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	01/28/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and review of facility documentation and policies, the facility failed to protect one resident (#511) rights in a manner that promotes enhancement of the resident's quality of life by having her own cell phone to access persons and services outside the facility. The deficient practice could lead to residents' rights being violated.Findings include:Resident #511 was readmitted to the facility on [DATE] and originally admitted on [DATE], with diagnoses that included type 2 diabetes mellitus, factitious disorder imposed on self, borderline personality disorder, major depressive disorder, anxiety disorder, and Huntington's disease.Resident's Clinical Resident Profile revealed that she was her own responsible party/representative.The resident had another care plan initially dated on August 15, 2023, and revised on January 15, 2025, which revealed the resident has a potential risk for alteration in mood state and psychosocial well-being related to panic disorder. The goal is for the resident or family will to understand the disease process and to be able to express feelings of anxiety and fear. The interventions included to encouraging alternative communication with visitors and/or family members, such as phone calls, Face-time, Skype, video phone, if possible and encourage the resident to participate in supportive visits and /or in room activities that are important and vital to the resident; and staff are to anticipate and meet resident needs. Check in with the resident as needed to reflect upon underlying emotional distress, difficulty with self-regulation, or unmet social or psychological needs. Addressing this behavior involves exploring its root causes, fostering constructive communication skills, and promoting positive engagement within the peer environment; consider the resident's and family preference for care such as: showering/bathing time, meal time and choice, activities, religious practices, bed/awake time.Another focus care plan review, initially dated on August 2, 2023, and revised on January 15, 2025, revealed that the resident was admitted to the behavioral secure unit related to Huntington's diagnosis. The intervention included for staff members to encourage resident's independence, and to assess for a lower level of care as needed.The quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a BIMS score of 15.0, indicating that the resident was cognitively intact. The assessment also revealed that physical and verbal behavioral symptoms occurred. In addition, the assessment revealed that resident exhibited rejection of care and wandering behaviors.A review of facility documentation dated October 30, 2025, revealed Resident #511 was denied an appointment of a public fiduciary to oversee her legal and financial decisions, ensuring care planning, medication management, and protection from self-harm due to her BIMS score of 15 out of 15 on July 31, 2025. Further, per the document, Resident #511 has a third party as her payee, and a sister as her Surrogate Decision Maker, following the resident's wishes if they are known.A progress note, Orders-Administrative Note, dated January 22, 2026, revealed a behavioral health charting. Per the document, the resident started complaining about her phone, asking the staff to use their online account to buy her a new phone. The (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

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	01/28/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident was informed that the business office and the social service will be notified to look into her request.Review of resident's financial statement revealed that the Resident had a balance in her personal fund managed by the facility in the amount of $543.00 as of January 22, 2026.An activity observation was conducted on January 26, 2026, at 1:59 PM, held in the first-floor dining room. Resident #511 was observed sitting in her wheelchair on one end of the table, slightly away from the tables where the other residents were seated. Resident #511 was interacting with a staff member who was holding a cellphone showing Resident #511 pictures of products online.An interview was conducted on January 27, 2026, at 1:58 PM with business office manager (BOM/Staff #44). Staff #44 stated that, regarding spending requests from residents with behavioral concerns, she will use the residents' trust fund to purchase items for their spend down. She also said that if a resident has cognition impairment, their finances will be handled by a third party. If the resident needs a spend down, she cannot let their account balance go over $2000.00. Therefore, she will ask the resident or the certified nursing assistants (CNAs) what the residents would need, such as socks, shoes or even a foam mattress. She said that the spend down receipts are filed monthly and audited. Regarding Resident #511, she said that the resident can verbalize her needs and had a list asking for clothes, coloring books, and if Resident #511 had enough money in her trust fund, Staff #44 would use the resident's trust fund to purchase the resident's request. Staff #44 stated that Resident #511 requested a cellphone but was waiting for the resident's sister to make the decision because the resident had overindulged in food spending $1000.00 using her debit card to order food via her cellphone. Staff #44 said that the resident does not have a cellphone now, and that is why Staff #44 was waiting for the Resident's sister to make the decision. Staff #44 said the reason why the resident does not have a cellphone was that the Resident broke her android cellphone during her behavior episode, resident threw it and it cracked. Staff #44 said that the resident's sister was aware. Regarding Resident #511 finances, Staff # 44 said that the resident receives money from a third party that manages her finances, and the money Resident #511 receives goes on her debit card. Staff #44 stated that she only handles the resident's trust fund, which she needs to keep below $2000.00 at all times. She said that Resident #511 does not have a shared cost, so everything the resident needs comes out of the Resident's trust fund account, and the third party that manages the resident finances sends $100.00 per month in a check, then the check gets transferred to the Resident's debit card. Resident #511 can also get money through the front desk for up to $50.00 per day from Monday through Friday and $25.00 per day on the weekends per CMS guidelines. Further, Staff #44 stated that the last time she communicated with the resident's sister was on November 13, 2024, at the request of the Social Service Director regarding the status of the resident's power of attorney (POA). Lastly, Staff #44 stated that their social services department handles communication with the resident's sister.An interview was conducted on January 27, 2026, at 3:58 PM with Resident #511. Resident #511 stated that last year her cellphone broke all of a sudden, that it busted in half, and she does not know how to get another cellphone. She said that her sister is the main person the staff talks to. She also said that she does not know the contact number of her sister; and she thinks that the facility made her sister her power of attorney. Further, she said that she has not spoken to her sister since last year, and she does not communicate with her sister because she does not have a cellphone anymore. During the interview, the resident kept on saying that she needed a cellphone.An interview was conducted on January 27, 2026, at 4:13 PM with licensed practical nurse (LPN/Staff #119). Staff #119 stated that she is not the regular nurse at the behavioral unit, and the nurse assigned to the unit was on vacation. Regarding Resident #511, Staff #119 said that she does not know if the resident has a cellphone.An interview was (continued on next page)

