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	11/13/2025

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, staff interviews, facility documentation, and policy review, the facility failed to protect the rights of 2 of 8 sampled residents (Resident #2 and #6) to be free from abuse by another resident (Resident # 1 and #5). The deficient practice could result in other residents being abused.Regarding Resident #1 on Resident #2 Abuse:-Regarding Resident #1:Resident # 1 was admitted [DATE] with diagnoses that included, sepsis, bacteremia, urinary tract infection, Schizophrenia, restlessness and agitation.A Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) that was unable to be completed due to Resident # 1 not understanding the questions and having a severely impaired altered level of consciousness. The MDS also revealed a history of physical behavior directed toward others.A comprehensive care plan dated October 22, 2025, revealed that Resident #1 had Schizophrenia symptoms that are manifested by cognitive memory impairment, and decreased awareness of environment in general.A nursing note dated October 22, 2025 revealed Resident #1 had physically assaulted Resident #2 and a Certified Nursing Assistant (CNA). The nurse was retrieved by a CNA and when nurse arrived Resident #1 in his room while Resident #1's Resident #2 was sitting in the hall. Residents were separated and Resident #2 was assessed and notifications to management and police were made. -Regarding Resident #2Resident #2 was admitted [DATE] with diagnoses that included encephalopathy, dementia, seizures, and major depressive disorder.A comprehensive care plan dated May 2, 2025 revealed that Resident #2 demonstrated behavior concern related to his cognitive decline including exhibiting verbal and physical aggression toward staff, refusal of care and medications, and places himself on the floor. An MDS dated [DATE] revealed a BIMS score of 3 indicating severe cognitive impairment. The MDS also revealed physical, verbal, and wandering behaviors. A comprehensive care plan dated September 18, 2025 revealed that Resident #2 had entered his room and was verbally aggressive toward roommate which caused a disagreement between the two.A nursing note dated October 22, 2025 revealed that at approximately 5:00 p.m. Resident #1 hit Resident #2 on the head with his hand. Skin check was performed and notifications to family and police were made. A skin assessment dated [DATE] at 7:40 p.m. revealed that Resident # 2 was bleeding from his lower gums in his mouth. Review of the Facility Reported Incident (FRI) Form follow-up report submitted on October 24, 2025 revealed that the facility verified the alleged abuse between Resident #1 and Resident #2. Resident #1 was escorted from the facility by the police department and was discharged from the facility. An interview with a Licensed Practical Nurse (LPN/Staff #62) dated November 13, 2025 at 2:17 p.m. revealed that he was attending a training seminar at the facility when a CNA pulled him out of the seminar and informed him that Resident #1 hit Resident #2 and another CNA. LPN #62 revealed that when he arrived on the scene Resident #3 was trying to get into Resident #1's room but was being held back by a CNA and LPN #62 was able to redirect Resident #3 away from the scene. LPN #62 revealed that Resident #2 was sitting in the hallway with some bleeding on his lower teeth. They were able to separate all the residents. LPN #62 revealed that Resident #1 was wandering the halls and trying to enter other resident rooms and a CNA tried to stop Resident #1 from entering a female resident's room that's when Resident #1 swung out and hit the CNA then swung again and hit Resident #2. Resident #1 then took Resident #3's walker into his room. Resident #3 was trying to get into room to get his walker but the CNA that was struck was blocking him from entering until LPN #62 arrived and were able to separate everyone.An interview with CNA (Staff # 160) on November 13, 2025 at 2:27 p.m. revealed that while she was trying to take care of trash Resident #1 was coming from the patio and trying to enter into other resident rooms, another CNA was trying to redirect Resident #1 out of the rooms but Resident #1 was heading toward a female resident room and because Resident #1 was only in a gown the CNA stopped Resident #1 from entering into the room. CNA #160 revealed that she immediately went to get LPN # 62 for help and when they got back Resident #1 had struck the CNA and Resident #2. All the residents were separated at that point and police were called.Regarding Resident #5 on Resident #6 Abuse:-Regarding Resident #5:Resident # 5, was admitted [DATE] with diagnoses that included Schizophrenia, anxiety disorder, major depressive disorder, dementia, and unspecified psychosis.A comprehensive care plan initiated on May 6, 2025 revealed that Resident #5 has behaviors including but not limited to refusing care, threating behaviors, slamming doors, and both physical and verbal aggression.An MDS dated [DATE] revealed a BIMS score of 7 indicating severe cognitive impairment. A nursing note dated October 28, 2025 at 1:42 p.m. revealed that at 11:15 a.m.