STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035016	A. Building B. Wing	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Handmaker Home for the Aging	2221 North Rosemont Boulevard 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 - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(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 - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record reviews, interviews, and review of facility policy and procedures, the facility failed to protect the rights of one resident (#1) to be free from verbal and physical abuse by another resident (#2). The deficient practice resulted in psychosocial harm to resident #1 and the potential for abuse of other residents. As a result, the condition of Immediate Jeopardy (IJ) and Substandard Quality of Care was identified.Findings include:On September 10, 2025, at 4:10 PM, a condition of IJ was identified. The administrator (staff #110) and the assistant administrator (staff #103) were informed of the facility's failure to ensure resident #1 was protected from abuse by resident #2. Review of the clinical record resident #2 revealed a pattern of verbal abuse that started in June and escalated to physical abuse on September 3, 2025. Staff interviews revealed that these incidents were reported to administration, however, there was no evidence that the facility took steps to protect resident #1 from further abuse by resident #2. Further, staff interviews revealed that these incidents were considered as behaviors and not abuse. On September 10, 2025 at 5:46 p.m., the administrator and assistant administrator submitted a removal plan which was not accepted because the the plan did not address how they were going to implement their plan, who is responsible in ensuring that plan was implemented, and when they will start and end their plan.On September 11, 2025, at 8:51 AM, the removal plan was not accepted because it failed to to include specific procedures and timelines involved in the removal plan.On September 11, 2025, at 11:27 AM, the administrator and the assistant administrator submitted the revised IJ removal plan which was not acceptable because it failed to include completion of resident interviews, in-service training to staff and new hires, specific procedures, and timelines involved.On September 12, 2025, at 8:46 AM, the revised Immediate Jeopardy (IJ) Removal Plan was accepted. The plan included the following actions:Resident #2 was assigned a 1:1 sitter and relocated to a different unit, with behavior monitoring for three days;Resident #1 was assessed for injuries, including possible psychosocial harm. Clinical documentation was reviewed, and behavior was tracked for three days;Individualized care plans were updated;Ongoing staff training was implemented on how to identify abuse;Ongoing staff training was provided on how to intervene and stop abuse;Ongoing staff training was conducted on the proper protocol for reporting abuse;All residents were interviewed to identify any potential abuse. For residents unable to be interviewed, the MDS nurse completed an assessment for signs or symptoms of abuse; and,Monthly Quality Assurance and Performance Improvement (QAPI) meetings were scheduled to review any incidents or concerns related to abuse.Multiple observations were conducted on the facility implementing their removal plan, including resident #2 placed on 1:1 sitter and moved to another unit, resident #1 was assessed for injury including psychosocial harm and in-service training completed. Staff interviews conducted revealed that staff acknowledged training had been completed according to the facility's removal plan.On September 12, 2025, at 1:55 PM, the administrator and the assistant administrator were informed that the condition of the IJ had been removed.-Resident #3 (witness) was admitted on [DATE] with diagnoses of dementia, abnormalities of gait and mobility and muscle weakness.The care plan dated December 22, 2020 included that the resident had behaviors of wandering, impaired safety awareness related to dementia and was receiving behavioral health services. Interventions included all ADLs (activities of daily living) will be met by staff daily and resident in the secured memory care unit.The late entry provider visit note dated August 19, 2025 revealed the resident was alert, oriented 2-3, ambulated with 1-person assist and had no focal neurological deficits. Assessment included dementia. -Resident #1 (alleged victim) was admitted on [DATE], with diagnoses of dementia, muscle weakness, and history of falling.Review of the care plan dated December 24, 2024, included the resident needed assistance with activities of daily living (ADL) and was an elopement risk. Interventions included encourage resident to participate in activities that promote exercise, daily staff assistance with ADL's, distracting resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, and books that resident prefers and, to monitor/document/report PRN any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in functionThe MDS (Minimal Data Set) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 00, indicating the resident had severe cognitive impairment. The NP (nurse practitioner) psychiatric progress note dated June 29, 2025 included that resident #1 had history of dementia without behaviors and had no issues or concerns regarding psychiatric needs. Diagnosis included dementia without behavioral disturbance. Recommendations included

