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	10/24/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (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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F 0842 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 interviews, review of clinical record, the State Agency (SA) complaint portal, and review of facility policy and procedure, the facility failed to ensure the facility investigation and medical record were complete and accurate for one resident (#2), and regarding an incident of abuse. The deficient practice could result in care team members not being adequately informed regarding the status of the resident and lead to missed or delayed care.Findings include:Resident #2 was admitted to the facility on [DATE], with diagnoses that include generalized muscle weakness, subsequent encounter for closed fracture with nonunion, other specific joint derangements of the right hip not elsewhere classified, and acute pain due to trauma.An admission Minimum Data Set (MDS), dated [DATE], indicated Resident #2 completed a Brief Interview for Mental Status (BIMS) and scored a 15, indicating the resident was cognitively intact.The SA complaint portal received an allegation related to Resident #2 being abused by a Certified Nursing Assistant (CNA/Staff #63) on Friday, October 3, 2025.Progress Notes revealed no evidence of entries related to the alleged employee-to-resident abuse that took place on October 3, 2025.A Condition Monitoring assessment, dated October 4, 2025, at 3:36 A.M indicated that the date of the original condition being monitored was September 30, 2025, for Resident #2's Right hand and Right thumb pain.Two other Condition Monitoring assessments, dated October 4, 2025, referenced the same September 30, 2025, incident and monitoring of the Right hand and thumb pain.Additional review of the clinical record revealed no evidence of resident assessments related to the Left arm/shoulder pain having been completed after the alleged incident took place on October 3, 2025. A facility Final Written Report, indicated that the initial report was made by the Administrator (staff #300) on October 5, 2025 at 5:58 PM via online reporting system. The final report revealed that on October 5, 2025 a nurse reported an allegation that occurred on October 3, 2025 regarding rough treatment by a CNA (staff #63). The report also revealed that the Administrator interviewed staff #63, and another CNA (staff #301) who was present at the time of the reported incident. The report included education of when incidents should be reported to the abuse coordinator. The report concluded that the allegation could not be verified. However, the report did not include any evidence that Resident #2 was interviewed by the Administrator regarding her allegation of rough treatment. A Care Plan, revised on October 8, 2025, indicated that Resident #2 had a potential for a psychosocial well-being problem related to alleged abuse being reported on October 5, 2025. Interventions included Social Services interviewing Resident #2 and determining no changes or referrals were needed, consulting with Pastoral care, social services, psychiatry services, and others, and allowing the resident time to answer questions and verbalize feelings, perceptions, and fears.An interview was conducted with Resident #2 on October 24, 2025, at 2:51 P.M. in her room. Resident #2 shared that Staff #63 was in her room with another CNA. After using a Hoyer Lift to put her back in her bed, Staff #63 pushed her left arm, and Resident #2 asked her to stop pushing her arm because she has damage in there. Resident #2 explained that Staff #63 acknowledged her and then grabbed her left arm and yanked it to have her turn to the side. At that point, Resident #2 shared that the staff was hurting her, but Staff #63 told the resident that she needed to be changed. Resident #2 added that after the incident, she had to get a muscle rub for the pain in her shoulder.An interview was conducted on October 24, 2025, with Licensed Practical Nurse (LPN/Staff #7) at 10:09 A.M. Staff #7 shared that she would document resident incidents, such as a change in condition, resident altercation, or an allegation of a resident altercation, into the resident's medical chart. She shared that she was not sure if it was the policy to do so, but she was always told to document. She also indicated that she is told to document what she sees, not what she hears. An interview was conducted on October 24, 2025, with LPN/Staff #51 at 10:29 A.M. Staff #51 shared that she would document anything, such as a resident having an issue with a roommate or resident complaints. When asked if this was a facility policy or her professional preference and she shared that she believed this was a standard process if there were any changes in her (residents). She identified that she knew that if there was a change in condition or physical issues with a resident, this would need to be documented but she was not sure if it was the policy and indicated that she would have to look at the policy itself. Staff #51 added that she would rather someone be over charted. Staff #51 shared that Resident #2 had mentioned to her that a staff member had pulled her arm and that she had made a complaint about it. Staff #51 shared that she would expect that the incident would be charted and then a change of condition charting is done afterwards so that additional monitoring can take place. This is done because it brings it to their attention if