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 04/15/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and review of facility policy and procedures, the facility failed to ensure one out of three samples residents (#1) remained free from self-harm by failing to immediately assess, report, investigate, and implement protective interventions after staff observed injuries. The deficient practice could delay in identification of resident's suicide attempt and could place residents at risk for continued self harm, serous injury or death. Findings Include:Resident #1 was admitted on [DATE], with diagnoses that included acute and chronic respiratory failure with hypoxia, heart failure, paroxysmal atrial fibrillation, muscle weakness, reduced mobility, gout, depression, hyperlipidemia, and hypertension.A care plan initiated on February 09, 2026, identified a communication problem related to a hearing deficit and included interventions to anticipate and meet needs, discuss with the resident/family concerns or feelings regarding communication difficulties, encourage resident to continue stating thoughts even if the resident is having difficulty, focus on a word or phrase that makes sense, or responds to the feeling resident is trying to express, ensure hearing aids is in place, ensure/provide a safe environment: call light in reach, adequate low glare light, bed in lowest position and wheels locked, avoid isolation, and monitor/document residents ability to express and comprehend language, memory, reasoning ability, problem solving ability and ability to attend.A care plan initiated on February 09, 2026 also identified impaired visual function related to blindness and included interventions to identify/record factors affecting visual function, including physiological, environmental, and choice (reduces the need to wear glasses, use a magnifying glass, turn on lights), monitor/document/report, as needed, any signs of acute eye problems: change in ability to perform daily activities, decline in mobility, sudden vision loss, pupils dilated, gray or milky, complaints of halos around lights, double vision, blurred or hazy vision and tell the resident where you are placing their items and be consistent.A Significant Change Minimum Data Set (MDS) dated [DATE], revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. The MDS also documented that the resident was receiving hospice services.Skilled Daily Charting Nursing dated February 24, 2026, at 3:07 PM revealed Resident #1 had new skin changes.An incident note dated February 25, 2026, at 3:54 PM revealed that at approximately 06:45 AM, Licensed Practical Nurse (LPN, staff #2) observed marks with dried blood on Resident #1's bilateral neck during morning rounds. Staff #2 asked Resident #1 about the injuries, and the resident stated they were scratch marks. There were no further documentation after the observation that the staff #2 reported the signs of injuries to the provider, Director of Nursing (DON), or management. There were no documentation of further assessment or protective interventions immediately after the observation of the marks on resident's neck.At approximately 12:20 PM, when staff #2 returned to clean the area, Staff #2 observed the injuries appeared deeper than scratches and again questioned the resident. Resident #1 then disclosed attempting suicide by trying to cut his carotid artery with a razor and expressed ongoing suicidal intent. Resident #1 was subsequently placed on one-to-one observation until emergency services arrived. The provider and DON were notified, and potentially harmful items including razor, letter (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 04/15/2026

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	opener, and pocket knife, were removed from the resident's room.Multiple call attempts were made to the Resident #1 on April 15, 2026, however it was unsuccessful.During an interview on April 15, 2026, at 12:10 PM, Staff #2 stated facility protocol required staff to assess injuries, determine cause, and immediately notify the provider and DON. Staff #2 acknowledged initially observing the injuries and dried blood, accepting the resident's explanation without further investigation, and delaying notification until later when the wounds were identified as deep cuts. Staff further stated that she will notify right away of any scratches and stated there is a risk of resident harming themselves again if failed to notify.An interview was conducted on April 15, 2026, at 1:59 PM with a Certified Nursing Assistant (CNA/ Staff #7), who stated that when she witness scratches on a resident or dried blood on a resident, first, she will make sure the resident is safe, ask the resident what happened, get the nurse, and report to higher-ups. She stated that even if the resident has scratches on the body, she will report them immediately. CNA further stated that if injuries are not reported after an observation, the risk can be fatal. During an interview on April 15, 2026, at 2:45 PM, the Assistant Director of Nursing (ADON/Staff #4) stated staff were expected to immediately report observed injuries, dried blood, or changes in resident condition to nursing leadership. The ADON stated Resident #1's injuries should have been reported immediately, and failure to do so placed the resident at risk for further self-harm, including death.An interview was conducted on April 15, 2026, at 2:54 PM with the Administrator (Staff #6), who stated that the expectation of staff members noticing blood and scratches on a resident is to investigate where it came from, notifying the nurse right away, ADON or the DON. He stated that potential risks would be further injury.A Policy titled Abuse, Neglect, and Exploitation was revised in July 2025, revealing that the facility protects each resident to prevent abuse, neglect, exploitation, and misappropriation of resident property. Analyzing the occurrences to determine why neglect occurred, and what changes are needed to prevent its occurrence.

