

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  035174	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/11/2025
NAME OF PROVIDER OR SUPPLIER  Park Avenue Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2001 North Park Avenue Tucson, AZ 85719	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review, staff interviews, facility documentation, and policy review, the facility failed to ensure 1 of 14 sampled residents (Resident # 28) was free from abuse by another resident (Resident # 23). The deficient practice could result in other residents being abused.</p> <p>Findings include:</p> <p>-Regarding Resident (#23)</p> <p>Resident (#23) was admitted to the facility on [DATE], with diagnoses of dementia and altered mental status.</p> <p>A nursing note dated August 10, 2022 at 9:52 p.m., revealed that Resident (#23) was hallucinating stating she was going to die because she was told by two ladies that the building was falling down. The note also indicated that the Resident (#23) was combative towards staff and yelling in the hallway.</p> <p>A nursing note dated September 10, 2022 at 3:38 a.m. revealed Resident (#23) was very combative with staff and threatening to kill a Certified Nursing Assistant (CNA).</p> <p>A nursing note dated September 22, 2022 at 7:12 p.m., indicated staff attempting to administer eye drops and Resident (#23) became aggressive towards staff by punching, kicking, biting, flailing her arms, pulling staffs hair and using vulgar language.</p> <p>A nursing note dated October 4, 2022 at 6:26 p.m., revealed that nurse spoke to Nurse Practitioner regarding resident's aggressiveness and combative behavior. Nurse Practitioner gave verbal order to send resident to Hospital for geriatric psychological evaluation for being a danger to self and others.</p> <p>A nursing note dated October 4, 2022 at 7:35 p.m., revealed that transport company did not transport patient to emergency room because patient refused to get on the stretcher.</p> <p>A Psychotherapy Progress note dated October 10, 2022 at 11:51 a.m., revealed a plan of continued monitoring of Resident (#23) with coordination of staff regarding moods and behaviors including nonpharmacological treatments.</p> <p>(continued on next page)</p>

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
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A nursing note dated October 11, 2022 at 3:41 p.m., revealed that resident (# 23) was disturbing her roommate by yelling and taking blanket from roommate's bed. The Progress Note also revealed that the incident was reported to the author's supervisor, but no follow up was documented.</p> <p>A comprehensive care plan initiated November 5, 2022, revealed antidepressant medication use, related to depression as evidenced by angry outbursts, complicated by cognitive deficits and difficult to redirect. The interventions included to monitor and record occurrence of target behavior symptoms such as physical aggression and document per facility protocol.</p> <p>A Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 00 indicating severe cognitive impairment. The assessment also indicated wandering behaviors but no hallucinations or delusions.</p> <p>-Regarding Resident (# 28)</p> <p>Resident (# 28) was admitted to the facility on [DATE], with diagnoses of dementia, bipolar disorder, major depressive disorder, and anxiety disorder.</p> <p>A comprehensive care plan dated November 2, 2021, revealed that Resident (# 28) had impaired thought processes, memory, safety awareness impairments due to dementia. Interventions included staff identifying self when communicating and keeping a consistent routine.</p> <p>A Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 12 indicating mild cognitive impairment. The assessment did not indicate any behaviors.</p> <p>A Skin Evaluation performed on Resident (#28) dated October 29, 2022 revealed that skin was intact. There was no indication of bruising on Resident (#28) legs.</p> <p>A nursing progress note for Resident (# 28) dated, October 31, 2022 at 3:03 p.m., by Licensed Practical Nurse (LPN/Staff # 3) revealed that Resident (# 28) was sitting at the end of a hallway looking out the window when Resident (# 23) approached and called Resident (# 28) evil and the devil. Resident (# 23) began to hit at her and struck her a couple times. It was reported that Resident (# 28) said she was minding her business when Resident (# 23) approached and called her evil and the devil. Resident (# 28) informed LPN (#3) that Resident (# 23) stood over her and hit her. The progress note also revealed that a wound nurse evaluated resident for injuries. Wound nurse noted bruise to right thigh area.</p> <p>A nursing progress note for Resident (# 23) dated October 31, 2022 at 3:59 p.m., revealed that Resident (# 23) was combative on the shift which included screaming and hitting another resident in the hall. The incident was witnessed by a CNA (not identified). The progress notes also indicated that Resident (# 28) had a bruise on lower left extremity.</p> <p>A nursing progress note for Resident (#23) dated October 31, 2022 at 9:29 p.m., revealed that Resident (#23) was moved to a single room [ROOM NUMBER] bed B and continuously monitored every 15 minutes.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility investigation report dated November 4, 2022, revealed that on October 31, 2022 Resident (#28) was sitting at the end of the 200 unit, near the window when Resident (# 23) wheeled up behind Resident (#28) and hit her arm and leg calling her the devil. Even though the facility report confirmed contact was made on resident (# 28) the facility concluded that they could not substantiate any injuries despite the multiple nursing notes documenting the bruising on Resident's (#28) legs.</p> <p>A Skin Assessment for Resident (#28) dated November 5, 2022 revealed a resolving bruise to right anterior thigh.</p> <p>An interview was conducted with LPN #3 on June 5, 2025 at 2:18pm, who stated that it was reported to her that Resident (# 23) had delusions where she thought Resident (# 28) was the devil and wheeled over and hit her. LPN (# 3) stated that she came out when heard there was an incident and separated residents and assessed Resident (# 28). LPN (# 3) acknowledged that Resident (# 28) was bruised on the right leg by Resident (# 23). LPN (# 3) reported that staff wanted to move Resident (# 28) into another room further down the hall because after the incident Resident (# 28) started to obsess about Resident (# 23) walking by her room trying to provoke Resident (# 23). Instead, they moved Resident (#23) to another wing of the building and monitored her.