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	01/28/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conducted on January 27, 2026, at 4:18 PM with certified nursing assistant (CNA/Staff #165). Staff #165 stated that when Resident #511's call lights is on, the resident immediately wants to get up, and the resident becomes angry and accuses everyone. Staff #165 stated that the resident told him that he had stolen her table and credit cards. Staff #165 said that Resident #511 used to have a cellphone, but her cellphone broke last month.An interview was conducted on January 27, 2026, at 5:01 PM with social service director (SSD/Staff #60,) and present during the interview in the social service office was the case manager (Staff #6). The SSD stated that the power of attorney (POA) process included an application form for POA medical and durable to be completed, and the SSD stated that she has been told that per Arizona State Statues, the the Public Fiduciary comes into play if all other options are exhausted. Regarding Resident #511, the SSD stated that the resident's public fiduciary was denied on October 30, 2025. The SSD stated that the public fiduciary petition process, with the help of the psych nurse practitioner, for Resident #511 was started because of the resident's refusals for medications and refusals for needed the extraction of her black dentition, which became a safety concern. The SSD also said that the resident's sister refused to take part as the resident's POA. The SSD said that the resident's sister was not cooperative. Further, the SSD stated that around September/October of last year, Resident #511 had access to her funds, and Resident #511 placed herself in danger by significantly gaining weight by ordering pizza daily and the resident had spent $1000.00. Further, the SSD stated that Resident #511 made an accusation about her phone, for instance, that her phone charger was broken; and there was a concern about the phone charger would get hot and potentially hurt the resident. The SSD stated that the interventions implemented were to keep the phone charger at the nurses' station; the resident to make phone calls at the nurses' station; the resident has access to call her sister via phone located in the unit; and access to social service department. The SSD stated that everybody is allowed a cellphone, but Resident #511 cellphone was a safety concern due to her phone charger getting hot; significant weight gain from ordering food through a cell phone; and resident was petitioned for public fiduciary regarding safety concern. The SSD stated that the Resident's cellphone was part of the discussion with her assistant social service (Staff #169) and will be up for discussion at the behavioral health meeting this week, on Thursday. The SSD said that Resident #511 has the right to access a phone. The resident's own cellphone was deemed unsafe; the resident's access to a phone was through the use of the facility phone, and the SSD reported that Resident #511 has not had a cellphone for several months. The SSD stated that the Resident's BIMS score was 15.0, and her petition for the Public Fiduciary was denied, with the resident described as non-compliant.An interview was conducted on January 28, 2026, at 4:17 PM with the Director of Nursing (DON/Staff #25). The DON stated that her responsibilities included clinical management; she is responsible for license nurses, CNAs, and other disciplines such as housekeeping, dietary and consultants. Regarding resident cellphones, she stated that because of the generation now, having a cellphone for the elderly was the only way for them to call their family; communicate outside; maybe their cellphone is their security to get some health services; and use their cellphone to buy something from online shopping or order food they like. The DON stated that having a cellphone facilitates communication both outside and with their family. She said that she heard about a resident with a broken cellphone that needs to be repaired. The DON said that the phone was not repairable, she needed to assist the resident in communicating with their family, to do so, she would refer the issue to social service. She said that the CNA should inform the charge nurse, and the charge nurse should notify the social service. Her expectation regarding the resident's cellphone with a BIMS score of 15.0 was to ask staff to help buy the phone with the resident's own money; the resident has the (continued on next page)

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	01/28/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	right to have their own phone; social services and the business office should assist the resident to buy the phone.Review of facility policy titled Resident Rights, adapted on May 1, 2024, revealed that all resident rights be followed per state and federal guidelines as well as other regulative agencies. The Resident has the right (1) to be treated with consideration, respect, and full recognition of his or her dignity and individuality, (16) to keep and use personal clothing and possessions in the Nursing Facility as space permits unless doing so would infringe upon the rights or safety of other residents, and (18) to reasonable access to a telephone for private conversation while in the Nursing Facility.

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	01/28/2026

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 review, staff interviews, facility documentation, policies and procedures, the facility failed to protect the rights of one resident (#911) to be free from physical abuse by another resident. The deficient practice could result in further abuse of residents and appropriate action not taken.Findings include: -Resident #911 (alleged victim) was admitted to the facility on [DATE] with diagnoses of aphasia, hemiplegia, hemiparesis, dementia, major depressive disorder, and anxiety disorder. A physician order dated January 17, 2025 indicated for resident to reside on secured unit due to vascular dementia. Review of the psycho-social/trauma care plan revised on January 14, 2026 revealed the resident was at risk for psycho-social well-being problem related to dementia with behaviors, anxiety and history of substance abuse. The care plan noted that the resident was involved in an altercation with another resident on January 12, 2026. The goal set was that resident will minimize risk for psychosocial well-being problem. Interventions included to offer emotional support, calm reassurance, provide activities with increased 1:1, monitor any changes in mood or behaviors status post incident, and to notify Social Services and Behavioral Health team if any adverse changes occur. A cognition care plan revised on January 14, 2026 indicated that the resident was at risk for cognitive problems and abuse related to dementia. The goal set was for resident to develop skills to cope with cognitive decline and maintain safety. Interventions indicated included offer emotional support, give calm reassurance, provide activities with increased 1:1, monitor for any changes in mood or behavior status post incident, and notify Social Services and Behavioral Health if any adverse changes occur. Review of the significant change in status Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident had both short and long-term memory problems. The assessment indicated that the resident had moderate cognitive impairment regarding daily decision making. Further review of the MDS assessment dated [DATE] indicated that the resident exhibited both physical and verbal behavioral symptoms directed towards others between 1-3 days during the assessment period. Per the MDS the resident exhibited wandering behavior 1-3 days during the assessment period. Review of the facility's Incident Report (with an unreadable date) pertaining to resident #911 documented a resident to resident altercation noted as Physical Aggression Received. The incident location was identified as the hallway. Per the report a staff member witnessed another resident (room [ROOM NUMBER]B occupant) suddenly rise from his wheelchair and struck resident #911 twice on the nose with a closed fist. The report noted that resident #911 sustained small, open, bleeding area across the bridge of the nose. Resident #911 was assessed with 5/10 pain scale. The provider was notified and an order was received for a stat x-ray and to send the resident to the ER (Emergency Room) to rule out a broken nose. A Radiology Interpretation report dated January 12, 2026 revealed that that resident's nasal bones and adjacent soft tissues were intact. Similarly, the frontal and maxillary sinuses as well as the skull and facial bones were normal. A Wound Care note dated January 12, 2026 documented that the resident had a new skin condition. Review of a Skin assessment dated [DATE] documented that the resident had an abrasion on the bridge of the nose. A Nurses Notes dated January 13, 2026 stated that at 6:00 p.m. (the incident is presumably the day before based on note's timestamp) a staff witnessed the resident sitting in his wheelchair when another resident (identified as room [ROOM NUMBER]B) approached him and punched resident #911 on the nose twice with a closed fist. The note documented that resident #911 sustained a small, open, bleeding area across the bridge of the nose. According to the note, the provider was notified and an order was received to send resident #911 to the ER via ambulance. Due to the 6-hr ambulance pick-up wait, the provider was informed and an order (continued on next page)

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	01/28/2026

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	for a stat inhouse x-ray for the resident's nose was received. Results from the x-ray revealed normal facial and nasal bone. A Social Services Note dated January 13, 2026 documented a psycho-social evaluation. The note indicated that Social Services met with the resident following a resident to resident altercation which occurred the evening prior. According to the note the resident appeared to be passively complaint, calm, and without observable signs of distress. The note stated that the resident demonstrated limited verbal communication. The resident primarily responded by nodding or providing brief, simple statements. The note indicated that the resident recalled the incident and said he was okay. The note documented that for safety and monitoring purposes, nursing staff will continue to observe the resident, and psychosocial follow-up will occur as clinically indicated. An IDT (Interdisciplinary Team) Note dated January 14, 2026 indicated that the team met to review the incident which occurred on January 12, 2026 related to a physical altercation between residents. The note stated that resident #911 resides in a secured behavioral unit. The resident has diagnoses of dementia with behavioral disturbances and major depressive disorder. Per the note a staff witnessed another resident approach and struck resident #911 on the nose. According to the note the interventions implemented were: Resident #911 offered emotional support, provided calm reassurance, aggressor was placed on 15-minute checks for 3-days. Furthermore, the note indicated that staff would monitor for any changes in mood or behavior status post incident, notify Social Services, and Behavioral Health team if any adverse changes occur. Review of a Nurses Note dated January 15, 2026 documented that bruising on the resident's right eye was noted status post altercation from January 12, 2026. Per the note, resident's abrasion on the nose showed no signs of infection. A Psych Follow Up note dated January 15, 2026 indicated that resident was seen for routine psychiatric follow-up. According to the note, the resident's safety was assessed and deemed current risk to be low. Additionally, the note indicated that a safety plan was not required. The note revealed no indication that the resident-to-resident altercation was discussed. A subsequent Nurses Note also dated January 15, 2026 documented bruising to the right eye persisted. The note indicated that there was no signs or symptoms of infection regarding the nose abrasion. A Physician Progress Notes dated January 16, 2026 documented that resident was punched in face by other resident. The note indicated that x-ray was negative but that there was residual bruising and small laceration on the nose which was healing well. -Resident #999 (alleged perpetrator) was initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included dementia, anxiety disorder schizophrenia, psychosis, and major depressive disorder. A care plan initiated on May 6, 2024 revealed that the resident was placed in a secured unit due to diagnoses of psychosis, and schizophrenia with behaviors such as verbal and physical aggression towards staff. The identified goal was for resident to remain safe and meet all needs. Interventions indicated for behavioral health services to evaluate and treat if indicated, cares in pairs, document all behaviors, and notify medical/psychiatric provider with updates as needed. A care plan revised on January 15, 2025 documented that the resident required cares in pairs due to physical aggression towards others. Interventions directed for two staff members to care for the resident at all times and notify psych/medical providers with updates as needed. A Nursing Note dated October 28, 2025 documented that the resident hit another resident on the nose. The note indicated that resident #999 stated that the other resident kicked his wheelchair three times so he got up and punched him. The note indicated that resident #999 stated They deserve it, I take care of my wheelchair. Per the note the resident was moved to another unit. However, review of the clinical record did not reveal that the incident on October 28, 2025 was addressed in a care plan with identified interventions to prevent further incidents. A subsequent Nursing Note also dated October 28, 2025 indicated that resident (continued on next page)

