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	04/22/2025

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 - 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, interviews, and review of facility policies, the facility failed to ensure residents (#1, #3, and #5) were free from abuse and neglect. The deficient practice could lead to physical and psychosocial harm to the residents. Findings include: -Regarding Resident #1 and #2 -Resident #1 was admitted to the facility on [DATE] with diagnosis that included spinal stenosis, Dementia, and major depressive disorder. A review of the annual Minimum Data Set (MDS) dated [DATE] revealed Resident #1 completed a Brief Interview for Mental Status (BIMS) score of 09 indicating moderate cognitive mpairment. -Resident #2 was admitted to the facility on [DATE] with diagnosis that included rib fractures, anxiety disorder, low vision in the Right eye, psychosis and Dementia. A review of the admission MDS, dated [DATE], indicated Resident #2 had a BIMS score of 02 indicated severe cognitive impairment. The same MDS also noted that Resident #2 was also inattentive, experienced disorganized thinking, physical and verbal behaviors, rejection of care, and wandering. A care plan initiated on March 29, 2025, revealed resident #2 experienced escalated physical and verbal aggression and was residing in a secured unit. Interventions included 1:1 supervision due to resident safety. A nurses' note, dated April 14, 2025 at 10:44 AM indicated that on April 11, 2025 resident #2 was taken off of 1:1 staffing on a trial basis due to a reduction in his behaviors. The nurses' note indicated that on April 13, 2025 resident #2 had a, violent outburst-difficult to redirect and that he was physically aggressive with a peer and a staff. The note revealed that resident #2 attempted to stand on a night stand and go out through a window. An order for resident #2 to be sent to the hospital to determine if there was an underlying medical condition was requested. A second nurses' note, dated April 14, 2025 at 11:47 AM indicated that the Physician authorized resident #2 to be sent to the hospital. (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 - Actual harm Residents Affected - Few	An interview was conducted on April 22, 2025 at 8:59 AM with Certified Nursing Assistant (CNA/Staff #112) who that resident #2's typically can come off as aggressive when staff attempt to redirect him as he does not like being told what to do. Staff #112 defined aggressive as physical hitting or slapping staff. Staff #112 confirmed that she witnessed the altercation between Resident #1 and #2. Staff #112 stated that Resident #2 had come out of his room and was attempting to go into Resident #1's room. Staff #112 attempted to redirect resident #2 but was unsuccessful and he was able to enter Resident #1's room. When staff #112 attempted to redirect Resident #2 out of Resident #1's room, he elbowed staff #112 on the side of the head. As Staff #112 attempted to assist Resident #1 out of her room, Resident #2 hit her on top of her right breast. Staff #112 called for assistance and two nurses came to redirect Resident #2. Staff #112 stated that the risk to the residents if they were abuse by other residents was having a more serious injury. An interview was conducted Licensed Practical Nurse (LPN/Staff #78) on April 22, 2025 at 9:16 AM who described Resident #2 as being confused and sometimes would try to go into other residents' rooms. Staff #78 stated that she was working the shift after Resident #2's altercation with Resident #1. Staff #78 also added that when the police had come to speak with Resident #1 about the incident, the resident had remembered a little bit but not much. She had just remembered that a resident had gone into her room and beat her up. When asked what the risks are to residents who are abuse by other residents, Staff #78 stated that residents could have injuries as well as emotional trauma. An interview was conducted with the Assistant Director of Nursing (ADON/Staff #63) on April 22, 2025 at 12:56 PM. Staff #63 described Resident #1 as someone who did not wander and was aware of what she's doing at the moment. Resident #1 was also described as someone who liked to socialize and do art projects. Staff #63 explained that Resident #2 was confused all the time, would wander around the unit, and move things in his room. She stated that staff would often attempt to redirect him to where he needed to go but he was resistive to the redirection. She also indicated that he was hard to redirect as well. Staff #63 stated that Resident #2 had gone into Resident #1's room and Resident #2 had hit Resident #1 on her chest near her pacemaker and the CNA had immediately attempted to separate the two residents. There were no injuries noted by the nurse and the wound nurse after the incident. When asked what were some possible risks to the residents when they are abused by other residents, Staff #63 indicated that the abused could have physical harm, emotional damage and the resident could also not feel safe. -Regarding Resident #3 and #4 -Resident #3 was admitted to the facility on [DATE] with diagnoses that included bipolar, insomnia, borderline personality disorder, and type 2 diabetes. A review of the admission MDS, dated [DATE], indicated Resident #3 had a BIMS assessment completed and scored a 13 which indicated she was cognitively intact. Review of the progress notes for Resident #3 revealed a Nurses Note, dated April 13, 2025 at 7:30 PM, indicating Resident #3, received physical aggression from resident in 106B. The note indicated there were no injuries or pain reported. