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	07/16/2025

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 - 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. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews, and policy review, the facility failed to protect the rights of two residents (#69, #77) to be free from abuse by another resident (#81, #76). The deficient practice could result in other residents being abused.Findings include: -Regarding Abuse allegation between Resident #77 (alleged victim) and Resident #76 (alleged perpetrator): Resident #77 (alleged victim) Resident #77 was originally admitted on [DATE] with diagnoses that included vascular dementia, type 2 diabetes mellitus and delirium. The assessment also indicated no evidence of behavioral symptoms were exhibited. A care plan revealed the following areas of focus:-Elopement risk/wanderer, , with interventions that included offering diversions and structured activities. -A second focus of elopement risk and/or exhibits wandering behavior related to vascular dementia. Interventions included to offer diversions, structured activities when wandering has increased.-On a secured unit related to vascular dementia and elopement/wandering behavior to ensure safety. Interventions included cares in pairs, document all behaviors, notify medical and psych provider with updates as needed, and frequent checks for safety.-Potential for behaviors that included non-compliance in cares, rummaging, cursing at and targeting staff, verbal/physical aggression, intrusiveness towards residents and staff. Interventions included to anticipate and meet the resident's needs, monitor behavior episodes and attempt to determine underlying cause. A quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderate cognitive impairment. A nursing progress note dated July 11, 2025 at 10:05 AM, revealed a CNA reported that Resident #77 was sitting in a wheelchair in the hallway and another resident (#76) grabbed the right side of Resident #77's face and neck. The note indicated that a skin check was completed and no scratches, redness or swelling were noted, and that the provider, resident's son, case manager and Assistant Director of Nursing (ADON) were informed of the incident. Further review of Resident #77's care planned focus for potential behaviors revealed that an intervention was initiated on July 11, 2025 after the incident with Resident #76 occurred. The intervention included to redirect when attempting to enter another residents space with a preferred activity or redirection, after the incident with Resident #76. A Facility Reported Incident Follow-up Report, submitted July 14, 2025, regarding the July 11, 2025 incident between Resident's #77, #76, revealed that the allegation was verified by evidence collected during the investigation. The investigation revealed that the incident occurred at 7:50 AM, and that the residents were separated immediately. The CNA (staff #31) who observed the altercation was interviewed and relayed that Resident #76 (alleged perpetrator) became upset with Resident #77 (alleged victim) for being in her way and taking her belongings. The CNA reported that she informed Resident #76, that it was untrue, which appeared to increase Resident #76's agitation, at which time Resident #76 jumped from behind Resident #77 and started pulling on Resident #77's face and neck, while the CNA instructed Resident #76 to let go of Resident #77. Resident #76 was also interviewed and explained that she became physical with a male resident (Resident #77) because he would not get out of her room and he had stole from her before. An order summary report dated July 16, 2025 revealed orders for behavior tracking of delusions and hallucinations every shift, cares in pairs for safety. Orders also included Valproic Acid 2.5 mg capsule two times a day for dementia as evidenced by mood shifts. An observation was conducted on July 16, 2025 at 9:52 AM, Resident #77 was in his room resting quietly. Resident #76 (alleged perpetrator) Resident #76 was admitted on [DATE] with diagnoses that included major depressive disorder, anxiety, unspecified psychosis, cognitive communication deficit and traumatic brain injury. A quarterly MDS assessment dated [DATE], revealed a BIMS score of 14, which indicated intact cognition. The assessment revealed no presence of behavioral symptoms. A care plan revealed the following areas of focus:-Admit to secured unit - escalated behaviors, with interventions that included frequent checks for safety.-Has psychosocial well-being problem (actual or potential) related to bipolar disorder with interventions included that when conflict arises, remove residents to a calm safe environment and allow to vent/share feelings. -Potential for behaviors (revised on July 1, 2025) acting in a generalized problematic manner, false accusations, verbal aggression, exhibits disruptive interpersonal behavior characterized by initiating or exacerbating conflicts among peers. Interventions included to discuss the resident's behavior, if reasonable, explain why the behavior is inappropriate and/or unacceptable (initiated March 18, 2025).-Mood/Psycho-social well-being problem that included anxiety and occasional outbursts, had history of making false accusations -Potential for behaviors including acting in problematic