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	01/28/2026

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	was transferred to unit C1. A Nurses Notes dated November 1, 2025 documented that as a Certified Nursing Assistant (CNA) was assisting the resident put his belt on following a brief change, the resident hit the hand of the CNA, was verbally aggressive, cussed out the CNA in Spanish language, and threw the bedside commode. However, review of the clinical record did not reveal that the incident on November 1, 2025 was addressed in a care plan with identified interventions to prevent further incidents. A behavioral care plan initiated on December 12, 2025 documented that resident had a behavior problem which included combative behavior, and aggressive behaviors such as yelling, hitting, and grabbing. The goals identified were for resident to not have evidence of behavior problems and have fewer episodes of physical aggression. Interventions included to anticipate/meet needs, monitor behavior episodes and attempt to determine underlying cause, administer medications as ordered, intervene as necessary to protect the rights and safety of others, and remove from situation/take to alternate location as needed. A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that a Brief Interview for Mental Status (BIMS) score of 10 indicating that the resident had moderate cognitive impairment. The MDS also noted that the resident had no indicators of psychosis and behavioral symptoms directed towards others at the time of the assessment period. Review of the facility's Incident Report dated January 12, 2026 pertaining to resident #999 revealed a resident to resident altercation noted as Physical Aggression Initiated. The incident location was identified as the hallway. The report documented that a staff witnessed resident #999 walk over to another resident (room [ROOM NUMBER]A occupant) and punched that resident on the nose with a closed fist twice. Per the report there was no injury noted on resident #999. The residents were immediately separated following the incident. The report indicated that resident #999 went into his room and slammed his door shut. The report stated that according to resident #999, he punched the other resident on the face because that resident grabbed his GF's (girlfriend) hand. The report noted that the girlfriend was nowhere in the hall when the incident happened. A revised behavioral care plan dated January 13, 2026 noted that the resident had physical aggression on January 12, 2026 in which he hit another resident. The goal identified were for resident to have fewer episodes of physical aggression, and not have evidence of behavior problems. Interventions noted indicated that resident was placed on 15-minute checks three times a day, referred for alternative high-acuity Behavioral Health placement, psych follow-up, and new medication was prescribed/started. A Nurses Notes dated January 13, 2026 documented that at 6:00 p.m. (presumably the day before given the timestamp of the note) staff witnessed resident #999 approach another resident and punched that resident on the nose with a closed fist twice. The residents were separated immediately. Per the note resident #999 appeared to not have sustained any injury to his hand. Resident #999 then went into his room and slammed his door shut. The note indicated that resident #999 informed staff that he punched the other resident in the face because that resident grabbed resident #999's girlfriend's hand. According to the note, the girlfriend was nowhere in the hallway when the incident occurred. A Social Services Note dated January 13, 2026 documented a Psycho-Social Evaluation which took place following an altercation with another resident the evening before. Per the note the resident was able to recall the incident and stated He was trying to touch my girlfriend. The note indicated that resident #999 laughed while he recounted the altercation. According to the note the IDT (Interdisciplinary Team) discussed the incident with the resident and attempted family contact to explore potential transfer to an alternate facility due to safety concerns. The note stated that that in response to the incident, nursing staff would continue frequent safety checks, and a room change was initiated to support resident and unit safety. However, review of the resident's clinical census revealed that the resident had remained in the same room he was assigned since (continued on next page)

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	01/28/2026

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	October 28, 2025 up until his discharge on [DATE]. Review of an IDT Note dated January 14, 2026 documented that the IDT met to review the incident on January 12, 2026 involving a physical altercation with another resident. Per the note resident #999 resided in a secured Behavioral Health unit. Based on witnessed event, the interventions implemented were to place resident on 15-minute checks three times a day, refer for placement to an alternative high-acuity Behavioral Health, psych follow-up, and new medication was prescribed/started. A Nurses Notes dated January 14, 2026 documented that resident was discharged to another facility. Review of the facility's Facility Reported Incident Form Follow-up Report dated January 15, 2026 documented an investigation pertaining to an incident involving residents #911 and #999. The investigation revealed that an oncoming shift's nurse witnessed resident #999 get up from his wheelchair and walk towards resident #999 and struck him on the nose. The report included interviews of both the alleged victim (resident #911), alleged perpetrator (resident #999) and witness (staff #98) statement. The report noted that according to resident #999, he became upset after he observed a friend's hand touched by resident #911. This caused resident #999 to react. Per the witness statement (staff #98), as she walked through the double doors of the unit, she saw resident #999 approach resident #911 who was sitting in his wheelchair and punched resident #911 on the nose twice with a closed fist. The investigation report concluded that the allegation of abuse was verified. An interview with a Certified Nursing Assistant (CNA/staff #166) was conducted on January 26, 2026 at 2:51 p.m. The CNA stated that she was not present when the incident occurred but heard that it had gotten physical between residents #911 and #999. The CNA said that resident #911 sustained a blackeye and a cut on his nose as a result of that altercation but that the injuries has healed. Per the CNA the incident was inappropriate and that resident #999's actions would be categorized as abuse. The CNA noted that to her knowledge the incident was unprovoked and commented that resident #999 had triggers. According to the CNA it is important for residents to not be subjected to abuse because the residents have rights. Additionally, the facility is responsible for the residents' care and dignity-part of that is to be free from abuse. The CNA stated that the potential impact of abuse is that residents could end up depressed, scared, withdrawn, and not trust others. In the case of resident #911 (alleged victim) the impact is not noticed because he does not fully understand what happened so he is essentially back to normal. During an interview with a Registered Nurse (RN/staff #99) conducted on January 26, 2026 at 3:03 p.m., the RN stated that in the behavior unit they have to closely monitor residents' safety and ensure that there are no incidents. Some residents have triggers so they are monitored to ensure they can prevent triggers that can affect other residents. According to the RN a physical altercation is abuse. The RN noted that it is important that residents are not subjected to abuse because their safety is a priority, the facility is tasked with caring for the residents/meeting the residents needs, and preventing abuse from happening. The RN said that if a resident is subjected to abuse, it affects them physically, emotionally, mentally, and they can be hurt and it affects their mind. Per the RN, she was informed that approximately two weeks ago, resident #999 punched resident #911 on the face. As a result of the incident resident #999 was transferred to another facility. The RN noted that she was told that resident #911 sustained a bruise on his eye and a cut on his nose. The injuries had since resolved. An x-ray was taken and no fractures were noted. The RN said that resident #999 had known behaviors and was aggressive. The RN shared that resident #999 have previously hit a CNA approximately 1 1/2 month ago and that the CNA sustained a bruise. An interview with the Director of Social Services (Dir SS/staff #60) was conducted on January 28, 2026 at 10:38 a.m. The Dir SS stated that the impact of a resident being subjected to abuse is that the potential that the resident is placed in danger and that resident and others would (continued on next page)