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (continued on next page)

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, interviews, and review of facility policy and procedures, the facility failed to implement their policies and procedures on resident protection, abuse reporting and investigation of an allegation of verbal and physical abuse for one resident (#1) by another resident (#2). The deficient practice resulted in further abuse of resident #1 Findings include:-Resident #3 (witness) was admitted on [DATE] with diagnoses of dementia, abnormalities of gait and mobility and muscle weakness.The late entry provider visit note dated August 19, 2025 revealed the resident was alert, oriented 2-3, ambulated with 1-person assist and had no focal neurological deficits. Assessment included dementia.-Resident #1 (alleged victim) was admitted on [DATE], with diagnoses of dementia, muscle weakness, and history of falling.The MDS (Minimal Data Set) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 00, indicating the resident had severe cognitive impairment. An infection note dated September 3, 2025 revealed that residents #1, #2, and #3 were sitting at the same table before dinner. Per the documentation, staff witnessed resident #2 standing over and yelling at resident #1; and that, staff intervened and moved resident #1 to the nurse's station and resident #2 returned to her room. The documentation also included that resident #3 told staff that resident #2 yelled and hit resident #1.A communication note dated September 6, 2025 included that the resident's family requested to speak with staff related to the resident's recent altercation with another resident (#2). -Resident #2 (alleged perpetrator) was admitted on [DATE], with diagnose of dementia, major depressive disorder, anxiety disorder, and schizoaffective disorder.A behavior note, dated June 12, 2025, revealed resident #2 displayed anger every time resident #1 who was sitting near resident #3. Per documentation, resident #2 had paranoia and reported that resident #1 was taking resident #3 from her; and that, resident #2 threatened resident #1 with physical violence and yelled at resident #1 who remained seated and looked confused while being yelled at by resident #2. The documentation also included that this behavior of resident #2 happens every time resident #1 tried to sit by resident #3. There was no evidence found in the clinical record and facility documentation that this incident was reported to the SA and APS; and, there was no evidence that the facility initiated and conducted an investigation of this incident. The clinical record revealed no evidence of any intervention implemented to prevent altercation from happening again between resident #1 and #2.The behavior note dated July 2, 2025 included resident #2 yelled at and threatened resident #1 because resident #1 was looking at her at the dinner table.Review of a behavior note dated July 8, 2025 revealed that resident #2 told resident #3 that resident #1 was wearing her shirt; and that, resident #2 then approached resident #1, grabbed the shirt of resident #1 and told resident #1 to give the shirt back. Per the documentation, resident #2 told resident #3 that they should beat up resident #1; and that, resident #3 told resident #2 they should not do that because they would go to jail. The documentation also included that the CNA (certified nurse assistant) was able to separate the residents. Another behavior note dated July 8, 2025 included that resident #2 was sitting with resident #3 and other residents watching tv. Per the documentation, resident #1 was just passing down the hallway to her room and resident #2 yelled at resident #1 to go away and to get out of here; and, staff noticed this behavior from resident #2 before when resident #1 was sitting with resident #3. The documentation included that staff called a family member who explained that the brother of resident #2 had married a woman with the same first name as resident #1 and that person was very abusive to the family and her children; and that, the family of resident #2 believed the resident was reliving her past when she sees resident #1. Further, the documentation included that the NP and the DON (Director of Nursing) were notified.A behavior note dated July 9, 2025 included resident #2 approached the dining room table where resident #1 was sitting at and yelled at resident #1. The documentation included that staff stepped in front of resident #1 to block the view of resident #2 who was then requested to return to her table. It also included that after a couple of minutes, resident #2 returned to her table but she was keeping an eye on resident #1.Another behavior note dated July 9, 2025 revealed that the ADON (Assistant Director of Nursing) notified the provider of the resident's behaviors. The behavior note dated July 10, 2025 included that resident #2 continued to make comments about resident #1 at meal times; and that, all 3 residents (#1, #2, and #3) were placed at different tables during meals. A general nursing progress note dated July 15, 2025 revealed that during dinner time, resident #2 was verbally aggressive toward resident #1; and that, resident #2 accused resident #1 of stealing her clothes and demanded that they were returned. Further, the documentation included that this behavior appear to frighten and intimidate

