STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **035004**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **01/25/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SANTA ROSA CARE CENTER	**1650 NORTH SANTA ROSA AVENUE TUCSON, AZ 85712**

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 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 reviews, staff and resident interviews, facility documentation, and a review of the facility's policy and procedures, the facility failed to ensure one resident (#94) was free from abuse from resident (#30) and that resident (#109) was free from abuse from resident (#33). Findings include: -Resident #94 was admitted to the facility on (MONTH) 20, 2013 and readmitted on (MONTH) 12, (YEAR), with [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set (MDS) assessment dated (MONTH) 23, (YEAR) revealed the resident scored a 6 on the Brief Interview for Mental Status (BIMS) indicating the resident had severe cognitive impairment. The assessment included the resident exhibited verbal behavioral symptoms such as threatening and screaming directed toward others A nurse practitioner note dated (MONTH) 7, (YEAR) revealed the resident was awake, alert, and oriented to self with memory loss and confusion and was able to independently propels herself in the wheelchair. A nursing note dated (MONTH) 9, (YEAR) revealed the resident was observed with scratches to her right cheek, back of neck, and right upper arm. A behavioral health team note dated (MONTH) 11, (YEAR) revealed on (MONTH) 9, (YEAR) the resident (#94) was witnessed to have scratches on her right cheek, back of her neck, and the right upper arm. Per the documentation, when the resident was asked about the scratches on her cheek, the resident stated that resident #30 caused the scratches. The documentation included the resident was asked why resident #30 scratched her and that she stated I don't know she (resident #30) just hates me and that they were talking when resident #30 struck her. The documentation included the resident was unable to elaborate more and stared blankly. -Resident #30 was admitted to the facility on (MONTH) 25, (YEAR) with [DIAGNOSES REDACTED]. Review of the quarterly MDS assessment dated (MONTH) 27, (YEAR) revealed the resident scored a 15 on the Brief Interview for Mental Status (BIMS) indicating the resident was cognitively intact. The assessment included the resident exhibited verbal behavioral symptoms such as threatening and screaming directed toward others Review of the monthly behavior summary report dated (MONTH) 20, (YEAR) dated (MONTH) 20, (YEAR) revealed the resident was being monitored for physical aggression as evidence by striking out and verbal aggression as evidence by yelling and antagonizing others. Interventions included 1:1 redirection, activities, and to anticipate possible triggers. A nursing note dated (MONTH) 9, (YEAR) at 12:00 p.m. revealed a CNA called the nurse to the patio area and that the nurse noticed resident #94 had multiple scratches to her right cheek, back of neck, and right upper arm. The note included resident #94 stated resident #30 scratched her and that resident #30 stated resident #94 was trying to take her bread. A behavioral health team progress note dated (MONTH) 11, (YEAR) revealed resident #30 was seen for a resident to resident altercation. Per the note, staff reported the resident was experiencing increased aggression and had an altercation. The progress note included that when the resident was asked about the altercation, she stated that she had the altercation with resident #94 because she gets in my way. Review of the facility's documentation dated (MONTH) 13, (YEAR) revealed that on (MONTH) 9, (YEAR) at 12:00 p.m., resident #94 and resident #30 were in the patio when a Certified Nursing Assistant (CNA/staff #14) saw resident #30 hands on resident #94 shoulders. Per the documentation, staff intervened and scratches were noted on resident #94's right shoulder, right cheek, and right biceps area. Review of the behavior and intervention monthly flow record for (MONTH) (YEAR) dated (MONTH) 16, (YEAR) revealed the resident (#30) was being monitored for yelling and striking out. The record included the resident exhibited multiple episodes of yelling out but no episodes of striking out were documented. During an interview conducted on (MONTH) 24, 2019 at 7:54 a.m. with a registered nurse (RN/staff #105), he stated a resident to resident altercation is a form of abuse. The RN stated that at the time of the incident resident #30 was exhibiting more aggression and hallucinations and that she was diagnosed with [REDACTED]. He further stated resident #30 had no prior altercations with other residents. An interview was conducted on (MONTH) 24, 2019 at 10:34 a.m. with a CNA (staff #14). She stated resident to resident altercations are a form of