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	01/28/2026

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	not be safe. Staff #60 stated that she was not familiar with the incident between residents #911 and #999. However, the Dir SS noted that resident #999 was the instigator in most of the incidents he was involved in. Staff #60 said that the facility spoke with resident #999's family about the incident but the family was not helpful and laughed about the incident. Due to this most recent incident it was decided that resident #999 be transferred to another facility. An interview with the Director of Nursing (DON/staff #25) was conducted on January 28, 2026 at 2:29 p.m. Staff #25 stated that it is important that residents are not subjected to abuse because the residents are in the facility for care, and to get their health condition managed. Therefore, the residents' safety, dignity, and rights are important. The DON said that impact of abuse is that the resident can get scared, depressed, be on guard, and lead to care refusal. The DON stated that it is not good for a resident to experience abuse since no one can give the resident a sense of safety except for staff. The DON said that with regards to the altercation between residents #999 and #911, the investigation revealed that the alleged victim was sitting and the aggressor punched him on the nose. The DON noted that per the investigation the incident was verified as a resident to resident altercation. The facility policy on Abuse and Neglect adopted May 1, 2024 revealed that it is the policy of the facility to provide professional care and services in an environment that is free from any type of abuse. Per the policy the prevention of abuse includes the assessment, care planning, and monitoring of residents with needs and behaviors which might lead to conflict such as residents with history of aggressive behaviors. A facility policy titled Quality of Care Accident Hazards/Supervision/Devices dated July 2018 stated that the facility recognizes that resident-to-resident altercations could be a situation of abuse. The policy noted that reasonable precautions will be taken when the risk of resident-to-resident altercation is present. Additionally, the facility will identify residents who exhibit behavior that make them more likely to be involved in an altercation. Furthermore, interventions will be implemented to minimize or control incidents of disruptive or intrusive behavior to minimize altercations.

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	01/28/2026

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and review of facility documentation and policies, the facility failed to protect the rights of one resident (#333) to be free from financial misappropriation/exploitation of resident property by another resident (#111). The deficient practice could result in further financial abuse of residents when appropriate actions are not taken.-Regarding Resident #111 (alleged perpetrator):Resident #111 was admitted to the facility on [DATE], with diagnoses that included major depressive disorder, obesity, and life management difficulty.Review of the care plan dated August 19, 2023, revealed that the resident has psychological aspects of chronic illness. The interventions included providing the Resident/Representative a list of community resources, and identifying the disease progression and when to notify the health care provider.A care plan dated October 25, 2023, revealed the resident has a history of self-harmful ideation (thoughts) and/or behaviors. The problems/needs are manifested by: sharing thoughts of self-harm when interviewed; and the ideation appears related to: poor impulse control. The interventions included to assess what and where it occurred, assess the circumstances surrounding the event, assess any precipitants and any current plan to harm; and establish a safety contract (verbal and/or written) with the resident.A review of the Resident's annual Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15.0, indicating that the resident was cognitively intact. The resident did not exhibit behavioral symptoms.A review of the administrative progress note dated October 29, 2024, revealed that the staff notified the health plan of a 30-day notice, and requested assistance with placement.On December 3, 2024, per the nursing progress note document, Resident #111 was discharged to another facility.-Regarding Resident #333 (alleged victim):Resident #333 was admitted to the facility on [DATE], with diagnoses that included anemia, chronic obstructive pulmonary disease (lung disease that causes difficulty breathing and chronic cough), weakness, and major depressive disorder.On August 20, 2024, the use of antidepressant medication related to the depression care plan was initiated. The interventions included to give antidepressant medications ordered by physician, monitor for side effects and effectiveness which include dry mouth, dry eyes, constipation, urinary retention, suicidal ideations; and monitor for ongoing signs and/or symptoms of depression unaltered by antidepressant meds: sad, irritable, anger, never satisfied, crying, shame, worthlessness, guilt, suicidal ideations, neg. mood/comments, slowed movement, agitation, disrupted sleep, fatigue, lethargy, or does not enjoy usual activities.A review of the Resident's quarterly MDS assessment dated [DATE], revealed a BIMS score of 13.0, indicating that the resident was cognitively intact.Review of the Resident's care plan dated October 22, 2024, revealed a potential risk for alteration in mood state and psychosocial well-being. The interventions included observing and reporting any changes in mental status/behaviors caused by situational stressors, and provide opportunities to express feelings related to these stressors.The nurses' progress note dated October 26, 2024, revealed per documentation that Resident #333 was placed on every 15-minute check since the day before. A cop was in the Resident's room for 30 minutes, and then the cop met with the social service after talking to Resident #333.A review of a nurse practitioner's progress notes dated October 28, 2024, revealed that Resident #333 was still upset about the encounter with a fellow resident being robbed. Resident #333 had spoken with the detectives and a few hours later, Resident #333 was experiencing some chest pain. Per documentation, Resident #333 felt better later and the pain had resolved; Resident #333 had increased anxiety and sadness and wants to move to another facility; and the social service was involved in finding a new facility for Resident #333.On January 6, 2025, per documentation from the nurse practitioner's progress notes, (continued on next page)

