

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  035016	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/12/2025
NAME OF PROVIDER OR SUPPLIER  Handmaker Home for the Aging		STREET ADDRESS, CITY, STATE, ZIP CODE  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 - 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.  (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:  035016	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/12/2025
NAME OF PROVIDER OR SUPPLIER  Handmaker Home for the Aging		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review, staff interviews, facility documentation, and policy review, the facility failed to ensure 2 of 5 sampled residents (Resident #1 and #4) was free from abuse by another staff member &amp; another resident (Staff #201 and Resident #5). The deficient practice could result in other residents being abused. Findings include:Regarding Resident #1:Resident # 1 (alleged victim) was re-admitted [DATE] with diagnoses that included hypertensive heart and chronic kidney disease, morbid obesity, major depressive disorder, anxiety disorder, and unspecified dementia.A comprehensive care plan initiated on August 15, 2025, revealed that the resident had an activity of daily living (ADL) performance deficit due to impaired balance and limited mobility. An admission Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 10 indicating moderate cognitive impairment. The MDS also revealed that the resident was dependent on staff for toileting hygiene and lower body dressing. A Nursing Note dated November 1, 2025, revealed that Resident #1 had care concerns with Certified Nursing Assistant (CNA/Staff #201) being angry and aggressive in her care on October 30, 2025. The nursing note also revealed that that the resident felt safe in the community as long as Staff # 201 was not taking care of her. A Weekly Body Check assessment dated [DATE], revealed red dry flaky skin to bilateral lower extremities and scab on her left upper back. Review of the initial facility report of alleged abuse to the State Agency from the Operations Assistant (Staff # 8) dated November 1, 2025, revealed that Resident #1 stated she received abusive care from Staff # 201 on Thursday, October 30, 2025. The facility report also revealed that Staff #8 came to the facility and interviewed Resident # 1 and confirmed residents concerns with her care. Staff #201 was removed from the schedule. Regarding Staff #201Review of Staff #201's (alleged perpetrator) personnel file revealed that she was employed as a Certified Nursing Assistant (CNA) with a start date of August 6, 2025.Further review of Staff #201's personnel record revealed an employee training checklist which included the topics of Resident Rights, and Elder Justice/Abuse/Neglect/Exploitation signed August 6, 2025.Review of Staff #201's personnel record also revealed a memo regarding Abuse Training Acknowledgement signed September 10, 2025. A Personnel and Payroll Notification form dated November 4, 2025 revealed that Staff #201 involuntary terminated from the facility due to resident's complaint and report that she was abusive on October 31, 2025. The personnel notification goes on to reveal that residents reported Staff #201 was aggressive, angry, had an abusive tone, and threw chips at them. A Facility Investigation Report dated November 4, 2025 revealed that Resident #1 gave a statement on November 1, 2025 in which she reported that Staff # 201 was abusive during care provided on October 31, 2025 between 10:00 p.m.- 6:00 a.m. shift. Per Resident #1, Staff # 201 was aggressive during personal care, and displayed an angry attitude. Resident #1 further revealed that when she requested a snack, Staff #201 threw the snack at her. Resident #1 stated that she did not feel safe around Staff # 201. The facility report documented that during staff and resident interviews, it was confirmed by several residents that Staff #201 was rough with cares and displayed an angry demeanor toward other residents. An interview was conduct with a CNA (Staff # 165) on November 12, 2025 at 2:49 p.m., which revealed that Resident #1 had never resisted cares and she is usually the first one they get out of bed in the mornings. Staff #165 said that Resident #1 is good and helping with cares so it does not take as long as some of the other residents. CNA noted that hitting a resident, grabbing onto residents or being rough with residents can be considered physical abuse. An interview with the Director of Nursing (DON/Staff # 19) on November 12, 2025 at 3:45 p.m., revealed that she was not in the position of DON during the incident with Resident #1 and Staff #201. However, the DON confirmed that Staff #201 was suspended then terminated when the allegations were substantiated. An interview with the Operations Assistant (Staff #8) on November 12, 2025 at 4:08 p.m., revealed that Resident #1 told her that Staff #201 was extremely rough and that her hands felt like vice grips on her arms. Staff #8 revealed that a full body check was done on Resident #1 with no bruising discovered. Staff #8 discovered during her investigation that Staff #201 was verbally rude to residents, threw a bag of potato chips at a resident and was identified by three other residents as physically aggressive and angry toward them. Staff #8 noted that residents did not want Staff #201 to take care of them. According to Staff # 8, Staff #201 refused to give a statement. Therefore, the facility decided to terminate Staff #202 due to all the statements from the residents. Regarding Resident # 4:Resident #4 (alleged victim) was admitted [DATE] with diagnoses that included metabolic encephalopathy, anxiety disorder, and muscle weakness A Behavior Noted dated November 5, 2025</p>		