

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  12/02/2024
NAME OF PROVIDER OR SUPPLIER  Sandstone of Tucson Rehab Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42319</b></p> <p>Based on staff interviews, clinical record review, facility documents and facility policy, the facility failed to ensure residents were free from abuse. This deficient practice could result in psychosocial harm and further instances of abuse.</p> <p>Findings include:</p> <p>Resident #114 was admitted on [DATE] with diagnoses of dementia and Bipolar Disorder.</p> <p>A 5 day MDS dated [DATE] included that this resident was moderately cognitively impaired with fluctuations of altered level of conscious, disorganized thinking and inattention. This resident requires partial/moderate assistance with lower body dressing and was independent with mobility.</p> <p>A care plan dated September 18, 2024 included that the resident had behavior concerns wandering into other resident rooms, and hoarding other resident's items/food related to dementia with an intervention to anticipate and meet the residents needs.</p> <p>A care plan included that the resident is on frequent checks for safety/wandering and includes an intervention on October 11, 2024 of safety checks every 15 minutes. This careplan also included that the resident was placed on every 30 minute checks for safety on November 21, 2024, which is less frequently. Another intervention dated October 11, 2024 included to redirect this resident from wandering into other resident's rooms as needed. However, this resident was not redirected from entering other residents rooms.</p> <p>A progress note dated September 23, 2024 included that this resident took all her clothes off and made her way to her neighbors' room which is a male's room and that this resident was redirected her back to her room to change her and get her back into bed.</p> <p>A provider note dated September 23, 2024 included that this resident required daily supervision for safety risks and includes that the resident's judgement is poor and that her cognition is confused/impaired.</p> <p>A progress note dated October 2, 2024 included The patient continues to present with wandering into other residents rooms regardless of the patient, publicly attempting to disrobe, verbal and physical aggression towards staff, rummaging through other residents belongings.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A progress note dated November 26, 2024 included that Resident is alert, difficulty making needs known related to cognitive impairment. She is wandering into rooms, hallways, needs cueing and redirecting most of the time. She is compliant with medications and care, incontinent of bowel and bladder at times. Ambulates with an unsteady gait .NO behaviors noted at this time</p> <p>A progress note dated November 27, 2024 included CNA went to assist male patient up to w/c to eat in dining room. Viewed male's hand in females groin. Female laying back on bed with pants off. CNA Immediately removed female from male room taken back to her own room. Then notified nurse of occurrence. Patient skin checked no redness, no c/o pain. Patient unaware of occurrence only complained of sock on left foot and removed it folding it and holding on to it. When asked if she was okay patient responded i'm alright. Patient body relaxed when sitting in a chair calm mood .</p> <p>-Resident #129 was admitted on [DATE] with diagnoses of Major Depressive Disorder, encephalopathy and cerebral infarction.</p> <p>A quarterly Minimum Data Set (MDS) dated [DATE] included that this resident was moderately cognitively impaired and required supervision or touching assistance with toileting hygiene, showering/bathing himself, lower body dressing, putting on/taking off footwear and personal hygiene.</p> <p>A care plan dated November 5, 2024 included this resident is on frequent checks for safety-aggression towards others.</p> <p>A progress note dated November 27, 2024 included At 1705 CNA entered resident room to assist up to w/c to eat in dining room. Viewed resident hand in females groin. Female laying down on bed without pants. Female removed from room back to her own room. When asked patient what he was doing he stated that female and him have known each other for awhile. Stated he didn't know her name but they where going to get married. Asked patient if he was hurt stated my feelings are hurt. Became agitated with nurse and stated again we are gonna get married .</p> <p>An interview was conducted on December 2, 2024 at 12:33 p.m. with a Certified Nursing Assistant (CNA/staff #27) who said that resident #114 does not like to put closes on and that she will put on a gown but that she likes to take her clothes off. This staff said that they were a float on the day of the incident and that she recalled that it happened when they were trying to get the residents into the cafeteria and that resident #114 was wearing pants that day but was found with her pants off and that she was told that resident #129 had his hand in her brief. This CNA stated that afterwards she watched #114 for the rest of the day. She said that resident #114 was not capable of consent and that she had to keep telling her lets go to the kitchen because otherwise she would be confused and stop. She said that there were enough people to watch the residents when there were 3 staff but if there were 2 and a float which worked on several halls on the same shift, it was not enough. This staff said that she could not really watch the residents when she was going between halls.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on December 2, 2024 at 12:45 p.m. with a CNA (CNA/staff #81) who said that this was her regular hall. This staff said that the patients need to be looked after more than the other halls. This staff said that usually they have 3 CNA on the hall per shift but that day one went out to escort a resident. This staff said that she was the one who found the residents. She said that she went to go get resident #129 and that resident #114 was in his room and her legs were open and she was laying back, and I walk in and he's touching her privates. This staff said that resident #129 had his hand inside resident #114's brief. This staff said that she asked the residents What are you doing? and resident #129 said nothing This staff said that resident #114 sat up and doesn't say anything and she grabbed resident #114's arm and her pants and that she escorted her out. This staff said that resident #129 is not capable of consent and that his cognition varied. This staff said that when there were 3 staff on the hall that it was enough but that that there was a new staff that day who was floating.</p> <p>An interview conducted on December 2, 2024 with a Licensed Practical Nurse (LPN/staff #14) who said that the hall that residents' #129 and #114 were on was a locked unit for exit seeking behavior and dementia. This nurse said that resident #114 was a very heavy wanderer, an exit seeker and that she had bad dementia and bad cognition and that resident #129 was occasionally delusional and that he was not able to distinguish dreams from reality. She said that resident #114 was not able to consent at all because she was very disoriented but that it was possible that resident #129 might be. This staff stated that she was unaware that residents' #129 and #114 had a sexual incident and said that she would separate them immediately because resident #114 is not her own person, and contact the unit manager and contact the resident's representative and ask the representative what they wanted us to do. This nurse said that she believed that this was not abuse but that if it was not addressed that it would be.</p> <p>An interview conducted on December 2, 2024 at 2:04 p.m. with a Registered Nurse (RN/staff #30) who said that she would separate them, then call the nurse manager and delegate a CNA to stay with them while deciding what to do next and informing management and the resident's guardian. She said that she thinks somebody else updates the care plan and that she believed it was the Director of Nursing or the Assistant Director of Nursing.</p> <p>An interview was conducted on December 2, 2024 at 4:03 p.m. with the Director of Nursing (DON/staff #43) who said care plans are updated as needed and that resident #114's care plan was updated on November 27th to perform frequent checks. This DON checked the care plan and stated that she did not know why the care plan would say that the resident was already on every 15 minute checks. She said the the residents are both currently on 15 minute checks. She said that normally the staff do not see the care plan and that the care plans are updated by the managers. This DON stated that a person was capable of consent unless a court deemed them not capable of making decisions and that the staff were not capable of saying that a resident was not capable of consent. This DON stated that both residents had a BIMS of 3, which indicates severe mental impairment. This DON was asked if residents who were tested as having severe mental impairment were capable of consent and said that she cannot comment on that.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A policy titled Abuse and Neglect adopted May 1, 2024 included it is the policy of this facility to provide professional care and services in an environment that is free from any type of abuse. This policy included abuse defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish and that abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. This policy included that willful, as used in this definition of abuse means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. This policy further revealed that sexual abuse is defined as non-consensual sexual contact of any type with a resident and that sexual contact is nonconsensual if the resident either appears to want the contact to occur but lacks the cognitive ability to consent; or does not want the contact to occur.</p>