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	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Handmaker Home for the Aging	2221 North Rosemont Boulevard Tucson, AZ 85712

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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 - 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 review, staff interviews, and review of facility documentation and policies, the facility failed to protect the rights of one resident (#54) to be free from physical abuse by another resident (#13). The deficient practice could result in further physical abuse of residents when appropriate actions are not taken.Findings Include:-Regarding Resident #13 (alleged perpetrator):Resident #13 was admitted to the facility on [DATE] with diagnoses that included dementia, major depressive disorder, and anxiety disorder.The care plan dated October 2, 2025, revealed that the resident has a behavior problem of making sexually inappropriate comments to female staff and persistent yelling out, verbal and physical aggression toward staff during care related to Dementia. The interventions included to administer medications as ordered, and monitor and document for side effects and effectiveness; anticipate and meet the resident's needs; intervene as necessary to protect the rights and safety of others; approach/speak in a calm manner; divert attention; remove from situation; and take to alternate location as needed.A review of Resident's admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 5.0, indicating a severely impaired cognition. Per resident's behavioral symptoms assessment, the physical and verbal behavioral symptoms directed towards others occurred.The clinical census review revealed that Resident #13 and Resident #54 (alleged victim) were in the same unit since December 12, 2025.A review of a behavior notes progress note dated December 30, 2025, at 3:18 AM revealed per document that Resident was up and down all throughout the night looking for a family member, and said that he did not like another male resident looking at him and wants to know why they are here. The staff redirected Resident #13 several times and was ineffective. The resident was administered an anti-anxiety medication for increased restlessness and the Resident activity included watching a sports game on television.Another progress note regarding behavior dated December 31, 2025, at 4:56 AM revealed per documentation that Resident #13 refused his vital signs and medication. Per documentation, Resident #13 yelled at staff to get out of his house. Further, an incident note progress note dated December 31, 2025, at 1:17 PM, per documentation, Resident #13's family member was notified about his aggressive behavior.On December 31, 2025, at 1:20 PM, an incident notes in the progress note revealed, per documentation, that Resident #13 was seen by staff coming out of his room looking very angry moving quickly towards Resident #54. Resident #13 hit Resident #54's back of the head, knocking Resident #54's hat off. Resident #54 was sleeping at the time. Resident #13 kept on saying that Resident #54 just got out of prison and denied him a job. Two staff members stepped in between Resident #13 and Resident #54 to stop any further hitting. Resident #13 went back to his room. Per documentation, Resident #13 was watched closely by staff until Resident #54 was moved to another unit.A review of the resident's revised care plan revealed that on December 31, 2025, the care plan included the resident has potential to be physically and verbally aggressive related to Dementia. The goal included (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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident will not harm self or others. The interventions included to administer medications as ordered, and monitor/document for side effects and effectiveness; analyze times of day, places, circumstances, triggers, and deescalate behavior; provide physical and verbal cues to alleviate anxiety; give positive feedback; assist verbalization of source of agitation; assist to set goals for more pleasant behavior; encourage seeking out of staff member when agitated; give the resident as many choices as possible about care and activities; when the resident becomes agitated, intervene before agitation escalates; guide away from source of distress; engage calmly in conversation; and if response is aggressive, staff to walk calmly away, and approach later.On January 13, 2026, Resident #13 was transferred out to a hospital. -Regarding Resident #54 (alleged victim):Resident #54 was admitted to the facility on [DATE] with diagnoses of urinary tract infection (bladder infection), dementia, altered mental status, and anxiety disorder.The clinical census review revealed that Resident #54 and Resident #13 (alleged perpetrator) were in the same unit since December 12, 2025.A review of his admission MDS assessment dated [DATE] revealed a BIMS score of 6.0, indicating a severely impaired cognition. He did not exhibit behavioral symptoms, and there was no wandering behavior exhibited.A review of the incident note documented in the progress note dated December 31, 2025, revealed per document, that Resident #54 was sitting at the dining room table sleeping when Resident #13 came out of his room and was very angry. Resident #13 hit the back side of Resident #54's head. Resident #54's cowboy hat was knocked off. Two staff members stepped in between Resident #54 and Resident #13. Resident #13 who was identified as the aggressive resident went back to his room. Both residents were separated. The director of