

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035190	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2026
NAME OF PROVIDER OR SUPPLIER Catalina Post Acute and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2611 North Warren 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident interviews, staff interviews, and a review of policies and procedures, the facility failed to ensure that one resident, out of three sampled residents (#201), had access to personal belongings within the facility, in reasonable timeframe, to ensure a homelike environment. The deficient practice could impact the resident's psychosocial well-being, and adjustment to the facility. Findings include: Resident #201 was initially admitted on [DATE] and the most recent re-admission was on July 22, 2026 with diagnosis including toxic encephalopathy, chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia, depression-unspecified, anxiety disorder, Parkinson's disease with dyskinesia, insomnia, hypertensive heart and chronic kidney disease with heart failure, atherosclerotic heart disease, chronic diastolic heart failure, localized edema, chronic pain, obesity, dependence on supplemental oxygen, osteoarthritis, and age-related osteoporosis. A review of the annual minimum data set (MDS) assessment dated [DATE] revealed no evidence of a BIMS (brief interview of mental status) score. A further review of the MDS revealed resident preferences that included: caring for personal belongings, use of phone in private, and a place to lock personal belongings. The Inventory of Personal Effect form dated July 4, 2026, revealed no personal belongings upon readmission. The physician orders revealed an order dated July 22, 2026 for non-pharmacological interventions which included to provide a quiet environment, to encourage the resident to express feelings, to talk to activities and to provide reassurance. The care plan revealed focus areas of COPD and oxygen therapy noting to monitor for breathing difficulty on exertion, respiratory distress and to remind the resident not to push beyond endurance. An additional focus area included that the resident was prescribed opioids for pain. The care plan also noted that the resident was at risk for impaired thought process and interventions included for social services to provide psychosocial support as needed. Furthermore, the resident was noted to be at risk for communication problems and interventions included to anticipate and meet the needs of the resident and to ensure/ provide a safe environment. The care plan also identified that the resident had self-care performance deficits due to weakness and impaired mobility, that the resident was at risk for falls and that the resident also was noted to have a potential for psychosocial well-being problem due to adjustment to a new environment. The care plan further identified that the resident was receiving both anti-anxiety and anti-depressant medications. An Inventory of Personal Effects form dated July 22, 2026 noted no evidence of new items or previously stored items by the facility. An observation was conducted on July 30, 2026 at approximately 8:43 AM. It was observed that plastic was wrapped around the room door handle and secured to the closet door, holding the door open. Behind the door, several plastic bags were observed to be stacked on top of one another. There was no evidence of personal items displayed in the resident's designated area. A telephonic interview was (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 035190	Facility ID: 035190 If continuation sheet Page 1 of 6

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, facility documentation, and policy review, the facility failed to ensure 1 of 3 sampled residents (Resident #301) was free from neglect related to adequate hydration and access to fluids to meet the resident's needs. The deficient practice could result in dehydration and associated complications, including physical discomfort and decline in the resident's health status. Findings include: Resident #301 was admitted on [DATE] with diagnosis including urinary tract infection, altered mental status, epilepsy, metabolic encephalopathy, anemia in chronic kidney disease, end stage renal disease, dependence on renal dialysis, unspecified atrial fibrillation, chronic diastolic heart failure, atherosclerotic heart disease of native coronary artery without angina pectoris, hypertensive heart and chronic kidney disease with heart failure and stage 5 chronic kidney disease, cirrhosis of the liver, type 2 diabetes mellitus, orthostatic hypotension, depression and anxiety disorder. A review of the 5-day minimum data set (MDS) dated [DATE] revealed that the resident had a BIMS (brief interview of mental status) score of 00, indicating that the resident was severely cognitively impaired. A review of the physician orders revealed a change of condition for a change in elevation dated July 29, 2026 6:00 PM. An order for in-house dialysis for Tuesday, Thursday and Saturday was observed to have had a start date of July 6, 2026. There was no evidence in the physician orders that the resident had a fluid restriction in place. A review of the care plan revealed a focus area noting that the resident had a potential/ actual impairment to skin integrity due to fragile skin and interventions included to encourage good nutrition and hydration in order to promote healthier skin. The care plan further noted that the resident was at risk for falls due to weakness and that interventions included to keep needed items, such as water ?etc' within reach. Another focus area noted that the resident was at risk for malnutrition/ hydration and noted interventions included to offer and encourage snacks / fluids between meals. A review of the fluid intake documentation on the Plan of Care (POC) Response History in the electronic medical record revealed the following fluid intake: July 7, 2026 (Tuesday): 9:59 PM no documented fluid intake noted as ?not applicable'. July 10, 2026 (Friday): 1:00 AM no documented fluid intake noted as ?not applicable'. July 11, 2026 (Saturday): 5:59 AM no documented fluid intake, noted as ?not applicable'. A total of 740 cc were (cubic centimeters) documented for the day. July 12, 2026 (Sunday): 5:59 no documented fluid intake, noted as ?not applicable'. A total of 720 cc documented for the day. July 13, 2026 (Monday): A total of 700 cc's was documented for the day. July 14, 2026 (Tuesday): 1:23 AM no documented fluid intake, noted as ?not applicable'. July 22, 2026 (Wednesday): Fluid intake only documented twice, once at 12:30 PM and once at 7:35 PM for a total of 960 cc for the day. A review of the progress notes revealed no evidence that the resident was out of the facility on July 7, July 10, July 11, July 12 and July 14 of 2026. An observation was conducted on July 30, 2026 at 8:34 AM in the room of resident #301. The left side of resident's bed was situated closet to the window and had a fall mat positioned to the right side of the bed