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	01/28/2026

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #333 was cleared to be discharged from the hospital but Resident #333 refused to return back to the facility.A review of the facility's incident follow-up report dated October 25, 2024, revealed that the names of the residents involved were not included in the report. Resident reported the incident to the director of nursing (DON), Business Office Manager (BOM), and social service director (SSD) regarding the alleged event. Perpetrator was interviewed by the DON, BOM, and the SSD. After the initial interview, the interdisciplinary team (IDT) completed a thorough investigation, which included an outreach to the police, APS (Adult Protective Services), and the ombudsman. The report revealed that the perpetrator reported that she assisted the victim with her funds, and the victim gave permission to use the funds, and then the perpetrator continued to use them without the victim's permission. Further, the report revealed that during interviews, it was not reported that staff had any knowledge that the victim had provided the perpetrator access to her funds until she reported the event. The facility verified the allegation. The report also included corrective action taken. The perpetrator was on frequent checks, and the perpetrator was given a 30-day notice to vacate the facility with the assistance from the SSD.A self-report for October 2024 involving Resident #333 was requested during the onsite survey. A review of the document provided by the administrator (Staff #87) on January 28, 2026, at 7:15 AM, revealed no self-report in October 2024 regarding Resident #333.An interview was conducted on January 28, 2026, at 8:28 AM with the business office manager (BOM/Staff #44). She stated that her responsibility included conducting interviews for residents applying for Arizona Long Term Care Services (ALTCS). Regarding Resident #333, she said that the resident handled her own finances, and the resident befriended Resident #111, whom Resident #333 met during bingo. She said that around October 2024, Resident #111 started stealing money from Resident #333. She said that Resident #333 gave her debit card and some cash to Resident #111 to hold for her. She said that Resident #111 used the money to buy clothes for herself and clothes for Resident #333. She also said that Resident #111 also purchased coins for virtual slot games. Further, she said that she found out about the incident when Resident #333 spoke to her. She stated that the social service director (Staff #60) conducted an investigation; the DON, the Arizona Department of Health (AzDHS), and the police were notified; and a police report was filed. Furthermore, she said that Resident #111 was confronted by a private investigator, Resident #111 was served a summon to see a judge, and Resident #111 was also transferred out to another facility. She stated that Resident #333 cancelled her debit card and was transferred out of the facility. She said that the administrator was not informed of the incident because the facility did not have an administrator in October. Regarding her abuse training, she said that abuse is when someone is taking advantage of another person in any way such as financially, physically, sexually, emotionally, and the person has no means to defend themselves. She said that financial abuse is when someone is taking advantage of a person's finances that cannot fight back. She said that she considered the incident between Resident #333 and Resident #111 an abuse because Resident #111 was much younger than Resident #333. She also stated that if she witnessed or was made aware of any abuse, her responsibility is to notify the administrator, call the police, speak to the victim, and call Adult Protective Services (APS). She will notify the administrator to make them aware of the allegation of abuse because it is everyone's responsibility to protect every resident. She said that Resident #333 wanted the police to be notified and Resident #111 arrested. She said that she does not have any documentation regarding the incident, and she only has the investigator's card, but the social service director (Staff #60) might have the documentation.An interview was conducted on January 28, 2026 at 8:50 AM with the social service director (SSD/Staff #60). The social service director stated that she conducts psychosocial interviews with her residents to assess (continued on next page)

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	01/28/2026

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	their cognitive assessment (BIMS score), mood interview (PHQ9), trauma evaluation for life event checklist, assess behaviors in MDS, and discharge planning. Regarding Resident #333, the social worker director stated that she notified the APS about Resident #111, who was Resident #333's roommate. She said that Resident #333 at first consented for her Resident #111 using her finances, but later found out that Resident #111 was using Resident #333's debit card. The social service director stated that the way she found out about the incident was when Resident #111 was not paying her share of the cost to the facility. She stated that she noticed boxes of purchases in Resident #111's room. She said that she notified APS; separated Resident #333 and Resident #111 by changing their rooms; and she helped Resident #333 report the fraud and get her a new card. She stated that she reported the incident to the DON (Staff #193), APS, and the ombudsman. She stated that the DON was in communication with the acting administrator (Staff #194) at that time. She stated that Staff #194 reported the incident to Arizona Department of Health Services. Regarding Resident #111, she said that Resident #111 was moved to another room and was given a 30-day notice to vacate for the safety of the other residents, and Resident #111 transferred to another facility on December 3, 2024. Regarding her abuse training, she stated that abuse is verbal, financial, sexual, physical, emotional, and anything that places a resident in harm or potential harm. She stated that financial abuse is when somebody's finances are exploited. She said that the incident between Resident #333 and Resident #111 was financial exploitation.An interview was conducted on January 28, 2026, at 9:27 AM with the administrator (Staff #87). Regarding Resident #333, the administrator stated that she had no knowledge about this incident because the incident happened before she was employed by this facility. She said that she was made aware of this resident-to-resident misappropriation of property incident yesterday. She also stated that she was unable to find the reportable event, and she is still searching for the report. The administrator also stated that the reportable should be a record of the event, and the investigation should be saved on paper or electronically in the facility for availability for review.Attempted to interview Resident #333 telephonically on January 28, 2026, at 11:09 AM, but it was unsuccessful.An interview was conducted on January 28, 2026, at 3:57 PM with a certified nursing assistant (CNA/Staff #69). Staff #69 stated that misappropriation would fall under abuse. She stated that the impact of misappropriation would affect the resident badly, especially if the resident was coherent and taken advantage of, and it is unfair. She stated that she was not familiar with Resident #333 and Resident #111.An interview was conducted on January 28, 2026, at 4:08 PM with a licensed practical nurse (LPN/Staff #85) regarding financial misappropriation. Staff #85 stated that misappropriation is a crime. She said that nobody wants that to happen; when a resident arrives in the facility with money, the money is counted, but is otherwise taken to the business office. Staff #85 remembered an incident that happened 2 years ago involving Resident #333. Staff #85 stated that Resident #333's money was being taken; Resident #333 befriended and was very close to Resident #111, who was a lot younger and was in a different unit. Staff #85 said that Resident #111 was among the leaders of the resident council, so Resident #111 was easily trusted; Resident #333 was older so Resident #111 would visit Resident #333 in her room and hang out; and Resident #333 and Resident #111 hung out in each other's room. Staff #85 stated that all of a sudden, Resident #333 reported that her money was being stolen; Resident #111 would use Resident #333's card and go online shopping; Resident #333 realized that her money was being stolen, and it was reported. Staff #85 said that Resident #111 got in trouble, the police and APS got involved, and Resident #111 ended up in another facility. Staff #85 stated that the incident changed Resident #333's demeanor and started secluding herself. Staff #85 remembered Resident #333 telling him My friend disappointed me; Resident #333 was depressed, stopped doing (continued on next page)

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	01/28/2026

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	activities, and shortly after that, Resident #333 was sent out to the hospital and she did not want to come back.Review of facility policy titled Abuse and Neglect, adopted on May 1, 2024, revealed that 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. If abuse is suspected the facility will conduct a careful and deliberate investigation centering on facts, observations and statements from the alleged victim and witnesses.

