STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035174	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Avenue Health and Rehabilitation Center	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, facility documentation and review of the facility policy, the facility failed to ensure that a change of condition, for one resident (#3) out of 3 sampled, was immediately reported to the physician. The deficient practice could result in clinically adverse outcomes for the resident.Findings include:Resident #3 was admitted on [DATE] with diagnosis including muscle weakness, difficulty walking, pressure ulcer of the sacral region, type 2 diabetes mellitus with hyperglycemia, fluid overload, essential hypertension, pneumonia, acute on chronic systolic congestive heart failure, nonrheumatic mitral valve disorder, edema, acute respiratory failure with hypoxia, pleural effusion, sepsis and dyspnea.A review of discharge MDS (minimum data set) dated January 28, 2024 did not show evidence of a BIMS (brief interview of mental status) score, but did document that there were no potential indicators of psychosis or no evidence of behaviors.A review of the progress notes revealed that on January 28, 2024 at 6:35 AM an 'O2 SATS WARNING' (oxygen saturation warning) was documented, noting a value 88% oxygen saturation. A progress note dated January 28, 2024 at 6:49 AM by registered nurse, staff #37, noted that the writer was informed that the resident started coughing early in the morning at approximately 4:00 AM and had desaturated to 87% on liters of oxygen. The documentation further revealed oxygen saturation levels of 88% on 5 liters of oxygen. Staff #37 documented that the resident had persistent coughing and continued to desaturate. It was noted that night nurse, staff #45, reported that the resident had been seated-up and remained at 87% oxygen saturation since 4:00 AM.Documentation further revealed that 911 was contacted per the providers orders and that the resident was taken to the emergency room by Tucson Fire Department.An earlier progress note entered by the night nurse, staff #45 revealed that staff #45 had contacted the resident's daughter at 5:30 AM to relay that the resident had been coughing and expectorating slightly brownish phlegm.The progress notes revealed no evidence that the night nurse had contacted the physician regarding the resident's oxygen saturation levels.A review of the care plan revealed that the resident had congestive heart failure and a noted intervention included to check for breath sounds and monitor/ document labored breathing as well as monitor / document and report to the medical doctor any signs of congestive heart failure to include shortness of breath upon exertion, dry cough and or orthopnea (difficulty breathing when laying down).A telephone call was placed to RN (registered nurse), staff #37 on July 31, 2025 at 9:47 AM, a message was left on voicemail but no return call was received.A telephone call was placed to RN, staff #45 on July 31, 2025 at 9:50 AM. The phone rang but did not cycle to voicemail.An interview was conducted on July 31, 2025 at 10:24 with LPN (licensed practical nurse), staff #7. Staff #7 stated that residents on oxygen are generally monitored every 2 hours and depending on the medication they are on, sometimes more frequently. The LPN stated that if a resident's oxygen saturation was dropping, vitals should be checked and oxygen levels should be adjusted if the setting was initially low, such as 2 liters. Staff #7 stated that she would also sit the resident up, coach them to take deep breaths and would immediately contact the provider (physician). The LPN stated that waiting for 2 hours to contact the provider, when a resident is desaturating, is not acceptable. Staff #7 stated that the risk for not notifying the provider of the resident's change in condition, could cause a further decline in the resident's health.An interview conducted on July 31, 2024 at 11:34 AM with CNA (certified nursing assistant), staff #21. Staff #21 stated that if vitals are outside of baseline for oxygen saturation, below 90% saturation, she would notify the nurse. Staff #21 stated vitals should be checked at least once per shift or potentially more as ordered. Staff #21 stated that if the nurse is not notified and if the nurse doesn't notify the doctor then the risk could include the resident having to go to the hospital or even dying.An interview was conducted on July 31. 2024 at 10:41 AM with LPN, staff #71. Staff #71 stated that if a resident's oxygen saturation drops, the doctor should be notified right away. Staff #71 stated that sometimes a 'senior' may have low oxygen saturation levels. Staff #71 stated it would not be acceptable to wait 2 hours or more before contacting the doctor, as a resident's health could go 'south'. Staff #71 stated that if a resident's oxygen drops she would sit them up and take another reading and if the reading was still low, below 90, call the doctor immediately.An interview was conducted on July 31, 2025 at 11:10 AM with the DON (director of nursing), staff #82. Staff #82 stated that a change in vitals, to include oxygen saturation ranging between 87% and 88% , would warrant a call to physician. Staff #82 stated that a physician should be notified of a change in condition immediately, if not already addressed in the orders or if medications, as applicable, did