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	11/19/2025

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, resident and staff interviews, and policy review, the facility failed to ensure that one resident (#200) was free from physical abuse from other residents (resident #300), and the facility failed to ensure that one resident #400 was free from abuse from staff. This deficient practice could result in further incidents of resident to resident abuse. Findings include:- Regarding resident #200 and resident #300. Review of information received from the SA complaint tracking system on October 18, 2025 at 5:40 a.m. revealed that on October 16, 2025 a complaint was received that revealed that resident #200 and resident #300 got into a verbal altercation in the dining room. The residents were separated, and then resident #300 took her electric chair and hit resident #200 in the leg, then the residents were again separated. -Resident #200Resident #200 was admitted to the facility on [DATE], with diagnosis that include heart disease, pneumonia, dementia, anxiety, and hypertension. Review of the significant change Minimum Data set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 7 which indicated the resident has significant cognitive impairment. A review of the care-plan initiated February 9, 2018 revealed that resident #200 has a communication problem related to dementia and hard of hearing, with a noted intervention of be conscious of resident position when in groups, activities, and dining room to promote proper communication with others. A behavioral care-plan revised February 26, 2020, revealed that resident #200 has a potential for psycho-social well-being problem related to dementia and cognitive communication deficits. With a noted intervention of encouraging resident #200 to communicate wants/needs/concerns to staff.A review of skin assessments for resident #200 dated October 16, 2025 at 5:50 under the section Resident Explanation revealed the resident stated that the other resident rammed into her with her wheelchair. A review of progress notes for resident #200 dated October 16, 2025 at 5:56 p.m. revealed that a Certified Nursing Assistant (CNA) reported that resident #200 had received verbal and physical aggression from another resident. Upon inspection, resident #300 had already left the dining room to her room as instructed but resident #200 was showing verbal distress and anxiety. Upon further questioning the CNA stated that resident #200 had asked the CNA to provide resident #300 a napkin, and then resident #300 got verbally upset and confronted resident #200, rolling up to her in her electronic wheelchair stating I don't fucking need your help, don't talk about me. CNA then attempted to redirect both residents, and then resident #300 rolled back to another table. Resident #200 then began to state out loud I didn't say nothing I just said she needed a napkin is all - then resident #300 became upset and used her electric wheelchair to attempt to ram into this resident resulting in a 3x1 abrasion on left lower leg. The note concludes that the CNA was able to separate the residents and called out for assistance, and was able to separate the residents. An interview was conducted with resident #200 on October 21, 2025 at 12:15 p.m. The resident stated that after the incident she had to put a trashcan between her and resident #300 because she was scared resident #300 was going to cut off my legs. She further stated that I was very scared, scared me to death, I don't know why she did it. She further stated that several other residents no longer sit with her because of resident #300's behavior. Resident #200 (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 - Minimal harm or potential for actual harm Residents Affected - Few	that is free from any type of abuse, corporal punishment, involuntary seclusion, misappropriation of property, exploitation, neglect, or mistreatment. -Regarding resident #400 Resident #400 was admitted to the facility on [DATE], with diagnosis that include Parkinson's disease, schizoaffective disorder, dementia, hypertension, atrial fibrillation, anxiety, and depression. A review of the annual Minimum data set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 9 which indicated the resident has significant cognitive impairment. A review of the care-plan initiated revised January 15, 2025 revealed that resident #400 has an Activities of daily living (ADLs) self-care performance deficit and mobility deficit related to alcohol use, anxiety, and other comorbidities, with noted interventions of 1-person assistance for all ADL's, encourage resident to participate to the fullest extend possible, and praise all efforts at self-care. A review of progress notes on October 1, 2025 at 4:16 p.m. revealed that a staff member was made aware of an allegation of abuse by the resident, the resident reported concerns and described the incident as abuse. The note further reveals that due diligence was completed, and the matter was reported in accordance with regulatory requirements, notifications were made to the SA, facility administration, and hospital representatives for further review and investigation. However, there is no evidence in the clinical record for resident #400 that details what abuse allegedly occurred. An interview was conducted with resident #400 on October 22, 2025 at 9:00 a.m. The resident stated that he has mobility issues because of his hand and his whole left side from a stroke. When asked about the abuse resident #400 states that it was from a knucklehead that's what she was and that the CNA's was staff #2 whom he referenced by her first name. He further stated that staff #2 stepped on his foot on purpose, and that staff #2 was a big bully. He further stated that in his wheelchair the wheels were locked, and standing and turning to sit in the wheelchair when staff #2 got impatient and stepped on his foot. He stated that all of his toes were broken. He further stated that she did it on purpose, and that he was afraid to say anything about it because they would come after me. He concluded that the incident was 3 weeks ago and staff #2 was strong and would throw us around, she was strong man. An interview was conducted with a Certified Nursing Assistant (CNA/staff #15) on October 22, 2025 at 9:31 a.m. The CNA stated that staff #2 would disappear from the unit for long periods. She further stated that staff #2 would yell down the hallway at residents and was a little bit rude, and definitely loud. The CNA concluded that staff #2 was rude in the way she spoke to residents, didn't help much, and sat too much. An interview was conducted with a Certified Nursing Assistant (CNA/staff #20) on October 22, 2025 at 9:37 a.m. The CNA stated that she worked 2-3 days a week with staff #2. The CNA stated that staff #2 always had a nasty attitude, and would speak to the residents in nasty ways. The CNA further stated that resident #400 said he didn't want staff #2 taking care of him because she was rough with him. The CNA stated that staff #2 was often abusive, to residents and even staff, and that resident #400 couldn't stand her. The CNA further stated that when staff #2 was there, resident #400 would ask staff #20 to take care of him because staff #2 was very rough with him. The CNA concluded that she reported every time staff #2 was seen being abusive. An interview was conducted with a Certified Nursing Assistant (CNA/staff #15) on October 22, 2025 at 9:54 a.m. The CNA stated that when staff #2 would help feed residents including resident #400 she would rush them and shovel the food too fast. The CNA stated he talked to staff #2 about the behavior and that she had no reaction. The CNA stated that other residents had also stated that staff #2 was rough with them. The CNA concluded that when staff #2 was there, she was always yelling and angry with the residents. An interview with the Director of Nursing (DON/staff #50) was conducted on October 22, 2025 at 10:08 a.m. The DON stated that staff #2 had been removed from the schedule and terminated. The DON stated that they also reported staff #2 to the board of nursing for the abuse. The DON stated that they had substantiated internally that staff #2 was abusive, physically and verbally, and confirmed that staff #2 had stepped on the foot of resident #400. The DON stated that staff #2 had attended lots of abuse trainings, and that actual abuse was happening which is why they reported her to the board. The DON concluded that of course it does not meet her expectations and that they are working on the (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	culture problem that is present in the facility. A review of facility policy titled ?Policy / Procedure - Nursing Administration' under the section ?Resident Rights' revealed it is the policy of this facility to provide professional care and services in an environment that is free from any type of abuse, corporal punishment, involuntary seclusion, misappropriation of property, exploitation, neglect, or mistreatment.