

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  03/13/2025
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47911</p> <p>Based on clinical record review, interviews, and policy and procedures, the facility failed to ensure that an allegation of verbal abuse and neglect, for one resident (#4), was reported to the State Survey Agency within the required timeframe.</p> <p>Findings include:</p> <p>Resident #4 was admitted on [DATE] with diagnosis including spinal stenosis-lumbar region without neurogenic claudication, hyperlipidemia, left foot drop, anxiety disorder, hypertension and chronic venous hypertension with ulcer and inflammation of bilateral lower extremities.</p> <p>A review of the quarterly MDS (minimum data set) dated February 28, 2025 revealed a BIMS (brief interview of mental status) score of 14 indicating that the resident was cognitively intact. The MDS further revealed that the resident had noted behavioral symptoms toward others 1-3 days a week and exhibited rejection of care 1-3 days a week.</p> <p>A review of the care plan revealed that the resident had an impaired coping mood disorder manifested by foul and abusive language to and about staff and families as well as being resistive or refusing care.</p> <p>An interview was conducted on March 13, 2025 at 11:13 A.M. with resident #4. Resident #4 stated that a CNA (certified nursing assistant, staff 31 had been mean to him and was subsequently taken off the schedule. The resident was unable to recall the date or time that this had occurred. He stated that he felt like he was being treated like crap, because staff were attending to other residents, that he stated, should be in a hospital and not here. He further stated that staff were unkind to him, but did not provide an example. He stated that he felt he was retaliated against when the CNA that he had reported was pulled from providing services for him. He further stated that his goal was to shut this place down, but did not elaborate further.</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on March 13, 2025 at 11:20 A.M. with CNA, staff #24. Staff #24 stated that resident #4 can be challenging and demanding at times. She stated that he angers easily but can usually redirect him. The CNA stated that abuse can incorporate a lot, to include physical, emotional, financial and verbal. The CNA stated that if resident reports abuse, regardless of credible it may appear, it has to be reported. She stated that she would report it to the nurse, who then reports it to management and conducts the notifications. She stated that she believed the reporting timeframe to be 2-hrs. The CNA further stated that if an allegation of abuse is not reported then the abuse could continue.</p> <p>An interview was conducted on March 13, 2025 at 11:31 A.M with LPN (licensed practical nurse, staff #42. Staff #42 stated that she works with some challenging residents. She stated that resident #4 would sit in the hallway and just complain to anyone about staff or other residents. She stated that resident #4 can be very impatient and demanding. The LPN stated that she had heard from resident #4 that CNA #31, said he was ugly and that she was verbally abusive and neglectful towards him. She stated that she did not recall the date that this had occurred and that the resident did not provide further information. Staff #42 stated that when there is an allegation of abuse, it has to be reported to management right away. When asked if the aforementioned allegation had been reported, she stated that she was pretty sure it was reported but could not recall by whom. She further stated that she thought night shift would have reported it as everyone already knew about it. She stated that she had not reported it to anyone. The LPN stated that she didn't report it because she was sure that the night shift nurse would have reported it, since everyone knew about it, but stated that she had not ask if it was reported. She stated that the risk for not reporting abuse and or neglect is that the abuse or neglect could continue to occur.</p> <p>Per internal state agency record review, there was no evidence that the alleged abuse allegation had been reported to the state agency.</p> <p>An interview was conducted March 13, 2025 at 11:47 A.M. with the DON (director of nursing, staff #63). The DON stated that she had not heard of any report regarding abuse or neglect from resident #4, nor had anything been reported to her. She stated that her expectation is that allegations of abuse and neglect are reported immediately. The DON stated that the risk to the resident for not reporting right away would include that it continues to happen and it could impact the resident's well-being. the DON reported</p> <p>A telephone call was placed on March 13, 2025 at 12:22 P.M. to CNA, staff #31. A voicemail message was left requesting a call back, but no return call was received.</p> <p>An interview was conducted on March 13, 2025 at 1:06 P.M. with CNA, staff #57. Staff #57 stated that when there is an allegation of abuse, staff first have to ensure that the resident is safe and then report the abuse right away. She stated that training, regarding abuse, occurs at least monthly and after an alleged incident there is always an in-service. She stated that she is not aware of any abuse allegations from resident #4.</p> <p>(continued on next page)</p>		

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