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	08/22/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interviews, review of clinical record, and review of facility policy and procedure, the facility failed to ensure infection control policies were followed during therapy sessions for five residents (#44, #45, #55, #180, and #181). The deficient practice could lead to spread of infection.Findings include:An observation was conducted on August 21, 2025, at 10:10 a.m. of a group therapy session occurring in the first-floor lounge room. Residents #44, #45, #55, #180, and #181 were present in the lounge, and being led in various therapy activities by a Physical Therapy Assistant (PTA/ staff #100). There was no hand sanitizer or handwashing station/sink or sanitizing agents such as spray or wipes observed in the lounge room. The PTA removed an ankle weight off of a female resident in a wheelchair and set the ankle weight on a chair without sanitizing it. The PTA did not sanitize or wash his hands. Then, the PTA picked up the ankle weight off of the chair and without sanitizing it, placed the ankle weight on Resident #44's leg. The PTA did not wash or sanitize his hands, and set up a front-wheeled walker in front of Resident #55. Then, the PTA donned a gait belt around Resident #55's waist and used touching assistance to help Resident #55 in a standing therapy activity with the walker. The LPN did not wash or sanitize his hands, and touched Resident #181 and her wheelchair, unlocked the wheelchair, and pushed Resident #181 back to her room. The PTA set up Resident #181 with her personal items in reach, and did not assist the resident with cleaning her hands. The PTA did not wash his hands at the sink in the room or sanitize his hands with the sanitizing dispenser located directly outside Resident #181's door, and left the room and started to walk back down the hall toward the lounge.An interview was conducted with PTA (Staff #100) on August 21, 2025, at the time he was walking back toward the lounge from Resident #181's room. Staff #100 stated that he was leading a therapy group in the lounge. The PTA stated that regarding infection control policies, that if a resident is on standard precautions that therapy staff would wear gown and gloves while working with a resident, and that if a resident was on universal precautions then the staff would wear a gown and mask when working with the resident. If a resident did not have any isolation precautions, then staff would be expected to wash hands or use hand sanitizer before working with the next resident. The PTA stated the importance of this would be to make sure that staff do not spread infection between residents. Regarding equipment, Staff #100 stated that staff wipe down equipment with sanitizing wipes before using it on another resident. The surveyor then notified Staff #100 that it was observed that he had not sanitized his hands or cleaned equipment between residents during the group, and that in group therapy, he may overlook sanitizing, and use equipment between residents, and then after the group sanitize the equipment. The PTA stated that he believed that this would meet the facility's infection control policy.The observation continued and the PTA (staff #100) walked directly back to the group therapy in the lounge and picked up the gait belt that had previously been used, and without sanitizing it, placed it on Resident #45. Additionally, without sanitizing the front wheeled walker that was previously used, Staff #100 placed the walker directly in front of Resident #55 to use.An interview was conducted with a Certified Occupational Therapy Assistant (COTA / Staff #138) on August 21, 2025, at 10:32 a.m. Staff #138 stated that staff perform handwashing or hand sanitizing after treating or touching a resident and before working with another resident. Additionally, Staff #138 stated that gait belts and other equipment are sanitized with (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wipes after being used and prior to using them with another resident. The lounge was observed with Staff #138, and Staff #138 stated that there was no handwashing station or hand sanitizer in the lounge, and that the closest one would be down the hall. Staff #138 stated that he was not sure about the facility's infection control policy, but that he could find out.An interview was conducted with the Therapy Program Manager and Physical Therapy Assistant (TPM / Staff #11), who stated that the facility's infection control policy requires staff to wipe down therapy equipment such as exercise bands and weights with sanitizing wipes prior to using it on another resident, and to wash hands or sanitize hands in between providing care or treatment for residents. Staff #11 stated that a therapist not sanitizing hands between residents or sanitizing equipment used between residents would not meet the facility's policy for infection control. Staff #11 stated that regarding the observation of Staff #100, that he would be doing an in-service with the therapy team.An interview was conducted with the Director of Nursing, (DON / Staff #91) on August 21, 2025, at 11:25 a.m., who stated that her expectation regarding infection control would be for staff to sanitize hands or wash hands in between working with patients. The DON stated that equipment would be sanitized between patient use, and that if residents were in group therapy and tossing a ball back and forth then the residents would be encouraged to wash their hands prior to tossing the ball back and forth, and that the ball would be cleaned afterward. The DON was notified that a staff was observed not sanitizing hands between touching residents and not sanitizing therapy equipment between resident use, and the DON stated that this would not meet the facility's infection control policy. The DON stated that she was notified of this by Staff #11, and that the facility is already taking steps to correct the issue.An additional interview was conducted on