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	01/28/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and review of facility documentation and policies, the facility failed to maintain documentation that an alleged violation related to the allegation of financial misappropriation of property for one resident (#333) by another resident (#111) was thoroughly investigated. The deficient practice could result in further financial abuse of residents when appropriate actions are not taken.-Regarding Resident #111 (alleged perpetrator):Resident #111 was admitted to the facility on [DATE], with diagnoses that included major depressive disorder, obesity, and life management difficulty.Review of the care plan dated August 19, 2023, revealed that the resident has psychological aspects of chronic illness. The interventions included providing the Resident/Representative a list of community resources, and identifying the disease progression and when to notify the health care provider.A care plan dated October 25, 2023, revealed the resident has a history of self-harmful ideation (thoughts) and/or behaviors. The problems/needs are manifested by: sharing thoughts of self-harm when interviewed; and the ideation appears related to: poor impulse control. The interventions included to assess what and where it occurred, assess the circumstances surrounding the event, assess any precipitants and any current plan to harm; and establish a safety contract (verbal and/or written) with the resident.A review of the Resident's annual Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15.0, indicating that the resident was cognitively intact. The resident did not exhibit behavioral symptoms.A review of the administrative progress note dated October 29, 2024, revealed that the staff notified the health plan of a 30-day notice, and requested assistance with placement.On December 3, 2024, per the nursing progress note document, Resident #111 was discharged to another facility.-Regarding Resident #333 (alleged victim):Resident #333 was admitted to the facility on [DATE], with diagnoses that included anemia, chronic obstructive pulmonary disease (lung disease that causes difficulty breathing and chronic cough), weakness, and major depressive disorder.On August 20, 2024, the use of antidepressant medication related to the depression care plan was initiated. The interventions included to give antidepressant medications ordered by physician, monitor for side effects and effectiveness which include dry mouth, dry eyes, constipation, urinary retention, suicidal ideations; and monitor for ongoing signs and/or symptoms of depression unaltered by antidepressant meds: sad, irritable, anger, never satisfied, crying, shame, worthlessness, guilt, suicidal ideations, neg. mood/comments, slowed movement, agitation, disrupted sleep, fatigue, lethargy, or does not enjoy usual activities.A review of the Resident's quarterly MDS assessment dated [DATE], revealed a BIMS score of 13.0, indicating that the resident was cognitively intact.Review of the Resident's care plan dated October 22, 2024, revealed a potential risk for alteration in mood state and psychosocial well-being. The interventions included observing and reporting any changes in mental status/behaviors caused by situational stressors, and provide opportunities to express feelings related to these stressors.The nurses' progress note dated October 26, 2024, revealed per documentation that Resident #333 was placed on every 15-minute check since yesterday. A cop was in the Resident's room for 30 minutes, and then the cop met with the social service after talking to Resident #333.A review of a nurse practitioner's progress notes dated October 28, 2024, revealed that Resident #333 was still upset about the encounter with a fellow resident being robbed. Resident #333 had spoken with the detectives and a few hours later, Resident #333 was experiencing some chest pain. Per documentation, Resident #333 felt better later and the pain had resolved; Resident #333 had increased anxiety and sadness and wants to move to another facility; and the social service was involved in finding a new facility for Resident #333.On January 6, 2025, per documentation from the nurse practitioner's progress (continued on next page)

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	01/28/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notes, Resident #333 was cleared to be discharged from the hospital but Resident #333 refused to return back to the facility.A review of the facility's incident follow-up report dated October 25, 2024, revealed that the names of the residents involved were not included in the report. Resident reported the incident to the director of nursing (DON), Business Office Manager (BOM), and social service director (SSD) regarding the alleged event. Perpetrator was interviewed by the DON, BOM, and the SSD. After the initial interview, the interdisciplinary team (IDT) completed a thorough investigation, which included an outreach to the police, APS (Adult Protective Services), and the ombudsman. The report revealed that the perpetrator reported that she assisted the victim with her funds, and the victim gave permission to use the funds, and then the perpetrator continued to use them without the victim's permission. Further, the report revealed that during interviews, it was not reported that staff had any knowledge that the victim had provided the perpetrator access to her funds until she reported the event. The facility verified the allegation. The report also included corrective action taken. The perpetrator was on frequent checks, and the perpetrator was given a 30-day notice to vacate the facility with the assistance from the SSD. However, the facility's incident follow-up report dated October 25, 2024, did not include interview statements from staff members or other residents who might have interactions with Resident #333 and Resident #111.A self-report for October 2024 involving Resident #333 was requested during the onsite survey. A review of the document provided by the administrator (Staff #87) on January 28, 2026, at 7:15 AM, revealed no self-report in October 2024 regarding Resident #333.An interview was conducted on January 28, 2026, at 8:28 AM with the business office manager (BOM/Staff #44). She stated that her responsibility included conducting interviews for residents applying for Arizona Long Term Care Services (ALTCS). Regarding Resident #333, she said that the resident handled her own finances, and the resident befriended Resident #111, whom Resident #333 met during bingo. She said that around October 2024, Resident #111 started stealing money from Resident #333. She said that Resident #333 gave her debit card and some cash to Resident #111 to hold for her. She said that Resident #111 used the money to buy clothes for herself and clothes for Resident #333. She also said that Resident #111 also purchased coins for virtual slot games. Further, she said that she found out about the incident when Resident #333 spoke to her. She stated that the social service director (Staff #60) conducted an investigation; the DON, the Arizona Department of Health (AzDHS), and the police were notified; and a police report was filed. Furthermore, she said that Resident #111 was confronted by a private investigator, Resident #111 was served a summon to see a judge, and Resident #111 was also transferred out to another facility. She stated that Resident #333 cancelled her debit card and was transferred out of the facility. She said that the administrator was not informed of the incident because the facility did not have an administrator in October. Regarding her abuse training, she said that abuse is when someone is taking advantage of another person in any way such as financially, physically, sexually, emotionally, and the person has no means to defend themselves. She said that financial abuse is when someone is taking advantage of a person's finances that cannot fight back. She said that she considered the incident between Resident #333 and Resident #111 an abuse because Resident #111 was much younger than Resident #333. She also stated that if she witnessed or was made aware of any abuse, her responsibility is to notify the administrator, call the police, speak to the victim, and call Adult Protective Services (APS). She will notify the administrator to make them aware of the allegation of abuse because it is everyone's responsibility to protect every resident. She said that Resident #333 wanted the police to be notified and Resident #111 arrested. She said that she does not have any documentation regarding the incident, and she only has the investigator's card, but the social service director (Staff #60) might have the (continued on next page)

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	01/28/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation.An interview was conducted on January 28, 2026 at 8:50 AM with the social service director (SSD/Staff #60). The social service director stated that she conducts psychosocial interviews with her residents to assess their cognitive assessment (BIMS score), mood interview (PHQ9), trauma evaluation for life event checklist, assess behaviors in MDS, and discharge planning. Regarding Resident #333, the social worker director stated that she notified the APS about Resident #111, who was Resident #333's roommate. She said that Resident #333 at first consented for her Resident #111 using her finances, but later found out that Resident #111 was using Resident #333's debit card. The social service director stated that the way she found out about the incident was when Resident #111 was not paying her share of the cost to the facility. She stated that she noticed boxes of purchases in Resident #111's room. She said that she notified APS; separated Resident #333 and Resident #111 by changing their rooms; and she helped Resident #333 report the fraud and get her a new card. She stated that she reported the incident to the DON (Staff #193), APS, and the ombudsman. She stated that the DON was in communication with the acting administrator (Staff #194) at that time. She stated that Staff #194 reported the incident to Arizona Department of Health Services. Regarding Resident #111, she said that Resident #111 was moved to another room and was given a 30-day notice to vacate for the safety of the other residents, and Resident #111 transferred to another facility on December 3, 2024. Regarding her abuse training, she stated that abuse is verbal, financial, sexual, physical, emotional, and anything that places a resident in harm or potential harm. She stated that financial abuse is when somebody's finances are exploited. She said that the incident between Resident #333 and Resident #111 was financial exploitation.An interview was conducted on January 28, 2026, at 9:27 AM with the administrator (Staff #87). The administrator stated that her responsibilities included overseeing regulatory compliance, facility operations, resident satisfaction, quality care, and resident mediation. Regarding an allegation of abuse, the administrator stated that abuse is physical, mental, sexual, financial, and technological. She said that she does not permit abuse; abuse will be addressed promptly, investigated, and the investigation will be reported to the Arizona Department of Health Services, police, ombudsman, and the Adult Protective Services. The administrator stated that the abuse investigation process depends on the type; if it involves a staff member, the staff member will be removed from the work environment; she will interview residents and staff members; conduct a skin assessment; may order a behavioral health assessment; and she will look at the environment, if applicable. She said that once she has the relevant information, their interdisciplinary team will assess all the information gathered, form a conclusion, put an intervention in place to protect the residents and ensure their safety. Once all information is gathered, she and her team will determine whether the allegation was verified. Then, she will turn the final investigation report to the department of health services; continue to monitor the resident; appropriately implement the interventions to care for the resident, and if necessary, terminate the employee, and report the employee to the state if verified. She also said that she will investigate to make sure that the resident was provided care appropriately and ensure quality care to residents. Further, she reports the allegation of abuse to the agencies because it is mandatory, and it is a way to ensure that employees will not be able to work in other places and abuse other vulnerable adults in other communities. Further, the administrator stated that the impact of an investigation of an abuse not being done could continue the abuse and impact the quality of care. She stated that the impact of not reporting the allegation of abuse to agencies could be a violation against regulations. Regarding Resident #333, the administrator stated that she had no knowledge about this incident because the incident happened before she was employed by this facility. She said that she was made aware of this resident-to-resident (continued on next page)

