

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035099	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/05/2026
NAME OF PROVIDER OR SUPPLIER Sandstone of Tucson Rehab Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, resident, family, and staff interviews, and policy review, the facility failed to protect the resident's (#10) rights to be free from abuse by another resident (#5). This deficient practice could result in further incidents of resident to resident abuse. Findings include:-Resident #5 (Alleged Perpetrator) was admitted to the facility on [DATE], with diagnosis that include depression, psychosis, anxiety, and dysphagia. Review of the Minimum Data Set (MDS) assessment dated November October 6, 2025 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident had intact cognitive function. A review of Resident #5's care-plan revealed the resident had a confirmed resident to resident altercation, and a history of such, as well as a history of resident to staff altercations, with noted goals including, resident will have no altercations with staff or residents through the review date, and noted interventions of remove resident from the environment when escalation verbally begins to occur. A review of progress notes dated December 14, 2025 at 7:42 p.m. revealed at approximately 1630, a Certified Nursing Assistant (CNA) informed that Resident #5 and Resident #10 were in the hallway was yelling do you want to fight?, went towards Resident #5, attacked, scratched her left arm, and Resident #10 backed up. Resident #10 stated while I was in my wheelchair she just stood and stared me down. The nurse and CNA immediately separated the residents, and Resident #5 was redirected to her room. The note concluded that Resident #5 was educated on proper behavior, and that the provider, unit manager, DON, administrator, and POA were all notified. A review of skin assessments for Resident #5 dated December 15,2025 at 3:14 a.m., revealed the cause for the skin assessment was she scratched me, and noted that Resident #5 had suffered three, 3mm(millimeter) by 3mm skin tears, However, the note was struck out with no reason given, and concluded that the nurse had contacted the POA for Resident #5, with a message left.A review of social service progress notes for dated December 15, 2025 at 10:08 a.m., revealed that social services reviewed and documented the incident involving Resident #10 and Resident #5 that occurred at approximately 1630 hours. Per staff report, Resident #5 approached Resident #10 in the hallway in an agitated manner, verbally stating, Do you want to fight? Resident #5 advanced toward Resident #10 and scratched Resident #10 on the left arm. Resident #10 backed away and verbally stated, I didn't do anything. I was just standing there and she scratched me. Staff intervened immediately, and residents were separated. Resident #10 was promptly assessed for injury. Assessment revealed three superficial skin tears measuring approximately 3 mm x 3 mm each on the left arm, with a small amount of bleeding noted. Wound care was performed per facility protocol. The provider was notified of the incident and injury, orders were received, and wound care was continued per order. Resident #10 reported pain at the site of injury and was administered PRN Tylenol with good tolerance. No further distress was observed. The Unit Manager, Director of Nursing, and Administrator were notified. The resident's POA was contacted, and a voicemail was left requesting a return</p> <p>(continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 035099	If continuation sheet Page 1 of 3

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>call.A different skin assessment for Resident #5 dated December 15, 2025 at 1:49 p.m., revealed the cause was another resident scratched her and that the resident had an injury on upper left antecubital, however, the measurements on the previous skin assessment that was struck out were not included.-Resident #10 (Alleged Victim) was admitted to the facility on [DATE], with diagnoses that include dementia, hypertension, chronic kidney disease, and depression.An admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 07 which indicated the resident had significant cognitive impairment. An interview was conducted with a resident representative (RR/#60) for Resident #10 on January 5, 2026 at 12:26 p.m. The RR stated that she spoke to someone at the facility about the incident, but that the details weren't clear because the person who called her didn't speak English well. The RR stated that she was caught off guard and that she was told by the facility that Resident #5 can be a little intrusive. The RR concluded that she was told about the incident, and that resident #10 had a skin tear on her arm as a result, but that was it.An interview was conducted with a resident representative (RR/#70) for Resident #5 on January 5, 2026 at 12:36 p.m. The RR stated that he was told Resident #10 had some wandering behaviors. He stated that what he thinks happened was Resident #10 kept poking her head into Resident #5's room and Resident #5 reacted to it, and had enough of it I guess. The RR stated that Resident #10 grabbed Resident #5 and scratched her, and stated that Resident #10 gets cabin fever and has otherwise been doing very well. He concluded that you can't really predict who is going to have a bad day.An interview was attempted with Resident #5 on January 5, 2026 at 1:35 p.m., however the resident was unavailable for interview.An interview was attempted with Resident #10 on January 5, 2026 at 1:50 p.m. Resident #10 was noted to be pleasantly confused and stated that she didn't see anything when asked about the incident, and stated Did they say if it was a man or a woman? I don't know. An interview with a Licensed Practical Nurse (LPN/#150) was conducted on January 5, 2026 at 2:02 p.m. The LPN stated Resident #10 is pleasantly confused, and alert and oriented 1-2 out of 4 most of the time. He stated that she is compliant with care, and pleasant most of the time, but that she can be a little anxious and restless. He also stated Resident #10 wanders a lot. The LPN stated he had heard about the incident but did not witness it. The LPN stated that there are lots of different kinds of abuse, financial, sexual, physical, and emotional, anything that takes advantage of the resident. The LPN further that the incident would be abuse and would consider the blame to fall on the employees for not preventing it. The LPN concluded that the administrator is the abuse coordinator and that's who they would report abuse to.An interview was conducted with the Director of Nursing (DON-RN/staff #90) and the Administrator (Admin/staff #100) was conducted on January 5, 2026 at 2:40 p.m. The DON stated that during the incident Resident #5 and Resident #10 were in the hallway, and Resident #5 had stated Do you wanna fight? to Resident #10 which caused the incident. The DON further stated the residents were separated immediately following the incident and that Resident #10 had sustained a scratch on her left arm. The administrator stated that the scratches were not deep, very superficial, and acknowledged that their internal investigation substantiated the complaint. The DON concluded that yes, she would call the incident physical abuse, and that it has to be treated like residents with behaviors, and that it does not meet her expectations. The administrator concluded that it was reported, and that they substantiated it stating further If it happened it happened, it doesn't matter if it was intentional or not.A facility policy titled 'Resident rights - Abuse and Neglect adopted May 1, 2024, 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. This includes but is not limited to freedom from</p> <p>(continued on next page)</p>		

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