abuse. She stated resident #94 is not aggressive and does not fights with other residents but that she does yell loudly. The CNA stated that during lunch the residents were outside on the patio when she observed resident #30's hands on resident #94's neck. She stated resident #94 was trying to get away from resident #30 and yelled get her off of me. The CNA stated that when she called out to the residents, the residents separated and that she observed scratches on resident #94. She stated she notified the licensed practical nurse (LPN/staff #15). Staff #14 further stated resident #30 and resident #94 were good friends prior to the incident. An interview was conducted on (MONTH) 24, 2019 at 11:05 a.m. with an LPN (staff #15). He stated that he did not recall the altercation between the two residents. During an interview conducted on (MONTH) 24, 2019 at 1:45 p.m. with resident #30, she stated that she did not have an altercation with resident #94. During an interview conducted on (MONTH) 25, 2019 at 9:31 a.m. with resident #94, she stated that she and resident #30 were outside on the patio arguing about money when resident #30 scratched her. She stated that she told resident #30 to get away. An interview was conducted on (MONTH) 25, 2019 at 10:58 a.m. with the Director of Nursing (DON/ staff #99). The DON stated resident #30 was experiencing an acute episode of [MEDICAL CONDITION] related to an infection at the time of the altercation. He stated that to his knowledge resident #30 had no prior incidents of verbal or physician aggression toward other residents. The DON stated that it was not witnessed how the altercation occurred, but that it was witnessed that resident #30 had her hands on resident #94 shoulders and resident #94 had scratches afterward. He stated the incident was identified as a behavioral occurrence because he was unable to conclude if there was intent or if resident #30 was responding to internal stimuli. He stated when resident #30 was questioned, she ignored him and did not say if she was trying to hurt resident #94. -Resident #109 was admitted to the facility on (MONTH) 27, (YEAR), with [DIAGNOSES REDACTED]. A review of the admission MDS assessment dated (MONTH) 2, 2019 revealed the resident scored a 14 on the BIMS indicating the resident was cognitively intact. -Resident #33 was readmitted to the facility on (MONTH) 21, (YEAR), with [DIAGNOSES REDACTED].

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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NAME OF PROVIDER OF SUPPLIER **SANTA ROSA CARE CENTER**		STREET ADDRESS, CITY, STATE, ZIP **1650 NORTH SANTA ROSA AVENUE TUCSON, AZ 85712**	

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F 0600 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) A review of the quarterly MDS (Minimum Data Set) assessment dated (MONTH) 3, (YEAR) revealed the resident scored a 13 on the Brief Interview for Mental Status (BIMS) indicating that the resident was cognitively intact. A behavior Care Plan revised on (MONTH) 15, (YEAR) revealed the resident had chronic combative and disruptive behavior and had the potential for violence toward himself and others. Interventions included assessing and monitoring the resident's agitation and combativeness which included hitting, pinching, kicking etc. and removing the resident from situations when he was combative. Review of the facility's investigative documentation dated (MONTH) 2, 2019 revealed that on (MONTH) 29, (YEAR) at 6:45 a.m., resident #33 was using the adjoining bathroom to his room, which is shared with resident #109. The toilet was clogged and resident #109 opened the bathroom door to tell resident #33 that the toilet was clogged and asked him not to flush the toilet. Resident #33 then pushed the bathroom door open and jumped on resident #109. The documentation included resident #33 choked resident #109 leaving red marks on his neck and scratched his right cheek. Resident #33 was not injured. When staff heard yelling, they responded and pulled the residents apart. The documentation included resident #33 agreed to move to another room further away from resident #109. On (MONTH) 23, 2019 at 1:40 p.m., an interview was conducted with resident #109 who stated that on the day resident #33 attacked him; the toilet in the bathroom located between their adjoining rooms was clogged. He stated resident #33 entered the bathroom from his room to use the toilet and that he barely opened the bathroom door from his room to asked resident #33 not to flush the toilet because the toilet was clogged. He said that resident #33 then pushed the door open and jumped on him. He said he fell and hit his head on the floor and resident #33 scratched the right side of his face and put both of his hands around his neck. He stated that he did not hit resident #33, but he did grab his head with both hands and tried to push