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	10/29/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0641 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, and review of facility policy and procedure, the facility failed to ensure one resident's (#91) assessment was accurate and reflective of the resident's status at the time of the assessment. The deficient practice could result in the resident not receiving appropriate care that is necessary for their wellbeing.Findings include:Resident #91 was admitted to the facility on [DATE] with diagnoses that included acute respiratory failure with hypoxia, generalized muscle weakness, tracheostomy status, and dysphagia following cerebral infarction.Resident #91 was discharged from the facility on October 10, 2025.Review of the admission Minimum Data Set (MDS), dated [DATE] indicated Resident #91 completed a Brief Interview for Mental Status (BIMS) and scored a 00 which indicated she had severe cognitive impairment. The same MDS also indicated Resident #91 had no impairments in in the upper (shoulder, elbow, wrist, and hand) extremity.Review of the discharge record from the resident's previous facility indicated that Resident #91 had an x-ray of the left humerus on August 28, 2025 at 1:52 P.M. Findings for the x-ray indicated there was a severely angulated fracture of the proximal humeral shaft. Glenohumeral joint alignment appears to be preserved. No focal soft tissue abnormality. It was also noted that per family, she broke it approximately 2 years ago and ortho determined she was too high risk for surgical fixation, daughter will bring in brace.A review of the Initial admission Record, dated September 10, 2025 at 5:46 PM indicated Resident #91 was nonverbal and was not admitted with a sling device. It also noted that Resident #91 only moved her extremities with tactile stimuli.A review of Resident #91's Care Plan, initiated on September 11, 2025, revealed no goals or interventions related to her history of shoulder dislocation.A review of a Physical Therapy Evaluation and Plan of Treatment, dated September 11, 2025 indicated Resident #91 was referred to Physical Therapy (PT) for several conditions and one of them was identified as a chronic left humerus fracture. It was also noted that the fracture took place 2 years ago and the resident was too high of a risk for surgical fixation. The same evaluation identified several precautions for the resident and one of the precautions was using a sling for comfort due to a left humerus fracture.A review of an Occupational Therapy Evaluation and Plan of Treatment, dated September 11, 2025, indicated Resident #91's Range of Motion (ROM) was impaired in the Left Upper Extremity (LUE).Review of the Physician's Orders revealed an order, dated October 8, 2025 for an x-ray of the left humerus and left shoulder, stat, for left shoulder looks displaced.A second order, dated October 9, 2025, indicated that a sling was to be used on the left arm continuously for 8 weeks for a fracture of midshaft of the humerus.Review of the clinical chart revealed a Daily Skilled Note, dated October 8, 2025 at 5:14 P.M. The note indicated that Resident #91 was spontaneously moving her left arm this evening at (4:30 P.M.) when the wound team was changing (resident's) wounds. The note continued to explain that Registered Nurse (RN/Staff #84) observed Resident #91 moving her left arm and that it appeared, to Staff #91, that the left shoulder was not in place. The note continued to explain that Staff #84 spoke with Resident #91's daughter, who was outside of the room, informing her what happened and that she was going to request an x-ray of the shoulder. The note indicated that the daughter explained that the left shoulder had been broken twice and Resident #91 was not a surgical candidate. The note indicated the provider was notified about the shoulder and a stat x-ray had been ordered for the left upper arm and shoulder.Review of a Nursing Note, dated October 9, 2025 at 5:58 P. M. indicated that the results of the x-ray was reported to the provider.Review of a Daily Skilled Note, dated October 9, 2025 at 1:00 P.M., noted the Resident's condition being monitored was the fracture of the left humerus with sling on at all times.An interview was conducted on October 30, 2025 at 8:24 A.M. with Certified Nursing Assistant (CNA/Staff #4). Staff #4 recalled Resident #91 as not moving all 4 extremities when she provided cares to her. She also did not recall Resident #91 using a shoulder sling however, she did remember when Resident #91 was being turned, her left shoulder looked like it had popped out. Staff #4 indicated that she did not know if the shoulder was broken. She shared that she shared the information with the nurse on duty but was unable to remember the name of the nurse she reported it to.An interview was conducted on October 30, 2025 at 8:39 A.M. with CNA/Staff #77. Staff described Resident #91 as incontinent, not talkative, didn't really move around and sometimes would track, Staff #77, with her eyes. She also described the left arm always hanging when providing cares. Staff #77 added that she would change Resident #91, sit her up to eat, changed her every two hours and repositioned her. She would sometimes groan during cares and Staff #77 would communicate the groans to the nurse on duty because she was not