STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035099	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandstone of Tucson Rehab Centre	2900 East Milber Street Tucson, AZ 85714

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** 47911 Based on clinical record reviews, facility documentation, resident and staff interviews, and policy review, the facility failed to ensure that two residents (#1) and (#2) were free from physical abuse. The deficient practice could result in further incidents of resident to resident abuse. Findings include: -Regarding resident #1 Resident #1 was admitted on [DATE] with diagnosis including alcohol-induced persisting amnestic disorder, Wernicke's encephalopathy, chronic obstructive pulmonary disease, epilepsy, cognitive communication deficit osteomyelitis and major depressive disorder-recurrent. A review of the care plan revealed a focus area indicating that the resident has a potential risk for alteration in mood state and psychological well-being with interventions including encouraging alternative communication, admission to a secure unit, documentation of all behaviors and monitoring of interactions and the presence of negative thoughts and feelings. The care plan further revealed a focus area of resident knowledge deficit and confusion due to Wernicke's disease. A review of the progress notes for resident #1 revealed an entry dated October 20, 2024 indicating that staff heard the resident yelling out and that he appeared shaky and agitated. It was noted that resident #1 stated that resident #2 came to his room and hit him multiple times in the head and face with his television remote control. It was noted that the resident had an injury (abrasion) to the back of his right ear. The progress notes further indicated that the resident was placed on 15-minute safety checks and that appropriate notifications took place. -Regarding resident #2 Resident #2 was admitted on [DATE] with diagnosis including unspecified dementia, psychotic disturbance, mood disturbance, anxiety disorder, major depressive disorder-recurrent, chronic systolic heart failure and Alzheimer's disease. A review of the MDS dated [DATE] revealed a BIMS score of 3, indicating severe cognitive impairment. (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: 035099	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Sandstone of Tucson Rehab Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 2900 East Milber Street Tucson, AZ 85714	

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the care plan revealed a focus area of wandering with interventions including distracting the resident by offering pleasant diversions, identification of any patterns or purpose of wandering and providing structured activities. The care plan further notes that that the resident is required to have a 2 person assist at all times during care. The care plan also indicated that the resident requires frequent safety checks and requires one to one supervision at all times. ______________ A review of the facility's documentation revealed a counseling/ disciplinary notice indicating that on October 19, 2024 at 3:00 A.M. staff #46 CNA (certified nursing assistant) was assigned as a one on one staff for resident #2 and failed to watch the resident, which allowed a resident to resident altercation to occur. The disciplinary notice was signed and dated October 21, 2024. An interview was conducted on October 29, 2024 at 4:26 P.M. with staff #10 CNA. Staff #10 stated that she did not observe the incident but was aware that resident #2 had hit resident #1. She further stated that she knew that resident #2 was noted to require 2 staff to assist when providing care and that he required a one to one at all times, meaning that the resident has to be at arm's length from the staff member assigned to them. An interview was conducted on October 29, 2024 at 4:35 P.M. with resident #1. The resident stated that he recalled the incident and stated that someone came into his room and was speaking Spanish and then hit him on the head and gave him a bloody ear. He stated that he did not recall the resident's name but stated that he knew the resident resided on the same hall. Resident #1 stated that he feels safe at this time but wants to leave to go to a half-way house. An interview was conducted on October 29, 2024 at 4:39 P.M. with staff #30 RN (registered nurse). Staff #30 stated that she was not present the day of the incident but had heard that about the incident. She stated that a one on one should always be in arm's length of the assigned resident, even when the resident is in the bathroom. She heard that the resident #2 was in the bathroom, but that the one on one was not within arm's length and resident #2 left the bathroom through the other door and subsequently injured resident #1. She explained that the bathroom was a jack and [NAME] bathroom facilitating entry to 2 separate resident rooms. She stated that resident #2 is no longer at the facility and had been moved to another facility on October 25, 2024. She stated that although the risk to resident #1 no longer exists, since the resident #2 is no longer there, the risk to residents in general when not supervised according to the care plan, could include injury to others. She further stated that she felt that resident #1 was initially reliving the incident and that she and other staff try to reassure the resident that he is safe. She stated that she felt he was more at baseline now. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A telephonic interview was conducted on October 29, 2024 at 5:15 P.M. with staff #46 CNA. Staff #46 stated that he was the assigned CNA for resident #2. He stated on the date of the incident, he was sitting outside of resident #2's bathroom as the resident had requested privacy. He stated that he was not aware that anything had happened until he heard resident #1 yell out. He stated that he did not actually witness the interaction between the residents. Staff #46 further stated that he kept trying to peek into the bathroom but resident #2 kept closing the door and locked it. He stated that resident #2 ultimately had slipped out of the other door and into the other room where he must have made his way to resident #1's room. Staff #46 reported that another staff member had come to assist and separate the residents, post incident. He further stated that knew resident #2 to wander but not that he could be violent. Staff #46 stated that in hind sight, he could have gone to the other door, as that one did not lock to ensure that the resident did not wander through the other room. He stated that when a CNA is assigned as a one on one that the resident has to be within arm's length and viewable. He stated that the risk for not ensuring that eyes are kept on a resident and that staff are at arm's length could include potential trauma or physical injury to another resident. An interview was conducted October 29, 2024 with the staff #118 DON (Director of Nursing). Staff #118 stated that the expectation is that residents are free from abuse. Staff #118 further stated that if residents are not supervised, as assigned, the risk could include injury to that resident or others. A review of the facility entitled Abuse and Neglect adopted May 1, 2024 revealed that it is the policy of the facility to provide professional care and services in an environment that is free from any type of abuse.