nursing (DON), assistant director of nursing (ADON), and the nurse practitioner (NP) were notified. Resident #54's family member was notified.On December 31, 2025, record review revealed that Resident #54 was moved to another unit.A review of the resident's revised care plan dated December 31, 2025, revealed a potential for psychosocial well-being problem related to resident- to- resident physical altercation. The interventions included to allow the resident time to answer questions and to verbalize feelings, perceptions, and fears; monitor and document resident's feelings relative to isolation, unhappiness, anger, and loss; and when conflict arises to remove resident to a calm safe environment.Further review of the resident's care plan revealed that on January 6, 2026, the resident has impaired cognitive function/dementia or impaired thought processes related to Dementia. The interventions included to administer medications as ordered and monitor and document for side effects and effectiveness; and cue, reorient and supervise as needed.Review of the facility's 5-day investigation report dated January 5, 2026 revealed that a certified nursing assistant (CNA/Staff #155) was interviewed and per report, Staff #155 saw Resident #13 smack the cowboy hat off Resident #54. Staff #155 quickly de-escalated the interaction, and Resident #13 was led by hand back to his room. Resident #13 and Resident #54 were immediately separated. Per report, both residents were unable to recall the event that occurred. Per report, a Registered Nurse (RN/Staff #90) was interviewed and she stated that she did not see the altercation between Resident #13 and Resident #54 that the CNA (Staff #155) reported to her. The investigation report conclusion revealed that the allegation of abuse was verified by the evidence collected during the facility's investigation.On January 21, 2026, at 1:24 PM, an interview was conducted with a CNA (Staff #112). Staff #112 stated that she works in the memory care unit of the facility. Her unit takes care of residents with dementia and Alzheimer's. She said that her responsibility included to assist and redirect the residents with their activities of daily living (ADLs). She stated that she observes for behaviors such as yelling or screaming that can tick off or make her residents feeling upset. She stated that her dementia care training before she started working involved a few weeks of training via online and following another staff (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in the unit before she can start working on her own. She stated that she also received abuse training. And, she stated that abuse could be verbal, restraining residents, and forcing residents to do what they do not want to do. She said that if a resident refuses care, she will leave the resident alone, and come back to the resident later. She does not recall any recent abuse incidents in her unit. She stated that if a resident who was wearing a hat and was smacked by another resident on the head, she stated that she considered it as abuse because somebody should not raise their hands towards somebody or their belongings. She stated that when it happens, she would separate the residents, and will notify her nurse so that the nurse can write a full report, and the nurse would be made aware of the incident. She stated that she was always told that if something happened to any resident that she should report to the nurse. She said that if she does not report the incident, the resident might continue to do it, the resident might think it is okay to do it, or the resident might think that it was funny.On January 21, 2026, at 1:40 PM, Resident #54 was observed sitting in the dining room wearing a cream-colored cowboy hat. Resident #54 stated that he used to live in another state. He stated that he does not remember anybody taking off his hat.On January 21, 2026, at 1:47 PM, an interview was conducted with CNA (Staff #155). Staff #155 stated that she works in the memory care unit of the facility. She said that she received dementia care training. For example, she stated that if her resident say no, she leaves and then will try again later. She said that her abuse training is once a year. She also said that abuse is verbal, physical, and financial. She stated that hitting and touching a resident while upset or mad at him or her, was an example of a physical abuse. Further, Staff #155 said that if she was made aware of or witnessed an abuse incident, she will report the incident to her supervisor immediately because if the abuse was not reported, she can get in trouble, and something else could happen to the resident. She said that she will report it to protect the residents' right and be an advocate for the resident. Staff #155 also stated that she recalled an abuse incident that happened recently, couple weeks ago between 12:30-1:00 PM after lunch. She said that the incident involved Resident #13, who was no longer in the facility, and Resident #54. She remembered Resident #54 was sitting with his back facing Resident #13. Staff #155 saw Resident #13 hand smacked the back of the head of Resident #54 who was asleep at the table. Staff #155 stated that Resident #13's room was near to the table were Resident #54 was sitting by the dining area. Staff #155 stated that after seeing what had happened, she immediately got up, and the nurse (Staff #90) came out from the nurses' station and followed her. Staff # 155 stated that she and Staff #90 redirected Resident #13 and helped Resident #13 to calm down. Staff #155 stated that Staff #90 notified the DON. Staff # 155 stated that she documented