</p> <p>An interview was conducted with the Executive Director (ED/Staff #164) on June 6, 2025 at 12:12 p.m. Staff (#165) stated that when there is an allegation of abuse staff will call or text the ED immediately. Sometimes if the Unit Manager LPN (#3) is working that day they will tell her and she will contact me. The ED stated that the investigation is conducted by a team, typically the Director of Nursing will do staff and resident interviews, while the ED contacts State Health Department and Ombudsman, usually the ED will instruct nursing to call police. ED (# 164) reviewed the facility report and stated that the facility did acknowledge that Resident (# 23) made contact with Resident (# 28) but unsubstantiated because there was no harm, despite the fact of numerous clinical reports of Resident (# 28) receiving a bruise on her thigh.</p> <p>A Policy and Procedure titled, Abuse: Prevention of and Prohibition Against, revised December 2023, stated the policy of the Facility is that each resident has the right to be free from abuse, neglect, misappropriation of resident property, exploitation and mistreatment.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review, interviews, facility documentation and policy review, the facility failed to provide care and services in accordance with the resident's care plan for one resident (#34) regarding administration of scheduled medications as ordered by the physician. This deficient practice has the potential to result in residents not receiving necessary antibiotic treatment as planned, placing them at increased risk for unresolved infections and adverse health conditions.</p> <p>Findings include:</p> <p>Resident #34 was admitted to the facility on [DATE] with diagnosis that included Traumatic Brain Injury, seizures, sepsis, and Methicillin Susceptible Staphylococcus Aureus (MSSA) infection.</p> <p>A review of the admission Minimum Data Set (MDS), dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had was cognitively intact.</p> <p>A review of the physician's orders, dated September 28, 2022, revealed Resident #34 was to take Cefazolin Sodium (antibiotic) solution, 2 grams (GM) intravenously every 8 hours for MSSA for 10 days. The medication was scheduled to end on October 8, 2022.</p> <p>Review of the care plan dated September 30, 2022 stated the was on antibiotic therapy as a related to her MSSA infection. The care plan goals included that the resident will be free from discomfort or adverse reactions related to antibiotic therapy. The care plan interventions stated to administer medications as ordered and to monitor, during every shift, for side effects such as diarrhea, nausea, vomiting, and hypersensitivity/allergic reactions.</p> <p>A review of the September 2022 Medication Administration Record (MAR) revealed that a dose of the Cefazolin Sodium was not administered on September 30, 2022 at 10:00 PM.</p> <p>A review of Resident #34's progress notes did not reveal an entry indicating why the scheduled dose was missed or that a physician was contacted about the missed dose.</p> <p>A review of the October 2022 MAR revealed that a dose of the Cefazolin Sodium was not administered on October 2, 2022 at 10:00 PM.</p> <p>A review of Resident #34's progress notes did not reveal an entry indicating why the scheduled dose was missed or that a physician was contacted about the missed dose.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on June 5, 2025 at 11:38AM with Licensed Practical Nurse (LPN/Staff #66). Staff #66 explained that if she missed a dose of scheduled antibiotics for a resident, she would contact the provider and get instructions on what to do. She would also document the missed dose on the MAR and progress notes for that resident so that the next shift was aware. Staff #66 also explained that if she came onto shift and noticed the MAR did not identify if a resident took a medication or not, she would call the provider to see if the nurse from the previous shift informed them of the missed dose and then contact the Assistant Director of Nursing (ADON) or the Director of Nursing (DON). She added that if a resident were to miss two dosages of antibiotics, the resident would be at risk for re-infection.</p> <p>An interview was conducted on June 5, 2025 at 12:03 PM with LPN/Staff #55. Staff #55 explained that if she missed a dose of the resident's antibiotics, she would contact the provider and the provider would usually extend the antibiotics for an additional two days. She also stated that she would document the omission in the MAR as well as in a progress note. The documentation would also include a statement indicating the provider was notified. When asked what she would do if she noticed there was no documentation indicating an antibiotic was administered the previous shift, Staff #55 explained that she would follow up with the outgoing nursing to see why it was not administered. She would also notify the unit manager and document that she found that missed documentation. She also added that she would not administer the dose until she followed up with the provider because it could result in a double dosage for the resident.</p> <p>An interview was conducted on June 5, 2025 at 12:50 PM with the Director-in-Training (DIT/Staff #170). Staff #170 shared her expectations of staff related to missed doses of antibiotics. Staff #170 indicated that nurses were to let the resident know that antibiotic treatments would be extended, notify the provider of the missed dose, and to contact the pharmacy to ensure medications were in stock to administer the additional doses. Staff #170 also explained that nurses are to document the missed antibiotic doses in the resident's progress notes as well as information about the provider being notified, including the date and time the notification was made. When asked which shift was responsible for administering medications at 10:00 PM, Staff #170 shared that the outgoing shift was responsible for administering it before their shift ended at 10:00 PM. Staff #170 was asked to verify if Resident #34 was administered Cefazolin Sodium during September and October of 2022. After reviewing the MAR, Staff #170 confirmed there were two missed doses on September 30, 2022 and October 2, 2022. Staff #170 was not able to identify why there was no documentation on the MAR and progress notes regarding if the medication was given or not on both dates. When asked if this met her expectation, she indicated that it didn't and the risks to the residents for not administering multiple doses of antibiotics were the infection wouldn't be cleared up and the residents would need to extend their treatment.</p> <p>According to the policy titled, Physician's Orders, last reviewed in August 2024, indicated that orders must be accurately implemented 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.</p>		