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, interviews, and review of facility policy and procedures, the facility failed to ensure allegations of verbal and physical abuse of one resident (#1) by another resident (#2) was reported to the State Agency (SA) and Adult Protective Services (APS). The deficient practice could result in abuse not investigated and resident not protected from further abuse.Findings include:-Resident #3 (witness) was admitted on [DATE] with diagnoses of dementia, abnormalities of gait and mobility and muscle weakness. The late entry provider visit note dated August 19, 2025 revealed the resident was alert, oriented 2-3, ambulated with 1-person assist and had no focal neurological deficits. Assessment included dementia. -Resident #1 (alleged victim) was admitted on [DATE], with diagnoses of dementia, muscle weakness, and history of falling.The MDS (Minimal Data Set) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 00, indicating the resident had severe cognitive impairment. An infection note dated September 3, 2025 revealed that residents #1, #2, and #3 were sitting at the same table before dinner. Per the documentation, staff witnessed resident #2 standing over and yelling at resident #1; and that, staff intervened and moved resident #1 to the nurse's station and resident #2 returned to her room. The documentation also included that resident #3 told staff that resident #2 yelled and hit resident #1.A communication note dated September 6, 2025 included that the resident's family requested to speak with staff related to the resident's recent altercation with another resident (#2). -Resident #2 (alleged perpetrator) was admitted on [DATE], with diagnose of dementia, major depressive disorder, anxiety disorder, and schizoaffective disorder.A behavior note, dated June 12, 2025, revealed resident #2 displayed anger every time resident #1 who was sitting near resident #3. Per documentation, resident #2 had paranoia and reported that resident #1 was taking resident #3 from her; and that, resident #2 threatened resident #1 with physical violence and yelled at resident #1 who remained seated and looked confused while being yelled at by resident #2. The documentation also included that this behavior of resident #2 happens every time resident #1 tried to sit by resident #3. There was no evidence found in the clinical record and facility documentation that this incident was reported to the SA and APS.The behavior note dated July 2, 2025 included resident #2 yelled at and threatened resident #1 because resident #1 was looking at her at the dinner table.Review of a behavior note dated July 8, 2025 revealed that resident #2 told resident #3 that resident #1 was wearing her shirt; and that, resident #2 then approached resident #1, grabbed the shirt of resident #1 and told resident #1 to give the shirt back. Per the documentation, resident #2 told resident #3 that they should beat up resident #1; and that, resident #3 told resident #2 they should not do that because they would go to jail. The documentation also included that the CNA (certified nurse assistant) was able to separate the residents. Another behavior note dated July 8, 2025 included that resident #2 was sitting with resident #3 and other residents watching tv. Per the documentation, resident #1 was just passing down the hallway to her room and resident #2 yelled at resident #1 to go away and to get out of here; and, staff noticed this behavior from resident #2 before when resident #1 was sitting with resident #3. The documentation included that staff called a family member who explained that the brother of resident #2 had married a woman with the same first name as resident #1 and that person was very abusive to the family and her children; and that, the family of resident #2 believed the resident was reliving her past when she sees resident #1. Further, the documentation included that the NP and the DON (Director of Nursing) were notified.However, there was no evidence that these incidents of verbal and physical abuse of resident #1 by resident #2 was reported to the SA and APS. A behavior note dated July 9, 2025 included resident #2 approached the dining room table where resident #1 was sitting at and yelled at resident #1. The documentation included that staff stepped in front of resident #1 to block the view of resident #2 who was then requested to return to her table. It also included that after a couple of minutes, resident #2 returned to her table but she was keeping an eye on resident #1.Another behavior note dated July 9, 2025 revealed that the ADON (Assistant Director of Nursing) notified the provider of the resident's behaviors. The behavior note dated July 10, 2025 included that resident #2 continued to make comments about resident #1 at meal times; and that, all 3 residents (#1, #2, and #3) were placed at different tables during meals. A general nursing progress note dated July 15, 2025 revealed that during dinner time, resident #2 was verbally aggressive toward resident #1; and that, resident #2 accused resident #1 of stealing her clothes and demanded that they were returned. Further, the documentation included that this behavior appear to frighten and intimidate resident #1 The behavior note