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	01/28/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	misappropriation of property incident yesterday. She also stated that she was unable to find the reportable event, and she is still searching for the report. The administrator also stated that the reportable should be a record of the event, and the investigation should be saved on paper or electronically in the facility for availability for review.Attempted to interview Resident #333 telephonically on January 28, 2026, at 11:09 AM, but it was unsuccessful.An interview was conducted on January 28, 2026, at 3:57 PM with a certified nursing assistant (CNA/Staff #69). Staff #69 stated that misappropriation would fall under abuse. She stated that the impact of misappropriation would affect the resident badly, especially if the resident was coherent and taken advantage of, and it is unfair. She stated that she was not familiar with Resident #333 and Resident #111.An interview was conducted on January 28, 2026, at 4:08 PM with a licensed practical nurse (LPN/Staff #85) regarding financial misappropriation. Staff #85 stated that misappropriation is a crime. She said that nobody wants that to happen; when a resident arrives in the facility with money, the money is counted, but is otherwise taken to the business office. Staff #85 remembered an incident that happened 2 years ago involving Resident #333. Staff #85 stated that Resident #333's money was being taken; Resident #333 befriended and was very close to Resident #111, who was a lot younger and was in a different unit. Staff #85 said that Resident #111 was among the leaders of the resident council, so Resident #111 was easily trusted; Resident #333 was older so Resident #111 would visit Resident #333 in her room and hang out; and Resident #333 and Resident #111 hung out in each other's room. Staff #85 stated that all of a sudden, Resident #333 reported that her money was being stolen; Resident #111 would use Resident #333's card and go online shopping; Resident #333 realized that her money was being stolen, and it was reported. Staff #85 said that Resident #111 got in trouble, the police and APS got involved, and Resident #111 ended up in another facility. Staff #85 stated that the incident changed Resident #333's demeanor and started secluding herself. Staff #85 remembered Resident #333 telling him My friend disappointed me; Resident #333 was depressed, stopped doing activities, and shortly after that, Resident #333 was sent out to the hospital and she did not want to come back.Review of facility policy titled Abuse and Neglect, adopted on May 1, 2024, revealed that 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. If abuse is suspected the facility will conduct a careful and deliberate investigation centering on facts, observations and statements from the alleged victim and witnesses.

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	01/28/2026

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and review of facility documentation and policies, the facility failed to develop a baseline care plan within 48 hours of a resident's admission for one resident (#191), which provides instructions to meet the resident's immediate needs. The deficient practice could result in resident's treatments and needs not appropriately addressed.Findings Include:Resident #191 was readmitted to the facility on [DATE], with diagnoses that included rhabdomyolysis (is a rare muscle injury where your muscles break down), adult failure to thrive, major depressive disorder, difficulty walking, and cognitive communication deficit.A review of the Clinical admission Evaluation progress note dated August 3, 2024, revealed that the resident's admission mode was wheelchair. The Resident was alert and oriented times 3; alert (some forgetfulness).A physician-admission history and physical progress note dated August 3, 2024, revealed per documentation that resident was in a medical center with a 2- day history of weakness and falls at home, unable to ambulate with associated dizziness.An admission Morse Fall Scale Evaluation dated August 3, 2024, revealed a score of 65.0, indicating resident was assessed for high risk for falling.Review of the resident's medical record revealed no baseline care plan developed within 48 hours of the resident's admission.A review of the comprehensive care plan dated August 5, 2024, revealed that the resident had an activities of daily living self-care performance deficit related to deconditioning; the resident was at risk for falls related to deconditioning and gait/balance problems. The interventions initiated on August 5, 2024 included to encourage the resident to participate to the fullest extent possible with each interaction; encourage the resident to use bell to call for assistance; anticipate and meet the resident's needs; be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed; the resident needs prompt response to all requests for assistance; and ensure commonly used items (ice water, glasses if applicable, call light, phone, remote) are within reach of resident prior to leaving room.On August 6, 2024, a Daily Skilled Charting progress note revealed per documentation, gait during shift-unsteady; poor balance during shift; bedfast all or most of the time during shift; the resident is sometimes displaying untoward behaviors; she refused to follow instructions; she insisted on doing her own; and she insisted on going to the bathroom even if she has briefs on.Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score 6.0, indicating that the resident's cognition was severely impaired.On August 9, 2024, a nurses' progress note revealed per documentation, that the resident was seen sitting on the floor with back leaning on the side of the bed and both legs extended. The Resident claimed that she slipped slowly while trying to stand up to go to the bathroom. The resident was assessed, no noted bruises or skin tear; resident was assisted back to bed; kept bed on lowest level for safety; neuro check was started; provider, assistant director of nursing, emergency contact were notified; put back non-slipped socks; reinstructed to use call light for assistance; and fall prevention signage was placed on the resident's room.Review of the Neurological Flow Sheet revealed a neuro check was completed on August 8, 2024, through August 13, 2024. The results of the neuro checks revealed that Resident #191 was fully conscious, her pupils' reaction was brisk, her speech was clear, she moved all of her 4 extremities equally and strong, and the Resident's vital signs were also monitored.On August 13, 2024, a nurses' progress note revealed per documentation resident was found lying on the floor; resident verbalized she did not hit her head; vital signs taken; neuro check started; no verbalized pain; resident was advised to use walker when ambulating; walker was placed at reach for use; bed was placed at the lowest position for safety; the provider, assistant (continued on next page)

