STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035190	A. Building B. Wing	09/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Catalina Post Acute and Rehabilitation	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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Facility The facility failed to ensure that food is labeled and dated in accordance with food safety practices.Based on observations, staff interviews and policy review, the facility failed to ensure that food is labeled and dated in accordance with professional food safety standards.Findings include:An initial kitchen walk-through was conducted on September 14, 2025 at 9:00 AM. The cook, staff #55, was present during the walk-through, as the dietary manager was not on premises at the time. A bag of jalapenos, dated August 27, 2025, was observed in the cooling refrigerator. Staff #55 stated that the jalapenos should not be in the refrigerator more than 2 weeks. She removed the bag and stated that the risk for storing the jalapenos past the 2 week designated time frame could include foodborne illness. A further observation revealed a tomato, not bagged, with no indication of date or how long it had been there. A bag of lettuce was observed dated September 7, 2025 with no noted use-by date. Staff #55 stated that she was unsure how long these could be kept.During the same initial kitchen walk-through, a freezer observation was conducted at 9:05 AM. Staff #55 was present. Within the freezer, 2 bags of bountiful harvest brussel sprouts, an open bag of breadsticks as well as an open bag of Hawaiian rolls were observed without an open or use-by date. In the refrigerator, a box of bananas was observed with a received by date of September 9, 2025, discolored and large areas observed to be blackened. Staff #55 stated that these were to be used for pancakes.A follow-up interview was conducted on September 14, 2025 at 9:15 AM with staff #55 post initial kitchen walk-through. Staff #55 stated that all food products that are stored in the kitchen should be labeled and dated once taken out of a box and or opened. Staff #55 stated that the risk could include no knowing how long an item has been stored and a potential for foodborne illness.An interview was conducted on September 15, 2025 at 7:24 AM with the Dietary Supervisor, staff #101. Staff #101 stated that the expectation is that all food is labeled and dated and that this should always be done. Staff #101 stated that she is constantly reminding staff and checking to ensure that it is done. Staff #101 stated that if something is not labeled and dated then it needs to be thrown out and that the risk could include residents getting sick.An interview was conducted on September 15, 2025 at 8:57 AM with the administrator, staff #88. Staff #88 stated that the expectation is that all food products are properly labeled and dated upon delivery and storage, as well as thereafter once items have been opened. Staff #88 stated that the risk could include not knowing when the food was received, stored or opened. A review of the policy entitled Food Storage with a copyright date of 2014 revealed that food should be covered, labeled and dated if stored and not for immediate use. The policy further noted that all foods will be checked to assure that foods (including leftovers) would be consumed by their use by dates.

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of the clinical record, staff interviews, and the facility's policies and procedures, the facility failed to ensure that 1 out of 23 residents (Resident # 7) received pain medication as ordered by the physician.Findings include: Resident # 7 was admitted on [DATE], with diagnosis of morbid obesity, muscle weakness, cognitive communication deficit, bipolar disorder, and major depressive disorder. Review of Resident # 7's care plan dated March 18, 2024, revealed that Resident # 7 was currently on opioids for pain management, with interventions that include administering opioids as prescribed. A review of the Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating that Resident # 7 is cognitively intact. Further review of the MDS revealed opioid usage. Review of Orders dated August 16, 2025, for Resident # 7 revealed an order for Oxycodone oral tablet 10 milligrams (mg) to be given by mouth every 4 hours as needed for pain rated as a 6-10. The Medical Administration Record (MAR) for the month of August 2025 revealed the following; August 26. 2025, at 10:03 p.m., Oxycodone was administered for a pain level of 8 out of 10.August 27, 2025, at 6:24 a.m., Oxycodone was administered for a pain level of 0 out of 10.August 27, 2025, at 10:29 a.m., Oxycodone was administered for a pain level of 9 out of 10. August 27, 2025, at 2:30 p.m., Oxycodone was administered for a pain level of 0 out of 10. Review of Resident # 7 MAR Administration notes revealed the following; August 27, 2025, at 6:28 a.m., the as needed (PRN) administration of Oxycodone on August 26, 2025, at 10:03 p.m. was effective and pain scale was a 0, even though the Oxycodone was administered again at 6:24 a.m. for a pain level 0. August 27, 2025, at 10:25 a.m., the PRN administration of Oxycodone at 6:24 a.m. was effective and the pain scale still remained 0, even though Oxycodone was administered again at 10:29 a.m. for a pain level of 9 out of 10. August 27, 2025, at 2:27 p.m. the PRN administration of Oxycodone at 10:29 a.m. was effective and the pain scale was a 0, even though Oxycodone was administered again at 2:30 p.m. for pain level 0.August 27, 2025, at 8:27 p.m. the PRN administration of Oxycodone at 2:30 p.m. was ineffective and the follow up pain scale was an 8. An interview conducted on September 16, 2025, at 8:38 a.m. with Licensed Practical Nurse (LPN/Staff #1) revealed that when Resident # 7 requested her pain medication, they would attempt non-pharmacological approaches to reduce the pain. If that did not work, they would obtain a current pain level and blood pressure to ensure that they were within parameters of giving the medication. Staff # 1 also revealed that the pain level and blood pressure are documented in the MAR, and the pain medication is administered. LPN Staff # 1 also revealed that she would wait roughly 30 minutes to an hour and check with Resident # 7 to see if the medication was effective, and this is documented as a MAR administration note. An interview conducted on September 16, 2025, at 9:11 a.m. with Director of Nursing (DON/Staff # 51) revealed that she expects medications to be administered within parameters that are set by the physician. Reviewing the medical administration record on August 27, 2025, DON # 51 revealed that the administration of oxycodone with pain level of 0/10 was outside the parameters set by the physician. The DON Staff # 51 revealed that giving medication outside of parameters has been an ongoing issue, and they have been working on correcting the issue, including having a Quality Assurance and Performance Improvement (QAPI) plan in place for medications outside of parameters. A Policy and Procedure titled; Physician Orders, dated May 2025. revealed that it is the policy of the facility to accurately implement orders 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.