, 2026, for oxygen at 2L.A telephonic interview was conducted with the hospice clinical liaison RN (Staff #305) on January 22, 2026, at 1:58 p.m. Staff #305 stated that the hospice company communicates with the facility via documentation that is sent over via email to the medical records director every other week. Additionally, Staff #305 stated that for each of the hospice residents, there should be a hospice binder that is kept by the facility, where hospice staff will add notes regarding care and any updates on the residents.A telephonic interview was conducted with a hospice RN (Staff #301) on January 22, 2025, at 2:26 P.M, who stated that she was the nurse who visited Resident #50 on January 19, 2026, and that she took the resident's vital signs and noted that the resident was hypoxic, with oxygen saturation around 88-90%, and that the resident had an oxygen concentrator at bedside already upon Staff #301 entering the room, and that Staff #301 did not know who had brought the concentrator into the resident's room or when. Staff #301 stated that she also noted that the resident's distilled water reservoir on the concentrator was empty, so she notified facility staff that the resident needed more distilled water in the concentrator.A follow-up interview was conducted with an LPN (Staff #45) on January 23, 2026, at 8:07 a.m. who stated that she was the floor nurse for Resident #50 on January 19, 2026, and that she came in late that day and did not receive report. Staff #45 stated that the hospice nurse (Staff #301) did not talk to her about oxygen for Resident #50. Staff #45 stated that the first she knew of Resident #50 being on oxygen was during the interview and room observation of Resident #50 with the state surveyor on January 21, 2026 at 1:52 p.m.An interview was conducted with the Director of Nursing (DON / Staff #100) on January 23, 2026, at 8:21 a.m. who stated that the facility's process to ensure that a change of condition or medical decline of a resident was not missed was to monitor the resident's care plan interventions and to assess the resident's vital signs. The DON stated that the facility monitors long-term care resident's vital signs monthly and if there was a change of condition, then vital signs would be assessed every shift. Staff #100 also stated that if a resident was on oxygen therapy, then oxygen saturation would be assessed every shift. Additionally, for a change of condition, Staff #100 stated there would be a physician order placed for change of condition monitoring and a progress note in the medical record that included that the physician was notified of the change. Staff #100 stated that if a resident was administered oxygen, then there would be a physician order for the oxygen. Regarding Resident #50, the DON stated that she believed the resident was placed on oxygen by the hospice nurse the morning of January 21, 2026, and the physician order for oxygen was also placed that day. The DON stated that she believed the oxygen was for comfort measures and that she was not aware of any episodes of hypoxia for Resident #50. The clinical record was reviewed, and the DON stated that it was not in the clinical record that the provider was notified of any change of condition for Resident #50, but she assumed it was in the hospice nurse's notes that a provider was notified. The DON stated that Resident #50's (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	oxygen saturation was documented to be 94% on January 21, 2026, and prior to that, the most recent reading in the clinical record was 94% on January 17, 2026. The DON stated that the importance of staff notifying a physician right away if a resident had a change of condition such as an episode of hypoxia would be to make the physician aware and include any adjustments to the plan of care. The DON stated that if a resident was hypoxic and the provider was not made aware, then the resident could have discomfort, pain, or an adverse outcome.Review of the facility policy titled Vital Signs, Weight and Height, revised May 2025, revealed the resident's vital signs shall be recorded as the physician's orders indicate, or as frequently as the resident's condition warrants.Review of the facility policy titled Change of Condition Reporting, revised June 2025, revealed it is the policy of this facility that all changes in resident condition will be communicated to the physician. For Acute Medical Changes:1. Any sudden or serious change in a resident's condition manifested by a marked change in physical or mental behavior will be communicated to the physician with a request forphysician visit promptly and/or acute care evaluation. The licensed nurse in charge willnotify the physician.2. If unable to contact attending physician or alternate physician timely, notify MedicalDirector for follow-up to change in resident condition.3. The responsible party will be notified that there has been a change in the resident'scondition and what steps are being taken.For Routine Medical Change:1. Unusual signs and symptoms will be communicated to the physician promptly. Routine changes are minor