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	12/24/2025

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 - 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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035016	A. Building B. Wing	12/24/2025

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 - 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 interviews, facility documentation, and policy review, the facility failed to ensure that 1 of 2 sampled residents (Resident #1) was free from abuse by staff members (Staff #163 and Staff #202). The deficient practice could result in other residents being abused. Findings include:-Regarding Resident #1Resident #1 was admitted on [DATE], with diagnoses that include unspecified dementia without behavioral disturbance, Bipolar disorder, major depressive disorder, and anxiety disorder. A comprehensive care plan initiated on January 27, 2023 revealed that the resident had behavior problems using abusive language, yelling, screaming, and threatening behavior related to dementia, bipolar disorder, and anxiety. The care plan also revealed that the resident refuses to ask for help when transferring, causing multiple falls. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. The MDS also revealed substantial maximum assistance required for shower assistance. An e-mail dated December 3, 2025 sent at 10:08 a.m. from Certified Nursing Assistant (CNA/Staff #7) sent to Nursing Home Administrator (ED/Staff #2) and the Director of Nursing (DON/Staff #69) revealed that on December 1, 2025 Staff # 7 was assigned to Resident #1 and was scheduled to provide a shower to Resident #1. It was revealed that Resident #1 had refused several attempts by Staff #7 to provide the shower, and he notified the Registered Nurse (RN/Staff #163), who was assigned to Resident #1. Staff #7 explained in the email that RN #163 told him not to ask Resident #1 for a shower, but just to take her into the shower. Staff # 7 opted to reapproach at a later time. Staff #7 revealed that the RN (Staff #163) had taken Resident #1 with the help of another CNA (Staff #202) against Resident #1's wishes into the shower and conducted a shower on Resident #1, Staff # 7 revealed that Resident # 1 was disagreeing being in the shower that she was cold and did not want wet hair. Staff #7 stated that both RN (Staff #163) and CNA (Staff #202) finished the shower and had CNA (Staff #7) dry the resident off and take her back to her room, where Staff # 7 describes Resident #1's mood as angry that this incident occurred. A late entry nursing note dated December 3, 2025, at 2:58 p.m. (created December 12, 2025, at 3:03 p.m.) revealed that Resident #1 was interviewed regarding the reported incident on December 1, 2025, and Resident # 1 reported that she felt safe in the facility and did not want to move rooms. Resident #1 denied any increase in depression and anxiety.A facility investigation interview with Resident #1, dated December 3, 2025 at 5:30 p.m., revealed that Resident #1 had stated that she was about ready to go to bed when Staff #163 and later identified Staff #202 pulled her out of bed by Resident #1's arms as she was yelling to stop. Resident #1 also revealed that they forced her to take a shower against her will. A nursing note dated December 3, 2025, revealed that police were present at the facility to look at red marks on Resident #1's arm and reported to the nurse that he did not think the red marks were from abuse. A comprehensive care plan initiated on December 9, 2025, revealed that Resident #1 has a potential for psychosocial well-being problem related to substantiated abuse that occurred on December 1, 2015. -Regarding Staff # 163Review of Staff # 163's (alleged perpetrator) personnel file revealed that she was employed as a Registered Nurse with a start date of June 29, 2023.An Employee Disciplinary Notice dated May 10, 2024, revealed that a written warning was presented to Staff # 163 for discourtesy toward resident, client, or other employee. The disciplinary notice revealed that Staff # 163 was treating kitchen staff disrespectfully on multiple occasions and being disrespectful in front of nursing students. An Employee Disciplinary Notice dated February 7, 2025, revealed that a written warning was presented to Staff # 163 for discourtesy toward resident, client, or other employee, Violation of / or failure to observe: company and/or departmental policies and work procedures, insubordination, and policies within code of conduct. Further review of the disciplinary notice revealed that Staff # 163 continued to have issues with attitude and behavior with other staff and being overly negative and vocal often complaining about duties expected of her. Staff # 163 was also noted for not following up on concerns with residents after issues are brought to her attention from CNAs, and she has told CNAs to falsify legal documents by making up numbers to complete vitals on residents.Further review of Staff #163's personnel record revealed an employee training checklist, which included topic of Resident Rights and Elder Justice/Abuse/Neglect/Exploitation, completed on February 24, 2025.Review of Staff # 163's personnel record also revealed a memo regarding Abuse Training Acknowledgement signed September 11, 2025. A Personnel and Payroll Notification form dated December 10, 2025, revealed that Staff # 163 was involuntarily terminated from the facility due to substantiated abuse