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted on April 21, 2025 at 1:45 PM with Resident #3 in her room. Resident #3 explained that another resident, who was moved to a different unit, had gone into her room, was laying on her bed and was wrapped in her blanket. Resident #3 then was able to get the other resident (Resident #4) out of her bed. As Resident #4 was walking to the door, Resident #3 asked for her blanket back as she grabbed it Resident #4 had hit Resident #3 in the back of the head hard with a closed fist. -Resident #4 was admitted to the facility on [DATE] with diagnoses that included dementia, major depressive disorder, Alzheimer's disease, and dysphagia. A discharge MDS, dated [DATE], indicated that a staff assessment for cognitive skills for daily decision making was severely impaired. The same MDS assessment indicated that Resident #4 wandered every 1 - 3 days. A care plan, revised on March 5, 2025, included a focus area of Resident #4's physical aggression towards others, wandering and exit seeking due to her Alzheimer's dementia diagnosis. Interventions included frequent checks for safety, documenting behaviors, and notifying the psych provider as needed. A review of progress notes revealed a nurses' note, dated April 13, 2024, that a resident had found Resident #4 in her bed. As the CNA assisted Resident #4 out of the room, she had become physically aggressive and placed on 15-minute checks. An interview was conducted on April 22, 2025 at 11:38 AM with CNA/Staff #175 who stated that the incident had occurred at the start of her shift when Resident #3 called out for her and told her that another resident was in her bed. Staff #175 indicated that she had observed Resident #4 sitting on Resident #3's bed and had Resident #3's wallet and blanket with her. Staff #175 indicated that Resident #4 is typically cooperative and redirectable when you finesse it with her by saying something like let's go check out something in the hallway. Resident #4 was more combative saying, this is my bed, this is my stuff. As I was attempting to have Resident #4 give Resident #3 her blanket and wallet back, I was telling Resident #4 that I would give her another blanket. Resident #4 then turned around and hit Resident #3 on the shoulder three times. Staff #175 shared that she then stepped in between the two residents and assisted Resident #4 out of the room. A telephonic interview was attempted on April 22, 2025 at 2:49 PM with Staff #142, however, she declined to participate in this investigation. An interview was conducted on April 22, 2025 at 12:56 PM with Staff #63 who stated that Resident #4 was a wanderer and would walk into other residents' rooms. She also stated that Resident #4 was mostly redirectable but sometimes can be difficult. Staff #63 stated that she did not know what triggered the incident between Residents #3 and #4 but she knew that Resident #4 had either hit or slapped Resident #3 on the forehead. Regarding Resident #5: Resident #5 was admitted to the facility on [DATE] with diagnoses that included Parkinson's Disease, schizophrenia, and anxiety disorder. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A review of the quarterly MDS assessment, dated January 25, 2025 revealed Resident #5 completed a BIMS and scored a 06 which indicated she had moderate cognitive impairment. A review of the care plan, revised on April 10, 2025, includes a goal of Resident #5 ensuring she was safe from burns using a non-spill cup when drinking warm/hot beverages, however, there were no interventions listed for this goal. A review of Resident #5's progress notes in the Electronic Health Record (EHR) note, dated April 10, 2025 at 1:25 PM, revealed that Resident #5 had sustained a burn on her right thigh from, very hot coffee while at activities on (April 9, 2025). It also indicated the resident's Power of Attorney (POA) and the provider were notified of the injury. A review of the Weekly Skin Observation assessment, dated April 10, 2025 at 11:30 PM, revealed that Resident #5 had a burn from coffee (spill) on the right front thigh. It also indicated the wound nurse had already assessed and treated the burn. A review of the wound assessment details report, dated April 17, 2025 at 10:54 AM indicated Resident #5 had a thermal burn on the right hip which was facility acquired. The same assessment also indicated the clinical stage of the wound was partial thickness. An interview was conducted on April 21, 2025 at 2:41 PM with the Activities Assistant (AA/Staff #111) who stated that she was aware of the residents' eating and drinking needs because she knows them well; and that, sometimes the CNAs will help them during activities. Staff #111 stated that sometimes they will need help with eating, but residents are able to drink