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, interviews and review of facility documentation, policies and procedures, the facility failed to ensure allegations of verbal and physical abuse of one resident (#1) by another resident (#2) were thoroughly investigated and appropriate corrective actions were taken. The deficient practice could result in resident not protected from further abuse.Findings include:-Resident #3 (witness) was admitted on [DATE] with diagnoses of dementia, abnormalities of gait and mobility and muscle weakness.The late entry provider visit note dated August 19, 2025 revealed the resident was alert, oriented 2-3, ambulated with 1-person assist and had no focal neurological deficits. Assessment included dementia.-Resident #1 (alleged victim) was admitted on [DATE], with diagnoses of dementia, muscle weakness, and history of falling.The MDS (Minimal Data Set) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 00, indicating the resident had severe cognitive impairment. An infection note dated September 3, 2025 revealed that residents #1, #2, and #3 were sitting at the same table before dinner. Per the documentation, staff witnessed resident #2 standing over and yelling at resident #1; and that, staff intervened and moved resident #1 to the nurse's station and resident #2 returned to her room. The documentation also included that resident #3 told staff that resident #2 yelled and hit resident #1.A communication note dated September 6, 2025 included that the resident's family requested to speak with staff related to the resident's recent altercation with another resident (#2). -Resident #2 (alleged perpetrator) was admitted on [DATE], with diagnose of dementia, major depressive disorder, anxiety disorder, and schizoaffective disorder.A behavior note, dated June 12, 2025, revealed resident #2 displayed anger every time resident #1 who was sitting near resident #3. Per documentation, resident #2 had paranoia and reported that resident #1 was taking resident #3 from her; and that, resident #2 threatened resident #1 with physical violence and yelled at resident #1 who remained seated and looked confused while being yelled at by resident #2. The documentation also included that this behavior of resident #2 happens every time resident #1 tried to sit by resident #3. There was no evidence found in the clinical record and facility documentation that the facility initiated and conducted an investigation of this incident. The behavior note dated July 2, 2025 included resident #2 yelled at and threatened resident #1 because resident #1 was looking at her at the dinner table.Review of a behavior note dated July 8, 2025 revealed that resident #2 told resident #3 that resident #1 was wearing her shirt; and that, resident #2 then approached resident #1, grabbed the shirt of resident #1 and told resident #1 to give the shirt back. Per the documentation, resident #2 told resident #3 that they should beat up resident #1; and that, resident #3 told resident #2 they should not do that because they would go to jail. The documentation also included that the CNA (certified nurse assistant) was able to separate the residents. Another behavior note dated July 8, 2025 included that resident #2 was sitting with resident #3 and other residents watching tv. Per the documentation, resident #1 was just passing down the hallway to her room and resident #2 yelled at resident #1 to go away and to get out of here; and, staff noticed this behavior from resident #2 before when resident #1 was sitting with resident #3. The documentation included that staff called a family member who explained that the brother of resident #2 had married a woman with the same first name as resident #1 and that person was very abusive to the family and her children; and that, the family of resident #2 believed the resident was reliving her past when she sees resident #1. Further, the documentation included that the NP and the DON (Director of Nursing) were notified.A behavior note dated July 9, 2025 included resident #2 approached the dining room table where resident #1 was sitting at and yelled at resident #1. The documentation included that staff stepped in front of resident #1 to block the view of resident #2 who was then requested to return to her table. It also included that after a couple of minutes, resident #2 returned to her table but she was keeping an eye on resident #1.Another behavior note dated July 9, 2025 revealed that the ADON (Assistant Director of Nursing) notified the provider of the resident's behaviors. The behavior note dated July 10, 2025 included that resident #2 continued to make comments about resident #1 at meal times; and that, all 3 residents (#1, #2, and #3) were placed at different tables during meals. A general nursing progress note dated July 15, 2025 revealed that during dinner time, resident #2 was verbally aggressive toward resident #1; and that, resident #2 accused resident #1 of stealing her clothes and demanded that they were returned. Further, the documentation included that this behavior appear to frighten and intimidate resident #1.The behavior note dated July 16, 2025 included resident #2 had a verbal altercation with resident #1 regarding a cat blanket which resident #2 claimed to belong to resident

