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	12/11/2025

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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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, interviews, review of facility documentation and policies, the facility failed to protect The rights of one resident (# 07) to be free from verbal and physical abuse by another resident (#33). This deficient practice has the potential to violate the resident's right to safety and prevent further harm. The sample size was 5. The facility census was 122. Findings include: -Regarding resident #7 Resident # 7 was admitted to the facility on [DATE] with diagnoses that included unspecified dementia, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; unspecified mood (affective) disorder, and autistic disorder. A review of the Interdisciplinary Team (IDT) Care Conference dated June 24, 2025, revealed the resident had a Brief Interview Mental Status (BIMS) score of 3, which indicated severe cognitive impairment. A review of the shower sheet dated December 2, 2025 revealed no issues were identified on the skin.A review of the nurse progress note dated December 3, 2025, revealed that the resident requested to have a room change, and was transferred to a different room on December 3, 2025. A review of the nurse progress note dated December 6, 2025, revealed that the resident complained that roommate Resident #33 had turned off the TV. Staff noted that Resident #33 stated the room was his, but nursing clarified that the room was shared by both residents.A review of the nurse progress note dated December 7, 2025, revealed that at 7:15 a.m., the Registered Nurse (Staff #25) heard a CNA yelling, Stop that, and immediately investigated. The progress note revealed that Staff #25 witnessed the CNA (Staff #88) separate and redirect Resident #33, who was attempting to hit resident #7 on the left arm while the resident was lying in bed. The note indicated that an assessment was performed and the skin was found intact, and that resident #7 denied pain. The note included that resident #7 was moved to another room on the unit and the family was notified.A psych follow-up progress note dated December 8, 2025, revealed the resident was seen for a routine psychiatric follow-up. The note revealed that staff reported to the provider that the resident had a recent altercation with his roommate, and that the resident did not recall the incident and was redirected to a different room. A social service note dated December 8, 2025, revealed the Social Services Director (SSD/Staff # 28) met with the resident, who was unable to recall any details about the incident that occurred over the weekend. Staff # 28 described Resident # 7 as having an overall stable, calm, and appropriately engaged presentation, with no observed behavioral concerns during the assessment. A day after the alleged incident, a weekly skin observation dated December 8, 2025, noted discoloration on the resident's right upper extremity and redness on the right side of the face. Additional notes indicated the facial redness was attributed to the resident sleeping on that side.A shower sheet dated December 9, 2025 revealed the resident had a fungus under the stomach. A weekly skin observation, dated December 9, 2025, revealed the resident had redness under the abdominal folds of both iliac crests. A review of the victim of physical abuse by roommate care plan, initiated on December 9, 2025, revealed the resident was referred to social services and behavioral health for emotional support, and that the resident was moved to another room for safety and emotional wellbeing. Regarding Resident # 33Resident # 33 was admitted to the facility on [DATE] with diagnoses that included unspecified dementia, anxiety disorder, unspecified, major depressive disorder, recurrent, unspecified, and unspecified psychosis not due to a substance or known physiological condition. A psychosocial evaluation, dated April 17, 2025, revealed the resident had a BIMS score of 3, which indicated severe cognitive impairment. The evaluation also revealed the resident had no impaired or slurred speech, with normal vision and hearing. A resident's behavior care plan, revised on September 5, 2025, indicated the resident had exhibited behavioral outbursts, including crying and overstimulation, with occasional refusal to change environments. Interventions included the provision of a structured, calm, and consistent environment to promote safety and minimize triggers associated with cognitive decline and behavioral disturbances.A psych follow-up progress note dated December 2, 2025. revealed that staff reported to the provider that the resident became aggressive at times with another male resident but was easily redirected. An IDT progress note dated December 4, 2025, revealed that resident #33 demonstrated behaviors that included, but not limited to: pacing the hallways, verbal and physical aggression, and noncompliance with cares and treatments. A nursing progress note dated December 6, 2025, revealed that staff needed to diffuse a situation which involved resident #33 unplugging resident #7's television. A nursing progress note, dated December 7, 2025, revealed the resident #33 had to be redirected from hitting Resident # 7, and was provided reorientation/education on proper behavior. A review of the