changes in physical and mental behavior, abnormal laboratory and xray results that are not life threatening.2. The nurse in charge is responsible for notification of physician prior to end of assignedshift when a significant change in resident's condition is noted.3. If unable to reach physician, all calls to physicians or exchanges requesting callbacks will be documented on the nursing progress notes.4. If the physician has not returned the call by the end of the shift, the on-coming nurse will be notified for follow-up.5. If unable to contact attending physician or alternate timely, notify Medical Director forresponse and follow-up to change in resident status.6. Document resident change of condition and response in nursing progress notes andupdate resident Care Plan, as indicated.7. All attempts to reach the physician and responsible party will be documented in thenursing progress notes. Documentation will include time and response.For Follow-Up: 1. The licensed nurse responsible for the Resident will continue assessment anddocumentation every shift for at least seventy-two (72) hours or until condition hasstabilized.2. Residents with acute medical changes (and some routine changes), will have progress and needs clearly communicated to each shift every shift for at least seventy-two (72) hours or until condition has stabled.3. Comprehensive Care Plan will be updated/ revised accordingly. Review of the facility policy titled Oxygen Administration, revised January 2026, revealed it is the policy of the facility that oxygen therapy is administered by licensed nurse as ordered by the physician or as a nursing measure and an emergency measure until the order can be obtained. The purpose of the oxygen therapy is to provide sufficient oxygen to the blood stream and tissues. The resident's clinical record will include: 1. That oxygen is to be administered.2. When and how often oxygen is to be administered.3. The type of oxygen device to use (i.e., mask, nasal)4. Any special procedures or treatment to be administered.5. Charting and documentation related to oxygen use6. Oxygen concentrators will be maintained in room when oxygen ordered Review of the facility policy titled Physician Orders, revised May 2025, revealed 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, and 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. No drugs or biologicals shall be administered except upon the order of a person (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	lawfully authorized to prescribe for and treat human illnesses. Verbal orders for drugs, treatments, procedures shall be received only by licensed nurses, psychiatric technicians, pharmacists, nurse practitioners, physicians, physicians' assistants (from their supervising physician only), and certified respiratory therapists when the orders relate specifically to respiratory care. Verbal orders must be recorded in the resident's chart by the person receiving the order and must include the date and time of the order. Medication, treatment or related procedure orders are transcribed in the eMAR/TAR (electronic MAR/TAR) accordingly.Review of the facility policy titled End of Life Care; Hospice, revised May, 2025, revealed it is the policy of the facility to provide end of life care for dying residents that emphasizes prevention and relief of symptoms as well as compassionate attention to the resident's dignity and preferences. Through continuing interdisciplinary assessment, individualized plans will be developed and implemented to address the resident's physical, intellectual, emotional, social, spiritual, and practical needs. A care plan will be developed based on the individualized assessments, the desires of the resident/surrogate decision-maker, and the physician's orders. Hospice services will be offered as appropriate and as ordered by the physician. These services will be integrated into the overall individualized, interdisciplinary care plan, to include collaboration with the hospice. Significant Change in Status Assessments may be deferred once identification of end-stage disease status is made unless the significant change is unrelated to the terminal illness. However, the facility will continue to provide necessary care and services to assist the resident to achieve his or her highest practicable well-being, to identify and respond to problems and needs associated with the terminal condition, and to update and implement an individualized, interdisciplinary plan of care.