the incident in the electronic medical record but does not know how and where it went because she could not find it. Staff #155 stated that she considered the incident between Resident #13 and Resident #54 physical abuse.An interview was conducted on January 21, 2026 at 2:39 PM with the DON (staff #160). The DON stated that abuse is any physical, mental, financial, verbal, and psychosocial attack on another person. An example of a physical abuse is like pushing, hitting, slapping, kicking, and touching somebody in a way that they do not want. The DON also said that once she was made aware of an allegation of abuse, she will initiate an investigation. She said that if the incident involved a staff, the staff will be suspended pending investigation. She will report the incident to the health department, conduct interviews with the staff, interview the residents that can give her valid information, review documentation to understand what went on, and continue the investigation until the submission of the 5-day follow up report. Regarding the incident involving Resident #13 and Resident #54, the DON stated that she was notified of the incident. The DON stated that the nurse from the memory care unit called the ADON at 1:00 PM. The DON stated (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that a CNA saw Resident #13 ambulating towards Resident #54. The DON said that Resident #13 stated that Resident #54 was someone who just got out of prison and he would not give Resident #54 a job, and that upset Resident #13. The DON said that Resident #13 got up and just went straight to Resident #54 and smack Resident #54's hat off. The DON said that Resident #13 just hit the rim of Resident #54's hat. The DON stated that Resident #13 and Resident #54's incident was not allowed because Resident #13 can't hit someone's hat. She said that she considered the smacking of the hat a physical abuse because even though it did not hit Resident #54, it was not a friendly gesture and Resident #13 was angry. The DON stated that Resident #13 and Resident #54 were immediately separated, and the CNA led Resident #13 back in his. The DON stated that Resident #13 and Resident #54's families were immediately contacted, and their BHT (behavioral health team) was also contacted to evaluated both residents for psychosocial effect of the incident. The DON stated that Resident #54 was assessed, and there was no injury, and no psychosocial effect from the incident. The DON said that Resident #13 did not have an escalating behavior towards residents, there was no indication of it, and there was no prior incident nor indication that Resident #13 was agitated at the time. The DON stated that it was in her 5 -day report that she verified the incident between Resident #13 and Resident #54 as abuse. Furthermore, the DON stated that from a prior abuse incident, she said that there was something similar that had happened before so, ever since then she and her ADON started doing rounds, having discussion about any resident with an escalating behavior, and trainings were conducted with staff regarding escalating behavior.The administrator (Staff #46) was interviewed on January 23, 2026 at 11:19 AM. The administrator stated that the abuse process included to notify the administrator and or DON; report the alleged abuse within 2 hours to the department of health services, APS, and law enforcement; staff to separate individuals/residents; and if a staff was involved, the staff will be suspended immediately pending the outcome of the investigation. The administrator stated that abuse is any kind of exploitation or harm to the resident physically, emotionally, financially, or psychological harm. Further, the administrator stated that abuse in their memory care unit include resident hitting another resident, or taking another resident's belonging. Regarding Resident #13 and Resident #54 incident, the administrator stated that Resident #13 hit the back head of Resident #54 which he considered it abuse.Review of the policy titled Abuse, Neglect and Exploitation updated on July 2025, revealed the facility's policy ensuring the health and safety of each resident. The policy also included (V) Investigation of Alleged Abuse, Neglect and Exploitation which included (B.4) Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and review of facility documentation and policies, the facility failed to ensure that one resident (Resident #99) was provided adequate supervision and interventions to prevent a preventable fall. The deficient practice places residents at risk for falls with serious injury.Findings Include:Resident # 99 was originally admitted to the facility on [DATE], with the most recent admission on [DATE]. The resident has diagnoses that consist of: type 2 diabetes mellitus without complications, other acute osteomyelitis, right ankle and foot, spinal stenosis, cervical region, major depressive disorder, recurrent, unspecified Bipolar disorder, current episode depressed, severe, without psychotic features. Acquired absence of the left leg below the knee. Morbid (severe) obesity due to excess calories. The record revealed that the resident's Brief Interview Mental Status (BIMS) score was 15 that indicated the resident is cognitively intact. No behaviors or moods were noted. A review of the resident's care plan revealed that the resident is at high risk for falls due to deconditioning. The resident had an actual fall with major injury on 01/10/2026. Interventions included: All staff were educated on the importance of not leaving the patient alone in the shower room as an intervention for the fall on 