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (continued on next page)

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F 0657 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 clinical record review, staff and family interviews, facility documentation and policy review, the facility failed to ensure the care plan for one resident (#2) was revised with interventions to address the resident's verbal and physical aggression towards other residents. The deficient practice could result in resident not meeting their needs according to their comprehensive assessment. Resident #2 was admitted on [DATE] with diagnoses including unspecified dementia, major depressive disorder, anxiety disorder. schizoaffective disorder-bipolar type and other idiopathic peripheral autonomic neuropathy.Review of the care plan dated October 17, 2024, revealed resident was dependent on staff and family for all emotional, intellectual, physical, and social needs. Interventions included to encourage ongoing family involvement and inviting to attend special events, activities, and meals, introducing resident to residents with similar backgrounds, interests, and encourage/facilitate interaction, invite the resident to scheduled activities and assist to and from programs to help encourage participation. The care plan did not include that the resident had behaviors such as verbal or physical aggression towards staff and/or residents.Review of the clinical record revealed documentation that the resident was verbally aggressive towards, yelled at and threatened another resident. A review of the quarterly MDS (minimum data set) dated July 17, 2025 revealed a BIMS (brief interview of mental status) score of 5, indicating severe cognitive impairment. The behavior section of the MDS revealed that resident #2 manifested verbal behavioral symptoms directed toward others 4 to 6 days a week.A review of the facility documentation revealed no evidence that the IDT (interdisciplinary team) had met and reviewed the quarterly MDS assessment for behaviors and updated the care plan accordingly at that time.Despite documentation that resident #2 exhibited verbal and physical aggression towards another resident, the care plan for resident #2 was not revised until September 11, 2025.The care plan initiated on September 11, 2025 revealed the resident had been physically and verbally aggressive towards other residents related to dementia. The goal was that the resident will not harm self or others. Interventions included 1:1 sitter in place, moved to another unit, remove other residents from resident #2 when her aggression escalates, intervene before agitation escalates, guide away from source of distress, administer medications as ordered and BHT services to evaluate and treat.An interview was conducted on September 11, 2025 at 9:39 A.M. with a registered nurse (RN/staff #108) who stated the MDS assessment resident #2 was done by a licensed practical nurse (LPN/staff #107). The RN stated that a unit staff will look at the MDS but do not enter information into the MDS; and that, information from the MDS gets pulled over into the resident's care plan. The RN said that care plans were utilized by the nursing staff to help identify the appropriate interventions for residents with behaviors and that everyone on the unit where resident #2 was residing had a behavioral focus area build into their care plan. During the interview, a review of the clinical record was conducted with the RN who stated that the resident's care plan did not have previous entries related to behaviors until September 11, 2025. The RN further stated that a behavioral component/focus of care should have been entered prior to September 11, 2025; and that, the lack of interventions in the care plan had a potential risk could be outbursts from the resident that staff might not be able to control.An interview was conducted on September 11, 2025 at 10:38 with the MDS nurse/LPN (staff #107) who stated that an MDS assessment was required on multiple occasions, which could include at admission, 5-day, quarterly, annual, change of condition, discharge or even coming on or off hospice. The LPN said that for behaviors on an existing resident, she would receive notification from nursing staff or the social worker that there was a behavior that a resident exhibited and what the behavior was. She stated that the documentation in the MDS, would determine if there was a need for care planning. During the interview, a review of the clinical record was conducted with the LPN who stated that there were verbal behaviors documented in the clinical record that should have been care planned. However, the LPN stated that the resident's care plan did not include the behaviors as a focus of care and had not been documented in the care plan. She stated that the resident had verbal behaviors and these should have been documented on the care plan. Further, the LPN stated that the risk for not documenting these in the care plan could impede behavior identification, de-escalation and continuance of the problem.An interview was conducted on September 11, 2025 at 11:09 A.M. with the assistant director of nursing (ADON/staff #104) who stated that if there was something identified on the MDS then it should be transferred to the care plan to address any concerns. A review of the clinical record was conducted by the ADON who stated that the clinical record documented the resident had identified verbal