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observations, interviews, facility documentation and policy, the facility failed to ensure that safeguards and systems were in place to ensure accurate reconciliation and accounting for all controlled substances for two of three medication carts sampled. The deficient practice could result in inventory loss and potential diversion. An observation of the 100 Medication Cart narcotic reconciliation log was conducted on January 20, 2025 at 2:52 p.m., and reviewed with with Licensed Practical Nurse (LPN/Staff #45),who revealed the missing nurse signature entries on 6 shifts from January 1-19, 2026, were not supposed to be left blank. An observation of the 300 Medication Cart Narcotic reconciliation log was conducted on January 20, 2025 at 3:05 p.m., and reviewed with LPN/Staff #140, revealed the missing nurse signature entries on 5 shifts from January 1-19, 2026, were not supposed to be left blank. The facility's in-service sign-in sheets revealed that education on daily narcotic log sign-in and sign-out procedures was provided by the Assistant Director of Nursing (ADON/Staff #25) was conducted between January 20-21, 2026 during three different sessions.The Quality Improvement Tool (QIT)/ Nurse Sign-Off sheet for Narcotic Cards-Medication carts, revealed the ADON conducted audits for the Medication Cart 100 and Medication Cart 300s on January 21, 2026.An interview was conducted on January 20, 2026, at 3:12 p.m. with an LPN/Staff #140. The LPN stated that two nurses are required to complete the medication cart narcotic count and reconciliation log to ensure accountability, verify that the residents receive required medications, and to prevent narcotics from becoming missing or misappropriated. The LPN stated that there should be no missing signature entries on the logs from January 1-19, because it cannot be proved that two nurses performed the count for those shifts. An interview was conducted on January 22, 2026 at 11:54 a.m. with the ADON. The ADON stated that she conducted in-services with the nursing staff on the proper procedure and importance of conducting narcotic counts properly. In addition, the ADON also revealed that she was assigned to perform an audit of the medication cart narcotic reconciliation, due to the missing nurse signature entries discovered by the surveyor, during the current survey period. The ADON revealed that the expectation is for nursing staff to conduct a dual licensed nurse count of all narcotics at change of shift to ensure accuracy, and minimize the risk of diversion.An interview was conducted on January 23, 2026 at 8:15 a.m. with the Director of Nursing (DON/Staff #100). The DON revealed that the requested narcotic reconciliation logs with the missing entries, that failed to meet facility expectations, have been submitted to the survey team. The DON stated that in response, the facility immediately conducted in-services to ensure the nurses properly executed narcotic count reconciliations every shift. The DON stated she has the expectation that each card/bottle be properly counted and documented by two licensed nurses at the exchange of the medication carts to ensure all narcotics are accurately accounted for to avoid any narcotic count discrepancies. The facility's Medication Access and Storage, E kit access policy, revised June 2025, instructed staff to reconcile controlled medications at least every shift by the incoming and outgoing licensed nurses at change of shifts.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, and review of facility policies and procedures, the facility failed to ensure insulin was administered according to provider instruction for one resident (#5). This deficient practice could result in side effects leading to negative resident outcomes. The sample size was 5. The universe was 56. Findings include: Regarding Resident # 5 Resident # 5 was re-admitted to the facility on [DATE] with diagnoses that included Type 2 Diabetes Mellitus (DM) with chronic kidney disease, moderate protein-calorie malnutrition, generalized muscle weakness, and sequelae of cerebral infarction. A physician order dated April 9, 2025, revealed the resident was to receive 20 units of Insulin Glargine Solution one time a day for diabetes, unless the blood sugar was less than 110. The resident's Diabetes Mellitus- Insulin Injection care plan, revised on April 14, 2025, revealed the resident was noncompliant with his therapeutic diet, and was to have diabetes medication as ordered by the doctor. The resident's annual Minimum Data Set (MDS), dated [DATE], revealed that the resident had a Brief Interview Mental Status (BIMS) score of 14 indicating he was cognitively intact. The assessment indicated that the resident had an active diagnosis of DM, received a diabetic therapeutic diet while a resident, and required insulin therapy. Review of the Medication Administration Record (MAR) for January 2026, revealed that from January 1- 23, 2026, Insulin Glargine was administered on 5 occasions when the recorded blood sugars were less than 110. Review of the clinical record revealed no evidence of the provider authorizing the administration of Insulin Glargine to be administered when blood sugars were less than 110. An interview was conducted during a medication pass observation on January 22, 2026 at approximately 7:30 a.m. with Certified Medication Aide (CMA/Staff #77). The CMA stated that when a medication is ordered with parameters, staff are expected to follow the order as written. The CMA stated that administering medication outside of prescribed parameters can overmedicate a resident and may cause the resident to have an adverse effect, which has to immediately be reported to the charge nurse, and the