him off of him. Resident #109 stated that resident #33 jumped on him twice. He stated staff came quickly to help him and were trying to pull resident #33 off of him. He said the police came and asked him if he wanted to press charges and he said, Yes, but that he has not heard anything. During an interview conducted on (MONTH) 24, 2019 at 8:49 a.m. with a CNA (staff #81), the CNA stated that there is always a CNA monitoring the hallway and completing room checks every 15 minutes. He stated that he has not seen resident #33 strike anyone because as soon as resident #33 begins raising his voice he intervenes before the resident becomes physically aggressive. An interview was conducted on (MONTH) 24, 2019 at 9:10 a.m. with a Licensed Practical Nurse (LPN/staff #90) who stated that resident #33 is very vocal when he is upset and that she knows to redirect him when he is upset and/or yelling before his behavior can escalate to physical aggression. The LPN stated that she will try to redirect him to the hallway area when he is upset, so that he can be monitored more closely. She said that resident #33 is checked on every 15 minutes. The LPN stated that the residents were educated to lock the bathroom door when they are in the bathroom. She also stated that when the bathroom door is locked, residents are to ask staff for assistance if they need to use the bathroom. Review of the facility's abuse policy revealed the facility is committed to protecting residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, and staff from other agencies. The facility's abuse prevention program policy revealed residents have the right to be free from abuse, neglect, and exploitation and that the facility is committed to protecting residents from abuse by anyone including other residents.
F 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews, facility documentation, and policy review, the facility failed to implement their abuse policy regarding reporting an allegation of abuse involving two residents (#94 and #30). Findings include: -Resident #94 was admitted to the facility on (MONTH) 20, 2013 and readmitted on e (MONTH) 12, (YEAR), with [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set (MDS) assessment dated (MONTH) 23, (YEAR) revealed the resident scored a 6 on the Brief Interview for Mental Status (BIMS) indicating the resident had severe cognitive impairment. -Resident #30 was admitted to the facility on (MONTH) 25, (YEAR) with [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set (MDS) assessment dated (MONTH) 27, (YEAR) revealed the resident scored a 15 on the Brief Interview for Mental Status (BIMS) indicating the resident was cognitively intact. Review of facility documentation dated (MONTH) 13, (YEAR) revealed that on (MONTH) 9, (YEAR) at 12 p.m. resident #94 and resident #30 were outside on the patio when a staff member (#14) observed resident #30's hands on resident #94's shoulders. Per the documentation, staff intervened and scratches were noted on resident #94's right shoulder, right cheek, and right biceps area. The documentation included that this incident was reported to the State Agency on (MONTH) 9, (YEAR) at 8:30 p.m. An interview was conducted on (MONTH) 24, 2019 at 7:54 a.m. with a registered nurse (RN/staff #105). He stated a resident to resident altercation is a form of abuse. The RN stated that for a resident to resident altercation the abuse is reported right away to all managers, Adult Protective Services, the State Agency, and the police within 2 hours. During an interview conducted on (MONTH) 25, 2019 at 9:09 a.m. with the Social Services Director (staff #26), she stated an allegation of abuse is to be reported within two hours to the State Agency. An interview was conducted on (MONTH) 25, 2019 at 10:58 a.m. with the Director of Nursing (DON/ staff #99). He stated staff are expected to immediately intervene if abuse is witnessed. He stated the abuse is then reported to the DON and administrator. The DON stated the State Agency is notified as soon as possible once a allegation of abuse has been reported. He stated that the incident between the resident #94 and resident #30 occurred at 12 p.m. and that he notified the State Agency at 8:30 p.m. The facility's policy regarding reporting allegations of resident abuse revealed the administrator must report incidents or allegations of abuse to the State Agency immediately in accordance with State and Federal regulations/statues.