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews, and policy review, the facility failed to ensure that an allegation of abuse was reported to the State Agency for one resident (#69). The deficient practice could result in abuse allegations not being reported. Findings include:Resident #69 was admitted to the facility on [DATE], with diagnoses that included bipolar disorder, type 2 diabetes mellitus, opioid abuse, anxiety disorder, borderline and personality disorder. A nursing note dated July 12, 2025 at 10:45 AM signed by a Licensed Practical Nurse (LPN/staff #7) revealed that Resident #89 became upset, asking the nurse to do something to calm down Resident #81, because he was upset talking to himself, and when Resident #69 approached Resident #81 he cursed. The nurse wrote that she asked Resident #69 not to disturb Resident #81, but Resident #69 kept going back and forth from her room to the hallway looking at Resident #81. The nurse's note continued relaying that Resident #81 started putting his attention on Resident #69, and sat in front of his door using foul language. The note included that Resident #81's room was away from Resident #69's room. The nurse relayed that Resident #69 requested that Resident #81 be sent out of the facility as he is threatened and Resident #69. felt scare of him. The nurse wrote that she requested Resident #69 continue to stay away from Resident #89. The note included that Resident #81 slammed Resident #69's door shut yelling if you flip me off, I will flip you off too. The nurse reported that Resident #69 admitted to a Certified Nursing Assistant (CNA) that she had done if first. The nursing note indicated that Resident #69 was educated to avoid provoking situations. A Facility Incident Report was requested on July 16, 2025, however the Administrator (staff #77) reported that an investigation had not been conducted regarding a July 12, 2025 incident, and was not aware of the occurrence and the incident had not been reported to the state agency. An interview was conducted on July 16, 2025 at 12:34 PM with a Licensed Practical Nurse (LPN/staff #7), who stated that Resident #69 had complained to her about Resident #81. The LPN stated that she heard Resident #81 yell at Resident #69, stating get the fuck out of here, and that Resident #69 asked the LPN to do something. The LPN further stated that this type of interaction would be considered verbal abuse, and that the policy for verbal abuse included separating residents and then reporting the incident to management. The LPN stated that she did report the incident to the ADON (staff #32). An interview was conducted on July 16, 2025 at 12:45 PM with a CNA (staff #8), who stated that that on July 12, 2025, Resident #69 and Resident #81 were going at it and that she reported the incident to the nurse, but no one came to speak with her about the incident. An interview was conducted on July 16, 2025 at 1:42 PM with the Director of Nursing (DON/staff #66), who stated that she had not been informed that an incident between Residents #69 and #81 had occurred on July 12, 2025, and that she was not aware of any investigation regarding the incident and that it had not been reported to the state agency. An interview was conducted on July 16, 2025 at 2:08 PM with the ADON (staff #32), who stated that physical, verbal, financial and sexual abuse should be reported to the state agency. She further stated that abuse reporting was based on what a resident stated including why they are scared and the resident's diagnoses. The ADON stated that if a resident reported feeling scared or threatened she would expect it to be reported to management. The ADON stated that she had received a report regarding racial slurs previously, but that the July 12, 2025 incident was not brought to her attention until today, July 16, 2025, just a few minutes ago, and that there had been no investigation initiated, and had not been reported to the state agency. The ADON further stated that based on what she read in the progress note dated July 12, 2025 at 10:45 AM, she would have further investigated the incident and based on the CNA's statement to the surveyor, the incident should have been reported to the state agency. The ADON also relayed that the LPN that heard the incident should have reported the incident immediately to management, but this did not occur. The ADON stated that this did not meet the facility abuse policy, and the risk of of resident to resident abuse could result in safety issues and possible physical harm. An interview was conducted on July 16, 2025 at 3:39 PM with the Administrator (staff #77) and the DON (staff #66). The DON stated that after reviewing the nursing progress note dated July 12, 2025 at 10:45 AM, that she would have expected the nurse to notify management at the time the incident occurred, and that did not happen and that the nurse did not follow the facility abuse policy. The Administrator (staff #77) further stated that the incident reporting process included notification of the DON, Administrator and medical director and reporting to the state agency. The Administrator also stated that they were not notified by the nurse and that there had been no investigation into the incident and had not been