doctor. An interview was conducted on January 23, 2026 at 8:15 a.m., with the Director of Nursing (DON/Staff #100). The DON stated insulin affects blood glucose levels by lowering blood sugar, not just in residents with diabetes, but in anyone that receives it. The DON continued, that when insulin is administered outside of prescribed parameters, it can cause hypoglycemia, which may result in serious adverse outcomes, including hospitalization. The DON stated that staff are expected to follow ordered parameters and to notify the provider when blood glucose values fall outside of those parameters. An interview was conducted with a Certified Nurse Assistant (CNA/Staff #68) on January 23, 2026, at 9:27 a.m. The CNA stated they are trained and responsible for performing finger-stick blood glucose monitoring. The CNA stated that low blood sugar may cause a resident to pass out or become delirious and that the nurse is immediately notified if blood glucose readings are below 60 or if the resident exhibits signs of hypoglycemia, such as cold, clammy skin or confusion. The CNA further stated that residents are positioned safely to prevent injury while nursing assistance is obtained and that provider orders are expected to be followed, as failure to follow orders may result in resident harm. An interview was conducted on January 23, 2026, at 10:05 a.m. with the Clinical Resource Nurse (Staff #99), who served as the Director of Nursing (DON)- by proxy, due to the unavailability of the presiding DON. The DON- by proxy reviewed the documentation and identified five occasions in which Insulin Glargine was administered when the resident's blood glucose level was below 110. The DON by proxy stated that the nurse responsible for administering the medication outside of the prescribed parameters was identified earlier that day and provided re education. The DON by proxy further stated that the expectation is for all medications to be administered in accordance with (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provider orders and that, upon review of Resident #5's documentation, this expectation was not met. The facility's Medication Administration Policy, reviewed in October 2025, revealed that when administering unit-dose medications, staff are required to obtain vital signs when indicated and to hold medications when parameters are not met. The policy further states that if there is any question regarding medication dosage, the medication should not be administered until clarification is obtained. The facility's Medication (Drug) Regimen Review (MRR) policy, reviewed April 2025, revealed the MRR includes identification of irregularities, medication-related errors, adverse consequences, and the use of unnecessary drugs.

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, facility documentation and policy, the facility failed to ensure the clinical record for one resident (# 9), contained an accurate representation of the actual experiences of a resident with an allegation of resident to resident abuse, and was accurate, complete and readily available for one resident (#50). The deficient practice could result in records that do not accurately and completely reflect the care and services provided to residents.Findings include: -Regarding Resident # 9 Resident # 9 was initially admitted to the facility on [DATE], and re-admitted on [DATE], with clinical diagnoses that included borderline personality disorder, post-traumatic stress disorder, chronic pain syndrome, insomnia, recurrent depressive disorders, other specified anxiety disorders, and factitious disorder imposed on self, with predominately physical signs and symptoms. An admission Minimum Data Set assessment, dated May 8, 2025, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating she was cognitively intact. The assessment included active diagnoses of anxiety disorder, depression, PTSD, and borderline personality disorder. The assessment also revealed the resident was taking antianxiety, and antidepressant therapy. A consultant psychiatric progress note, date of service May 13, 2025, revealed the resident was recommended to have Dialectical Behavior Therapy (DBT) upon availability for Borderline personality disorder. In addition, the progress note revealed the resident was admitted to the hospital for not feeling safe, after a roommate verbally threatened the resident at a previous facility. A care plan focus: confabulation, and false accusation care plan, initiated May 27, 2025, directed the staff to intervene as necessary to protect the rights and safety of others, and to provide Care in Pairs A Grievance Resolution Form, dated January 8, 2026, revealed the resident felt the ADON mishandled the resident's room placement on purpose on January 3, 2026. The grievance found that the roommate complained of the amount of dolls and belongings the resident was bringing into resident # 10's room. A Facility Reported Incident Form – Follow-up Report, submitted January 28, 2026, concluded that the allegation of abuse was not verified. The report revealed that Licensed Practical Nurses (LPN) # 76 and # 