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews, facility documentation, and policy review, the facility failed to ensure an allegation of abuse involving two residents (#94 and #30) was reported to the State Agency within two hours. Findings include: -Resident #94 was admitted to the facility on (MONTH) 20, 2013 and readmitted on e (MONTH) 12, (YEAR), with [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set (MDS) assessment dated (MONTH) 23, (YEAR) revealed the resident scored a 6 on the Brief Interview for Mental Status (BIMS) indicating the resident had severe cognitive impairment. -Resident #30 was admitted to the facility on (MONTH) 25, (YEAR) with [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set (MDS) assessment dated (MONTH) 27, (YEAR) revealed the resident scored a 15 on the Brief Interview for Mental Status (BIMS) indicating the resident is cognitively intact. Review of facility documentation dated (MONTH) 13, (YEAR) revealed on (MONTH) 9, (YEAR) at 12 p.m. resident #94 and resident #30 were outside on the patio when a staff member (#14) observed resident #30's hands on resident #94's shoulders. Per the documentation, staff intervened and scratches were noted on resident #94's right shoulder, right cheek, and right biceps area. The documentation included that this incident was reported to the State Agency on (MONTH) 9, (YEAR) at 8:30 p.m. An interview was conducted on (MONTH) 24, 2019 at 7:54 a.m. with a registered nurse (RN/staff #105). He stated a resident to resident altercation is a form of abuse. The RN stated that for a resident to resident altercation the abuse is reported right away to all managers, Adult Protective Services, the State Agency, and the police within 2 hours. During an interview conducted on (MONTH) 25, 2019 at 9:09 a.m. with the Social Services Director (staff #26), she stated an allegation of abuse is to be reported within two hours to the State Agency. An interview was conducted on (MONTH) 25, 2019 at 10:58 a.m. with the Director of Nursing (DON/ staff #99). He stated staff

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F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) are expected to immediately intervene if abuse is witnessed. He stated the abuse is then reported to the DON and administrator. The DON stated the State Agency is notified as soon as possible once a allegation of abuse has been reported. He stated that the incident between the resident #94 and resident #30 occurred at 12 p.m. and that he notified the State Agency at 8:30 p.m. The facility's policy regarding reporting allegations of resident abuse revealed the administrator must report incidents or allegations of abuse to the State Agency immediately in accordance with State and Federal regulations/statues.
F 0655 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and resident and staff interviews, the facility failed to ensure a summary of the baseline care plan was provided to one resident (#63). Findings include: Resident #63 was admitted to the facility on (MONTH) 28, (YEAR) with [DIAGNOSES REDACTED]. Review of the clinical record revealed a form titled Baseline Care Plan Summary, this form included the resident's goals during his admission, medication orders, and diet orders. This form included a space for the resident to sign. However, there was no resident signature documented. Further review of the clinical record revealed no evidence the resident was provided with a summary of his baseline care plan. Review of the admission Minimum Data Set (MDS) assessment dated (MONTH) 5, (YEAR) revealed the resident scored a 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was cognitively intact. During an interview conducted on (MONTH) 22, 2019 at 12:28 p.m. with the resident, he stated that the staff do not include him in his care. An interview was conducted on (MONTH) 25, 2019 at 10:04 a.m. with a unit coordinator/ registered nurse (RN/ staff #40). She stated baseline care plans are developed within two days after admission and include resident diagnoses, activities of daily living needs, and dietary status. She stated baseline care plans and goals are reviewed with the resident and a copy is offered to the resident. The RN stated that the resident will sign on the baseline care plan summary that a copy of the baseline care plan was provided to them. After reviewing the clinical record, she stated the baseline care plan summary for resident #63 was not signed but that she reviewed the care plan with the resident. An interview was conducted on (MONTH) 25, 2019 at 10:58 a.m. with the Director of Nursing (DON/ staff #99). He stated baseline care plans are developed within 48 hours after admission. He stated the baseline care plan includes medications, high risk concerns, and activities of daily living. The DON stated a final summary of the baseline care plan is given to the resident or the resident's representative. He stated on the baseline care plan summary form the resident will sign indicating the resident received or refused a copy of the baseline care plan. He stated that it is the facility's expectation that a copy of the baseline care plan is given to the resident or the resident's representative. The DON also stated that the facility does not have a policy for baseline care plans.