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Handmaker Home for the Aging	2221 North Rosemont Boulevard 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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on interviews, facility documentation and postings, the facility failed to ensure the assistant administrator was duly appointed by the governing board. The deficient practice could contribute to actions, inactions or decisions regarding facility deficiencies, as related to attaining or maintaining the highest practicable physical, mental and psychosocial well-being of each resident.Findings include:A review of the personnel file for the assistant administrator (staff #103) revealed a job description dated September 1, 2023. The job description revealed that the position of an for assistant administrator was signed on September 13, 2023 by staff #103. The approval line within the document noting CEO (chief executive officer) approval was blank. Further, a handwritten line had been added which noted HR (human resources) containing the signature of staff #103 and dated on September 13, 2023.Review of the resume for staff #103 revealed that from September 17, 2024 to current, staff #103 had the title of an Assistant Administrator/ Marketing/Admissions Director for the facility. It also included that from October 25, 2025 to September 16, 2024 staff #103 had a job title of Marketing/admission Coordinator for the facility. Subsequent entries revealed a job title of Marketing Representative, and Receptionist for the facility. It was noted that staff #103 was self-employed from 1976 through 2000, training horses and giving riding lessons. The educational component of the resume revealed attendance at a community college from 1978 to 1980, with no notated degree. No licenses or certifications were documented in the resume.A facility business card for staff #103 revealed a title of Assistant Administrator.The staff list provided by the facility noted staff #103 as the Assistant Administrator.Further review of the facility documentation revealed a letter dated July 30, 2025 noting that under the Arizona Administrative Code R9-10-303, subsection (B)(3) staff #103, the assistant administrator, was designated as the individual who was present and accountable for the nursing care institution when the administrator was not present on the premises. The letter was signed by Licensed Nursing Home Administrator (staff #110).There was no evidence found in the facility documentation the Assistant Administrator (staff #103) was the qualified assistant administrator appointed by the facility's governing board.An interview was conducted on September 10, 2025 at 10:51 A.M. with a certified nursing assistant (CNA/staff #101) who stated that an incident of abuse had been reported to the Assistant Director of Nursing (ADON/staff #104) and to the Assistant Administrator (staff #103). The CNA stated that the incident was reported and the intruction from ADON and Assistant Administer was to let the incident go and to stop escalating it, as it involved residents in behavioral unit and that the residents would forget about it. However, both verbal abuse and intimidation, per staff interviews and facility documentation continued after the initial incident and no evidence of a thorough investigation or report to the state agency were observed in the facility documentation.An interview was conducted on September 11, 2025 at 9:39 A.M with RN (registered nurse/ staff #108). The RN stated that if resident to resident abuse occurred, she would separate the residents, ensure that there were no injuries, make sure they are safe and then report to the ADON (staff #104), the Assistant Administrator (staff #103) and the Administrator (staff #110). Staff #108 identified the ADON, Assistant Administrator and Administrator by first name and title. The RN stated that they would conduct the investigations and ensure that the proper notifications transpired.An interview was conducted on September 11, 2025 at 11:37 A.M. with staff #103 and staff #110. During the interview staff#103 identified herself as the Assistant Administrator. Staff #110 further stated that the facility did not have a policy for Assistant Administrator appointment, nor was he aware that the assistant administrator had to be appointed by the governing board. No risk was identified by staff #110.The facility did not have a policy for Assistant Administrator appointment.