their beverages on their own. When asked if Resident #5 was able to drink beverages on her own, Staff #111 indicated that she could, depending on the day because sometimes she was shaky and sometimes she can do it. Staff #111 confirmed that she was present the day of the alleged incident and shared that they were doing a morning activity and at the end of the activity they had passed out coffee to the residents. Staff #111 indicated that Resident #5 typically drinks her coffee with a straw; but, on that day the coffee had been placed in front of the resident without a straw. Staff #111 was assisting another resident before returning to Resident #5 to put a straw in her cup. Resident #5 then had asked for assistance to go to the bathroom to change her clothes. Staff #111 shared that it was then that she had seen Resident #5 with stained shorts on the right side and that she directed her co-worker to take Resident #5 to see the nurse for a skin check because the coffee was hot. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted on April 21, 2025 at 2:54 PM with AA/Staff #140. Staff #140 stated that if a resident uses a wheelchair or if they had symptoms of Parkinson's she would know if a resident required assistance with eating or drinking beverages as well as visual observations of the residents. Staff #140 stated that she would also ask her peers and they will tell her which residents need more assistance. Staff #140 confirmed that she was present the time of the incident and recalled that Resident #5 typically would have a cup at the table and she was able to lean down and drink out of the straw. Staff #140 stated that herself and Staff #111 had their backs to Resident #5 as they were assisting another resident when Staff #140 heard Resident #5 say that she needed to go to the bathroom. Staff #140 then observed Resident #5's coffee on the table, her sweatpants, and the floor. Staff #140 took Resident #5 to the nurse to get checked out and then returned to the activity room. Staff #140 explained that when the nurses had brought Resident #5 back to the activity, some time later, she had on shorts and she had a cold washcloth on her leg. She also shared that she saw the leg was red in color. Since the incident took place, they had stopped serving coffee and were now giving the residents lemonade, because of what happened. An interview with Resident #5 was attempted on April 21, 2025 at 3:10 PM in her room, however, the resident was not interviewable. An interview was conducted on April 22, 2025 with the Activities Director (AD/Staff #46) who shared that they typically engage the nurse in a discussion about what food and beverages residents can have and then they provide the items in a safe container to the residents. Staff #46 stated that coffee services were not taking place during activities at the moment due to the recent incident and they were only doing cold beverages. Staff #46 shared that Resident #5 was to have a non-spillable cup with a straw because she is not able to pick up the cup. She has to lean over and take a sup from the straw. Staff #46 shared that Resident #5 had an open cup with a straw and had leaned over to drink from it and it spilled hot coffee which had burnt her leg. Staff #46 stated that she expected staff to watch the residents more closely and help when they are drinking from their cups; and that, the cups also needed to be further from the residents so they didn't burn themselves. Staff #46 indicated that staff did not meet her expectations in monitoring the residents, because she got burnt. If they were watching her closely, this wouldn't have happened. An interview was conducted on April 22, 2025 at 12:00 PM with the Administrator (Adm/Staff #187) who confirmed that Resident #5 had spilled coffee on herself during activities and she had injuries which the wound nurse immediately treated. Staff #187 stated that her expectation was that the kitchen staff check the temperatures of the beverages so the coffee was not hot, and that, any food that is a choking hazard is to be kept away from the residents. She also expected staff to be scanning the room and observing what is going on. Staff #187 stated that she believed staff had performed to her expectations because the coffee was not hotter than what it should have been and she thought it was unfortunate because I think she had very sensitive skin. Staff #187 also added that they are now making sure the cups have lids on them. When asked what are potential risks to the residents when not providing hot beverages to residents with no staff assistance, she indicated that there are risks of potential injury to the residents. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the facility policy, titled Abuse and Neglect, adopted on May 1, 2024, defines abuse as willful infliction of injury . It also defines Willfull as the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. It also includes physical abuse as one of the seven categories of abuse. The same policy also defines Neglect as the failure of the facility, its employees, or service providers to provide goods and services to a resident that is necessary to avoid physical harm, pain, mental anguish, or emotional distress.