with a bedside tray table observed to the right of the fall mat and out of reach of the resident. No water pitcher or glass was observed on the bedside table or dresser in the resident's room. The resident was observed to have dry, and chapped lips. An observation was conducted on July 30, 2026 at 10:49 AM in the room of resident #301. Bedside tray table was observed to still be to the right side of the fall mat, outside of the resident's reach. No observed water pitcher or glass in the resident's room. An observation was conducted on July 30, 2026 at 11:17 AM in the room of resident #301. No water pitcher or glass was observed in the resident's room. The tray table was still located (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to the right of the fall mat and outside of the resident's reach. An interview was conducted on July 30, 2026 at 10:49 AM with resident #301. Resident #301 stated that she was thirsty. She stated that every time she wants water she would have to use the call light to ask for it; however, she was unable to locate the call light which had been tucked into the side of her bed. Once the resident did locate the call light, she activated it and requested water. An interview was conducted on July 30, 2026 at 8:47 AM with licensed practical nurse (LPN/ staff #31). Staff #31 stated that signs of dehydration could include a change in blood pressure or other vital signs, dry skin, dry / chapped lips, frequent urinary tract infections and dizziness. Staff #31 stated that there should be water pitchers in every room and that they are refreshed at least twice per shift or more if the resident requests it. The LPN stated that she usually likes to see her residents take in 1000 cc or more of fluids unless they are on fluid restriction. Staff #31 stated that if a certified nursing assistant (CNA) reported that a resident was not drinking a lot or refusing fluids, she would attempt to discuss it with the resident and if the issue did not resolve, she would elevate it to her director of nursing (DON). An interview was conducted on July 30, 2026 at 10:38 AM with CNA/ staff #7. Staff #7 stated that some of the signs of dehydration would include if a resident's skin looked dry, if they were going to the bathroom less frequently then they had been, if the color of their urine has suddenly become darker, if a resident appears more fatigued or if they experience dizziness. Staff #7 stated if she observed that the resident wasn't drinking a lot, she would encourage fluids and advise the nurse. Staff #7 stated that fluid intake is documented once per shift in the CNA POC section of the electronic health record. She further stated that 'not applicable' in the POC should only be used if the resident was out of the facility or on an appointment. An interview was conducted on July 30, 2026 at 11:06 AM with LPN/ staff #18. Staff #18 stated that resident #301 had no fluid restrictions and should have a pitcher of water in her room that should be refreshed several times per shift or more if the resident requests it. Staff #18 entered the resident's room and confirmed that there was no water pitcher or glass in the resident's room and that the bedside table was not within reach of the resident. Staff #18 stated that the resident's lips did look a little dry. Staff #18 obtained water for the resident and moved the fall mat in order to position the bedside tray table closer to the bed and ensure that it was within reach of the resident. Staff #18 stated that the risk of not being able to access water readily could include dehydration. An interview was conducted on July 30, 2026 at 11:15 AM with CNA/ staff #21. The CNA stated that she always moves the tray table close to the resident, but stated that she had not seen that it was out of reach this morning. Staff #21 further stated that when dialysis comes in, they sometimes move the tray table back for easier access and then forget to move it back closer to the resident. The CNA stated that she goes into the resident's room at least every couple of hours to check on the resident, make sure the tray table is positioned close to the resident, offer water and ask if she needs anything; however, there was no water observed in the resident's room and the tray table was out of reach of the resident since 8:34 AM on July 30, 2026. An interview was conducted on July 30, 2026 at 11:38 AM with the director of nursing (DON/ staff #94). The DON defined neglect as not providing the care to someone of who needs it, which would include food, water and basic needs. Staff #94 stated that the expectation for hydration is that ice water is passed every shift, and that residents receive water during medication administration and meals. Staff #94 further stated that unless a resident was on fluid restrictions, she thought residents should be receiving between 1200 and 1500 cc of fluids daily. Staff #94 pulled up the POC documentation regarding fluid intake for resident #301. The DON stated that it appeared that the CNA's may have missed some documentation and that several days indicated that the resident had below 1000cc of fluids. She further stated that she would be most concerned with the entry selection in the POC indicating 'not applicable'. Staff (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#94 stated that if a resident is not eating or drinking for a day or two, she would expect staff to 'move it forward' and that a change of condition would be noted and this may result in the resident receiving supplements and or intravenous hydration. Staff #94 stated that the POC for fluid intake is not 100% accurate as it did not account for water given with medications or during snacks. Staff #94 further stated that water should be within reach of the resident and if there is a fall mat that there is a way to position the bedside table to ensure that the resident has access to the table. Staff #94 stated that the risk for not receiving enough fluids or having access to fluids could result in dehydration and psychological stress. A review of the facility policy titled Intake dated May of 2026 revealed that the purpose of the policy was to provide an accurate record of the resident's fluid intake. The policy further noted that nursing assistants will document fluids (in cc's) consumed and to monitor and record fluid intake from diet trays and from water pitchers at bedside. The policy titled Hydration dated January 2026 revealed that it is the policy of the facility to provide each resident with sufficient fluid intake to maintain proper hydration and health. The policy further noted that each resident is provided a container of fresh water, which is located on the resident's bedside stand, unless contraindicated. The policy titled Abuse: Prevention of and Prohibition Against revised December 2025 revealed that each resident has the right to be free from abuse, neglect, misappropriation, exploitation and mistreatment. The policy defined neglect as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress.		