52; and Certified Nurse Assistant (CNA/Staff #126) denied that any altercation took place between residents #9 and # 10. The report revealed that based on interviews, documentation, and staff response, that the incident involved a verbal disagreement between the two residents. However, the resident's clinical record revealed no evidence regarding the verbal disagreement, prior to the conclusion of the survey period. A police department web report narrative, retrieved February 4, 2026, web revealed resident #9, alleged that resident #10 threatened to suffocate her. As of report retrieval date, the investigation is still pending. Review of the clinical record, revealed no evidence involving room changes or verbal disagreements (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	during the 72-hour significant change of condition period from January 3, 2026 through January 6, 2026. An interview was conducted with Resident #9 on January 21, 2026, at 10:20 a.m. Resident #9 stated she was upset with the Assistant Director of Nursing (ADON/Staff #25) for placing her in two roommate situations within a few days that she felt compromised her mental health and safety. The resident reported she was first placed with a roommate who was claustrophobic and required the door to remain open. The resident stated this was distressing due to her neurological condition, which causes extreme pain when exposed to loud noises and requires the door to be closed. The resident stated she was later relocated to a room with Resident #10, who she stated made fun of her and threatened to suffocate her. Resident #9 stated she reported the behavior to the CNA caring for her and described repeated verbal altercations, including a screaming match. Following this incident, the ADON was contacted and Resident #9 was moved to her current room. Resident #9 stated that she has PTSD, and as a result of the incident, she experienced an episode of night terrors. An interview was conducted with the Executive Director (ED/Staff # 103) on January 21, 2026, at approximately 11:00 a.m. The ED stated that this was the first time hearing of the allegation of resident to resident abuse, and follow-up on the allegation according to facility policy. An interview was conducted on January 21, 2026 at 11:54 a.m. with the ADON (Staff #25). The ADON revealed that she is no longer allowed to be the primary point of contact for resident #9, per the resident's request, due to the resident feeling that she did not look out for the resident's best interest in regards to room change placement. The ADON stated that adverse behaviors or events that result from roommate changes are to be documented into the progress note, as it is important to document the steps taken in order to care for and defuse the situation. Roommate challenges are also reported to the case management for follow complaint and grievance follow up. The ADON stated having great familiarity with resident #9 over the past year, and that the facility tries its best to accommodate for the resident's need. The ADON recalled that the first room choice failed due to the resident being unhappy that the room door was not allowed to be closed. The ADON stated that admissions had already spoken with the family, prior to the resident's return, however she voiced not being sure if the aspect of the room door was explained to her. The ADON recalled receiving a phone call from Licensed Practical Nurse (LPN # 52) , and hearing the resident crying and hollering in the background. The ADON stated that she was unable to determine what the resident was saying over the phone, but because the resident was upset, the ADON revealed making the decision to move her into the room with resident # 10. Later that same day, the ADON stated that the staff called back again, because resident #9 became upset again. The ADON revealed being told that the roommate asked the resident if she was a child, and also stated that Don't worry you will die here anyway. The ADON stated she did not feel this was a death threat, but rather she felt it was referring that the facility was a long-term care facility. The ADON stated that she would have expected for these incidents to recorded in the progress notes, and that for room changes, there is an order placed for 72-hour monitoring of vital signs, and documentation as to how the resident is adapting to the change. Upon return to work, the ADON stated there was no report of any threatening conversation that occurred between resident # 9 and #10, otherwise the expectation was that would have been documented according to facility procedure and reported to the abuse coordinator. An interview was conducted on January 21, 2026 at approximately 1:50 p.m., with Licensed Practical Nurse (LPN/Staff # 52). The LPN recalled, that while he was charting, he could hear resident # 9 yelling. The LPN stated that resident # 9 occasionally exhibits behavioral outbursts at times, but revealed being uncertain initially, as to why the resident was upset with the roommate change, since she (continued on next page)

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