August 21, 2025, at 11:28 a.m. with a Certified Nursing Assistant and Restorative Nursing Assistant (CNA/RNA/ Staff #47), who stated that gait belts are sanitized after each resident use, equipment is sanitized after each resident use, and staff are required to sanitize their hands prior to resident care. Staff #47 stated that the risk if sanitization is not done is that there could be cross contamination of microorganisms which could spread infection.An In-Service/Education Summary sign-in sheet dated August 21, 2025, revealed the topic of the in-service was Sanitization/Infection Control, and that the contents included the procedure for sanitizing all therapy equipment before and after use, all therapists and therapy aids are to wash hands with soap before and after therapy session with patient, and use of sanitization wipes in accordance with directions printed on bottle, and hand sanitizer for patients.Review of the facility policy titled Hand Hygiene, revised October 2022, revealed it is the policy of the facility to provide the necessary supplies, education, and oversight to ensure healthcare workers perform hand hygiene based on accepted standards. Hand hygiene is one of the most effective measures to prevent spread of infection. All personnel shall follow handwashing/hand hygiene procedure to help prevent the spread of infections. Hand hygiene is a general term that applies to hand washing, antiseptic hand wash, and alcohol-based hand rub. The procedure included to wash hands with soap and water when hands are visibly soiled and after caring for a resident with known or suspected Clostridioides Difficile or Norovirus infection. Additionally, the procedure included to use an alcohol-based hand rub containing at least 62% alcohol; or soap and water for the following situations: before and after coming on duty, before and after coming into direct contact with residents, after contacting a resident's intact skin, and after contact with objects in the immediate vicinity of the resident.Review of the facility policy titled IPCP Standard and Transmission-Based Precautions revealed Standard Precautions are infection prevention practices that apply to the care of all residents regardless of suspected of confirmed infection or colonization status. They are based on the principle that all blood, body fluids, secretions, and excretions may contain transmissible infectious agents. Standard Precautions include: proper selection and use of personal protective equipment (PPE), hand hygiene, environmental cleaning and disinfection, and reprocessing of reusable medical equipment. If common use equipment for multiple patients is unavoidable, clean and disinfect such equipment before use on another patient.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, resident and staff interviews, and review of facility policy, the facility failed to ensure that the catheter bag was covered for one resident (#176). The deficient practice could result in resident not being treated with dignity and respect.Findings include:Resident #176 was readmitted to the facility on [DATE], with diagnoses that included acute kidney failure, elevated white blood cell count, depression, and dysphagia.The Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The assessment also included that the resident had an indwelling catheter.The indwelling catheter care plan initiated on July 30, 2025, included interventions to position the catheter bag and tubing below the level of the bladder and away from the entrance room door. There was no evidence of a cover on the catheter bag. During an observation that was conducted on August 19, 2025, at 1:22 p.m., Resident #176 was observed lying on his bed in his room, with an indwelling catheter bag placed below the bladder hanging on the left side of the bed with yellow liquid visible from the entrance room door. There was no evidence of a cover on the catheter bag.A second observation was conducted on August 19, 2025, at 2:44 p.m., Resident #176 was lying on his bed in his room, with his indwelling catheter bag placed below the bladder hanging on the left side of the bed with yellow liquid visible from the entrance room door. There was no evidence of a cover on the catheter bag.In another observation conducted with a Certified Nursing Assistant (CNA/ staff #73) on August 20, 2025, at 7:52 a.m., Resident #176 was lying on his bed in his room, with his indwelling catheter bag placed below the bladder hanging on the right side of the bed with yellow liquid visible. The CNA stated that the resident's catheter bag was not covered and that this would be a dignity issue.In an observation conducted with a Licensed Practical Nurse (LPN, staff #142) on August 20, 2025, at 8:10 a.m., Resident #176 was lying on his bed in his room, with his indwelling catheter bag placed below the bladder hanging on the right side of bed with yellow liquid visible. The LPN stated that she observed that Resident #176's catheter bag was uncovered, and yellow liquid inside the bag was visible. The LPN then stated that resident #176 was readmitted to the facility from hospital with an uncovered catheter bag. The LPN further stated that the facility does not use an uncovered plastic bag for resident privacy and dignity concerns.An interview was conducted with an Infection Preventionist (IP, # 300), on August 20, 2025, at 11:02 a.m., who stated that the catheter bag should be covered for patient privacy and dignity.In an interview conducted with the Director of Nursing (DON/staff #91) on August 21, 2025, at 1:10 p.m., who stated that the catheter bag should be placed in a covered bag and secured to the side of the bed or under the wheelchair. The DON further stated that the catheter bag should be covered for dignity, especially when the resident is in a public area.A facility policy titled, Catheter Care, Indwelling, reviewed on July 7, 2024, revealed that catheter tubing should be kept below the level of bladder and the drainage bag should be covered with a privacy bag.