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NAME OF PROVIDER OR SUPPLIER Handmaker Home for the Aging		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, facility investigation review, and review of facility policies and procedures, the facility failed to conduct a thorough investigation into neglect involving one of the three sampled residents (#1). The deficient practice could lead to failure in preventing further potential neglect. Findings Include: Resident #1 was admitted on [DATE], with diagnoses that included acute and chronic respiratory failure with hypoxia, heart failure, paroxysmal atrial fibrillation, muscle weakness, reduced mobility, gout, depression, hyperlipidemia, and hypertension. A care plan dated February 9, 2026, identified communication impairment related to hearing deficit and included interventions for communication support, safety monitoring and cognitive observation. A Significant Change Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #1 was cognitively intact. An incident note dated February 25, 2026, at 3:54 PM revealed that at approximately 06:45 AM, staff #2 observed marks with dried blood on Resident #1's bilateral neck. Resident #1 initially stated the injuries were scratch marks. At approximately 12:20 PM, when staff #2 reassessed and attempted to clean the area, staff #2 identified the injuries appeared more deep and re-questioned the resident who stated he had attempted to cut his carotid artery with a razor and expressed suicidal ideation. Resident #1 further stated that life was not worth living and verbalized continued intent for self-harm. Resident #1 was placed on one-to -one observation until emergency responders arrived. A razor, letter opener and pocket knife were removed from the resident's room. Review of the facility's 5 day investigation report dated February 25, 2026, revealed the investigation was incomplete and lacked resident interview, staff interviews, skin assessment documentation, detailed description of the events leading to the incident, and investigative conclusions. An interview was conducted on April 15, 2026 at 2:45 PM with Assisted Director of Nursing (ADON/Staff #4), who stated that the five-day report is completed within five day. She stated she is unsure what is included in the five-day report, but stated the DON (Director of Nursing) usually filled it out within the five day period which includes incident follow ups and any pertinent information regarding the incident. She stated the risk of not having completed the five-day report is to be non-compliant. Also stated the risk to the resident would be elapsed communication with the resident. An interview was conducted on April 15, 2026, at 2:54 PM with Administrator (Staff #6), who stated that the five day reports are completed within five business days after the event occurred. He stated in the five-day report, the witness, resident, and employee statements are included. Also, he stated that victim aggressors and other residents who might be affected by their statements are also included. He stated that he is the one who completes the five-day report, but previously, when an incident occurred for Resident #1, he did not have access to the system to complete the five-day report, and the previous DON (staff #3) was completing the five-day reports. He stated that in the five-day report for Resident #1 for suicidal ideation, there should have been statements on the incident that led up to it, what happened that day, what was done by the facility, and what happened afterwards. He stated that not having completed the five-day report could risk a potential further abuse incident and a lack of reformation. He also stated that the incomplete five-report does meet his or the facility's expectations. A Policy titled Abuse, Neglect, and Exploitation was revised in July 2025, revealing that an immediate investigation is warranted when suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect, or exploitation occur. Written procedures for investigation include identifying staff responsible for the investigation, exercising caution in handling evidence that could be used in a criminal investigation, investigating different types of alleged violations, identifying and interviewing all involved persons, such as the alleged victim, alleged perpetrator, the witness, and others who might know about the allegation. Also focusing the investigations on determining if abuse, neglect, exploitation, and or mistreatment has occurred, the extent, and causes, and providing complete, thorough documentation of the investigation.