1/10/2026. Anticipate and meet The resident's needs, be sure The resident's call light is within reach and encourage the resident to use it for assistance as needed. The care plan included that the resident needs prompt response to all requests for assistance, facility fall protocol needs to be followed and staff needs to ensure that resident is wearing non-skid footwear when ambulating or mobilizing in wheelchair. Morse Fall Scale, dated December 31, 2025, at 6:01 pm, listed a score of 40, indicating that the Resident was at moderate risk for falling. Review of incident note under progress notes dated January 10, 2026 at 10:54 pm included that the resident had unwitnessed fall in shower room at 5pm. The note stated the resident stated she slipped off from her bed. The note included that xray was ordered to left hip and the resident had no open areas but only had left hip pain. General Nursing progress note dated January 11, 2026 at 1:42 am stated that the left hip xray showed acute fracture of the left hip at the intertrochanteric region, DON was notified and pt was send to ED around 12:22 am. Incident Note Text dated January 11, 2026 at 4:39 pm stated, resident sustained a fall inside the shower room, was left alone by CNA. CNA left resident alone twice to go get assistance to stand pt. Was relayed in report that she needs 2 person assist to transfer and Hoyer in which she did not follow safety protocol with transfer. resident found on floor, complaining of left hip pain. after informing NP xray ordered and confirmed fracture, resident was transferred to hospital. Incident Not Text dated January 12, 2026 at 10:31 am stated, IDT Team met to discuss fall with major injury on 1/10/26- staff and agency educated on fall precautions including not leaving resident in shower room unattended, also signs placed in shower room to remind staff, NO RESIDENT UNATTENDED IN SHOWER ROOM. During an interview with the DON (Director of Nursing, Staff #160) on January 22, 2026 at 9:50 am, Staff #160 stated that residents should never be left unattended in the shower. Staff # 160 stated that Resident # 99 Was only alone for a few brief seconds. Staff # 160 stated that the resident is typically able to ambulate with little assistance, but was feeling weak that day. An interview was conducted with a CNA (Certified Nursing Assistant, Staff # 97) on January 22, 2026 at 11:25am. Staff # 97 stated that she had been a CNA for over twenty years. When asked regarding the procedure for showing a resident, Staff #97 stated that it begins with positioning the wheelchair and shower chair to ensure stability during the transfer. Staff #97 stated that ideally, there are two people, but it can be done with one. Staff # 97 was asked if a resident should be left unattended in the shower, and she stated that it was never (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	permissible. During an Interview with LPN (Licensed Practical Nursing, Staff # 164) on January 22, 2026 at 12:55 pm, Staff #164 revealed that she had provided assistance to Staff # 180 with pulling up Resident #99's pants and brief after her shower and in getting the Resident back on the shower chair. Once the Resident was back in the chair, Staff #180 told Staff #164 that she had it from there and that she could go. Staff #164 stated that had she known that once she was gone, Staff # 180 was going to leave the Resident unattended, she would have never left. Staff # 164 was asked if it was ever permissible to leave a resident unattended in the shower, and she said no. An attempt to contact Staff #180 was met with negative results. The facility 5-day report stated that after the LPN had assisted the CNA with pulling up the residents pants and brief the CNA told the LPN that she was good and the LPN could go. A few moments later the CNA went to get assistance to transfer the resident to the to the wheelchair per the residents request of two staff. While the CNA was getting assistance the resident attempted to reposition herself and slipped out of her chair onto the floor. A review of the facility policy titled Incident and Accidents, no date implementation, revision or review date revealed the following: In the event of an incident or accident, immediate assistance will be provided or securement of the area will be initiated unless it places one at risk of harm. Any injuries will be assessed by the licensed nurse or practitioner and the affected individual will not be moved until safe to do so. First aid will be given for minor injuries such as cuts or abrasions. The supervisor or other designee will be notified of the incident/accident. If necessary, law enforcement may be contacted for specific events. The nurse will contact the resident's practitioner to inform them of the incident/accident, report any injuries or other findings, and obtain orders, if indicated, which may include transportation to the hospital dependent upon the nature of the injury(ies). In the event of an unwitnessed fall or a blow to the head, the nurse will initiate neurological checks as per protocol and document on the neurological flow sheet. Abnormal findings will be reported to the practitioner. A review of the facility policy titled Resident Shower Policy, implemented April 01, 2021, and revised June 01, 2022, states, It is the practice of this facility to assist residents with bathing to maintain proper hygiene, stimulate circulation, and help prevent skin issues per current standards of practice. Help the resident into the shower. If the resident needs to remain seated in the shower chair, ensure it is locked in place. Encourage the use of safety rails.