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, facility documentation and policy review, the facility failed to ensure an oxygen order was in place for 1 of 27 sampled residents (#45) in accordance with professional standards of practice. The deficient practice could result in being oxygen administered when not needed, oxygen concentration levels not aligned with the resident's needs, as well as appropriate monitoring, changing of oxygen tubing and documentation.Based on clinical record review, interviews, facility documentation and policy review, the facility failed to ensure an oxygen order was in place for one resident (#45) out of 21 The deficient practice could result in being oxygen administered when not needed, oxygen concentration levels not aligned with the resident's needs, as well as appropriate monitoring, changing of oxygen tubing and documentation.Findings include:Resident #45 was initially admitted on [DATE] with diagnosis including type II diabetes mellites with diabetic neuropathy, chronic obstructive pulmonary disease, insomnia, gastro-esophageal reflux disease without esophagitis, hypertension, heart failure, chronic kidney disease stage, chronic respiratory failure with hypoxia, muscle weakness, dysphagia, unspecified atrial fibrillation and cognitive communication deficit.The quarterly MDS (minimum data set) dated August 27, 2025 revealed a BIMS (brief interview of mental status) score of 13, which indicated that the resident was cognitively intact. The MDS further revealed that the resident was noted to be on oxygen therapy while residing at the facility.A review of the physician orders revealed no evidence of an order for oxygen; however, an order dated November 17, 2024 did reveal a pulmonary consult and treat as needed.A review of the care plan revealed that the resident had a focus area of emphysema/ chronic obstructive pulmonary disease with noted interventions including giving aerosol or bronchodilators, monitoring for breathing difficulty on exertion, monitoring for signs and symptoms of acute respiratory insufficiency, monitoring documenting and reporting to the medical doctor and signs and symptoms of respiratory infections use of enhanced barrier precautions and providing oxygen as ordered. However, review of facility documentation revealed no oxygen order.An observation on September 15, 2025 at 3:27 P.M. revealed resident #45 reclining in her hospital bed with the oxygen canula properly inserted and looped around her ears. It was observed that the oxygen concentrator was set at 2 liters per minute. No documentation noted on the tubing indicating when it had last been changed.An interview was conducted on September 15, 2025 at 9:10 A.M. with LPN (licensed practical nurse, staff #65). Staff #65 was asked if this resident and one other resident had orders in place for oxygen, staff #65 reviewed the electronic health record for resident #45 and stated that she did not see orders in point click care (PCC) for this resident, but stated that some residents are followed by the respiratory therapists and they may have the orders elsewhere.An interview was conducted on September 15, 2025 at 3:34 P.M. with resident #45. The resident stated that she is on 2 liters of oxygen and reported that she had been on oxygen since arriving at the facility. The resident stated that she sometimes feels out of breath.An interview was conducted on September 15, 2025 at 3:34 P.M. with the DRT (Director of Respiratory Therapy, staff #4). Staff #4 stated that respiratory therapy does not have the capacity to follow every resident in the building, but those that are followed by respiratory therapy would have the orders in place under assessments section in PCC as opposed to the physician orders section. Staff #4 further stated that all other residents not followed by respiratory therapy directly would be followed by nursing and would have orders in place under the physician order section of PCC. Staff #4 reviewed the electronic health record and master list and stated that resident #45 was not followed by the respiratory therapy team. Staff #4 reviewed the physician orders for resident #45 and stated that she did not see orders for oxygen for this resident.An interview was conducted on September 15, 2025 at 3:56 P.M. with the DON (director of nursing, staff #51). Staff #51 stated that her expectations are that when a doctor gives orders that these are documented and carried out as ordered. Staff #51 further stated that oxygen orders are to (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be in place and properly documented for residents not followed by respiratory therapy. Staff #51 reviewed the resident's medical record in PCC and stated that she did not see any indication that the resident was being followed by the respiratory therapy team and stated that the resident was being followed by nursing. Staff #51 reviewed the resident's physician orders and stated that she did not see orders for oxygen for resident #45. Staff #51 further stated that this did not meet her expectations. She stated that the risk would include staff not being aware and able to monitor the resident accordingly for oxygen, as well as not documenting the oxygen saturation levels and changing out the tubing as required.A review of the policy entitled Oxygen Administration reviewed July 2025 revealed that the resident's clinical record will include that oxygen is be administered, when and how often it is to be administered, the type of oxygen device to be used, charting and documentation related to oxygen use, oxygen concentrators to be maintained in the room when oxygen is ordered, and staff are to replace oxygen tubing as needed.A review of the policy entitled Physician Orders revised May 2025 revealed that it is the facility policy that drugs shall be administered only upon the order of a person duly licensed and authorized to prescribe such drugs.