not elicit a positive change in the resident's condition. Staff #82 reviewed the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, and policy and procedures, the facility failed to ensure that an allegation of abuse was reported to the state agency for one of of three residents. The deficient practice could further endanger the resident and impede an investigation.Findings include:Resident #7 was admitted on [DATE] with diagnosis including bipolar disorder, anxiety disorder, atherosclerotic heart disease, chronic pain, fibromyalgia, dependence on supplemental oxygen, dementia without behavioral disturbance, insufficient sleep syndrome and post-traumatic stress disorder.A review of the annual MDS (minimum data set) dated May 4, 2025 revealed a BIMS (brief interview of mental status) score of 01, indicating severe cognitive impairment. The total mood severity score noted was a 9, indicating mild depression. There were no noted potential indicators of psychosis or behaviors noted.An encounter note dated July 14, 2025 in the electronic health record revealed that in light of current accusations and the resident's inability to express herself appropriately regarding her feelings, it was recommended that staff use a two-person system and the 'utmost' care while documenting everything that the resident says or does.A review of the electronic health record revealed no documented evidence of an abuse allegation reported on July 24, 2025.A review of the submitted facility 5-day investigative reports revealed no evidence of an allegation of abuse that was reported on July 24, 2025 for resident #7.A review of the state agencies reporting portal revealed no evidence of an abuse allegation reported on July 24, 2025 for resident #7.An interview was conducted on July 31, 2025 at 11:05 AM with CNA (certified nursing assistant), staff #10. Staff #10 stated that there are many layers of abuse and these could include financial, verbal, physical and isolation. Staff #10 stated that as soon as he is made aware of an allegation of abuse, he would report it to the abuse coordinator (administrator). The CNA stated that abuse training is conducted at least once a year and periodically throughout the year.An interview was conducted on July 31, 2025 at 11:11 AM with RNA (restorative nursing assistant), staff #93. Staff #93 stated that abuse should never happen, but stated that if it does happen then it needs to be stopped and reported right away to the administrator and if necessary the police. Staff #93 stated that if not reported timely it could make the resident feel unsafe, cause more trauma and breach of trust. Staff #93 stated that there is regular abuse training annually and then additional training every couple of months.An interview was conducted on July 31, 2024 at 11:20 AM with LPN (licensed practical nurse), staff #76. Staff #76 stated that abuse can be verbal, physical, sexual or anything denying care to a resident. Staff #76 stated that if a resident reports an allegation of abuse, she would immediately report it to her supervisor. She stated that she would further call the doctor and notate a change of condition. An interview was conducted on July 31, 2025 at 12:27 PM with LPN, staff #5. The LPN stated that she is very passionate about resident care. She stated that if she was made aware of an incident of abuse, she would separate the parties involved, ensure their safety and report the incident forward. Staff #5 stated that resident # 7 had reported to her that staff #115 beat her up and hit her on the legs. The LPN stated that the incident had occurred the previous week and stated that the staff member was removed from caring for the resident and that it had been reported. Staff #5 stated that the director of nursing had been notified on July 24, 2025 at 12:56 PM via a text message and that this was when staff #115 had been removed from providing care for resident #7.An interview was conducted at 07/31/2025 at 1:45 PM with the DON (director of nursing), staff #82. Staff #82 stated that regardless of a resident's cognition or if allegatio9ns had been made in the past, an abuse allegation would always need to be reported to the state agency. Staff #82 stated that she thought the reporting timeframe was either 2 hours of 5 days, but then stated that it was 2 hours. Staff #82 stated that abuse could be physical, mental, emotional or financial. The DON stated that the flow of communication would be from staff to the DON and then to abuse coordinator. She further stated that her expectation is that abuse is always reported timely and immediately addressed.An interview was conducted on 07/31/2025 at 3:31 PM with the administrator/ abuse coordinator, staff #101. Staff #101 stated that he was not aware of an abuse allegation from resident #7 on July 24, 2025. He stated that the issue may have been one of miscommunication between staff and himself. The administrator stated that the expectation is report abuse as soon as possible, within 2 hours on an abuse allegation. He further stated that the risk could include that it could occur to other residents in the building and that the occurrence would not be mitigated.A review of the Resident Rights policy entitled Reporting Alleged Violations of Abuse, Neglect, Exploitation or Mistreatment with a review date of September 2020 revealed that the facility will ensure that all alleged violations involving