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	01/28/2026

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	director of nursing (ADON), were notified and resident's emergency contact cannot be reached.Review of the Neurological Flow Sheet revealed a neuro check was completed on August 13, 2024 through August 16, 2024. The result of the neuro checks revealed that Resident #191 was fully conscious, her pupils' reaction was brisk, her speech was clear, she moved all of her 4 extremities equally and strong, and the Resident's vital signs were also monitored.On August 16, 2024, a nurses 'progress note revealed per documentation, the incident was unwitnessed fall; resident was seen on the floor, on prone position; forehead laceration bleeding and was controlled; left knee skin tear; resident cannot verbalize what had happened prior to fall; she appears to be confused; resident was assessed; neuro check initiated; resident was able to verbalized pain over the affected area; 911 called; resident was transferred out to the hospital; and management, provider, and emergency contact were notified.An interview was conducted on January 28, 2026, at 8:32 AM with a certified nursing assistant (CNA/Staff #148). Staff #148 stated that fall risk was discussed with the new admission. Staff #148 stated that for a fall risk resident, the mattress is placed at the side of the bed; she is instructed to lower the bed; and when the resident arrived from the hospital, the resident have a fall risk tag. Staff #148 stated that it was important to monitor the resident closely because the impact of residents not being monitored is that they can have a fracture, or be afraid to do things after a fall, lose confidence, and get hurt.An interview was conducted with a licensed practical nurse (LPN/Staff #85) on January 28, 2026 at 9:05 AM. Regarding fall, Staff #85 stated that staff can move resident closer to the nurses' station, have call light, increase safety checks; maybe have a fall mattress. Staff #85 stated that fall has a lot of risk such as broken bones, injuries and hospitalization.An interview was conducted on January 28, 2026, at 3:31 PM with a Registered Nurse (RN/Staff #66). Staff #66 stated that if a new resident was admitted , he will do an initial assessment which includes a skin assessment, a fall assessment, especially with a history of falls, ground level fall, wandering, dementia, old age, and new residents tend to be uneasy with a new place. He said that he will inform the certified nursing assistant (CNA) about the resident's risk of falls. He said that for resident identified as having a high risk for falls, the intervention includes lowering the bed, call light within reach, ask the provider to order floor mattress, place a yellow star for fall risk signage. He stated that for an unwitnessed fall, he will assess the resident, check their vital signs, notify the provider, director of nursing, start neuro check assessment. He said that neuro assessment was needed to compare resident's baseline and current situation and be aware of any changes or any injury. Regarding Resident #191, Staff #66 stated that he does not remember caring for the resident. Staff #66 stated that the unit manager initiates the baseline care plan; and he did not find a baseline care plan for resident #191 in the electronic medical record.A follow-up interview was conducted on January 28, 2026, at 5:11 PM with the director of nursing (DON/Staff #25). The DON stated that a fall assessment includes identifying diagnoses, history of falls, use of medications, any behaviors that can cause a fall, the resident's mobility, and orientation. The DON stated that if the resident was assessed as having a high risk for falls, she said to monitor, observe, check the resident, and report the high risk for falls to the staff. In addition, the DON stated other interventions such as, if a room was available to place the resident near the nurses' station, lower the bed, make sure the mattress does not slide out, have grab bars, call light within reach, anticipate the resident's needs, answer the call light promptly, and offer food and toileting before the resident goes to bed. Regarding Resident #191, who had 3 fall incidents, the DON stated that the resident has a fall care plan that did not have the resident at high risk for falls as indicated in the resident's fall assessment; she said that after the resident's fall incidents, the care plan was not updated. The DON stated (continued on next page)

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	01/28/2026

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that a resident's care plan is an interdisciplinary team approach because a care plan needs feedback from different disciplines, such as from dietary, rehab, or social services.According to MDS Training Institute, dated June 27, 2024, The intent of the baseline care plan is to promote continuity of care and communication among nursing home staff, increase resident safety, safeguard against adverse events that are most likely to occur right after admission and to identify needs of supervision, behavioral interventions, and assistance with activities of daily living.Per the CMS (Centers for Medicare &Medicaid Services) regulation at S483.21(a)(1), The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-Be developed within 48 hours of resident's admission.Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-Initial goals based on admission orders.Physician orders.Dietary orders.Therapy services.Social services.PASARR (Preadmission Screening and Annual Resident Review) recommendation, if applicable.A review of facility policy titled Fall Prevention adopted on May 1, 2024, revealed that it is the policy of this facility that the Fall Prevention Program is designed to ensure a safe environment for all residents. Each resident will be evaluated upon admission, quarterly, and as needed by an RN/LPN to assess his/her individual level of risk. The Interdisciplinary Team will review the Fall Risk Assessment completed by the nursing department, and if appropriate, a fall prevention protocol will be initiated. The purpose of the policy was to identify residents at risk in a timely manner; to gather accurate, objective, and consistent data for the purpose of implementing an individualized Plan of Care designated to meet the resident's needs; to ensure consistency in the implementation of preventive measures to assist with the reduction of falls; and to evaluate outcomes. The policy procedure include a licensed nurse will complete a Fall Risk Assessment within 24 hours of admit to determine the resident's risk factors associated with the potential for falls; the Interdisciplinary Team will be responsible for reviewing the Fall Risk Assessments, if assessed to be a high risk and/or is appropriate they will initiate fall prevention interventions; and the Director of Nursing/designee will be responsible for ensuring that residents who have been identified at risk or who have experienced a recent fall have all recommended interventions in place as well as current assessments and documentation reflecting notification of applicable disciplines, resident's physician and resident's family/responsible party.

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	01/28/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and review of facility documentation and policies, the facility failed to review and revised the care plan for one resident (#191) after each fall incident. The deficient practice could place the resident at risk for more falls.Findings Include:Resident #191 was readmitted to the facility on [DATE], with diagnoses that included rhabdomyolysis (is a rare muscle injury where your muscles break down), adult failure to thrive, major depressive disorder, difficulty walking, and cognitive communication deficit.A review of the Clinical admission Evaluation progress note dated August 3, 2024, revealed that the resident's admission mode was wheelchair. The Resident was alert and oriented times 3; alert (some forgetfulness).A physician-admission history and physical progress note dated August 3, 2024, revealed per documentation that resident was in a medical center with a 2- day history of weakness and falls at home, unable to ambulate with associated dizziness.An admission Morse Fall Scale Evaluation dated August 3, 2024, revealed a score of 65.0, indicating that the resident was assessed for high risk for falling.A review of the comprehensive care plan dated August 5, 2024, revealed that the resident had an activities of daily living self-care performance deficit related to deconditioning; the resident was at risk for falls related to deconditioning and gait/balance problems. The interventions initiated on August 5, 2024 included to encourage the resident to participate to the fullest extent possible with each interaction; encourage the resident to use bell to call for assistance; anticipate and meet the resident's needs; be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed; the resident needs prompt response to all requests for assistance; and ensure commonly used items (ice water, glasses if applicable, call light, phone, remote) are within reach of resident prior to leaving room.On August 6, 2024, a Daily Skilled Charting progress note revealed per documentation, gait during shift-unsteady, poor balance during shift, bedfast all or most of the time during shift; the resident is sometimes displaying untoward behaviors, she refused to follow instructions, she insisted on doing her own. She insisted on going to the bathroom even if she has briefs on.Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score 6.0, indicating that the resident's cognition was severely impaired.On August 9, 2024, a nurses' progress note revealed per documentation, the resident was seen sitting on the floor with their back leaning on the side of the bed and both legs extended. The Resident claimed that she slipped slowly while trying to stand up to go to the bathroom. The resident was assessed, no noted bruises or skin tear; the resident was assisted back to bed; kept bed on lowest level for safety; neuro check was started; provider, assistant director of nursing, emergency contact were notified; put back non-slipped socks; reinstructed to use call light for assistance; and fall prevention signage was placed on the resident's room.Review of the Neurological Flow Sheet revealed a neuro check was completed on August 8, 2024, through August 13, 2024. The results of the neuro checks revealed that Resident #191 was fully conscious, her pupils' reaction was brisk, her speech was clear, she moved all of her 4 extremities equally and strong, and the Resident's vital signs were also monitored.Review of the comprehensive care plan dated August 5, 2024, related to activities of daily living, self-care performance deficit related to deconditioning, and the resident at risk for falls related to deconditioning and gait/balance problems revealed that the care plan was not updated after Resident #191 fall incident on August 8, 2024.On August 13, 2024, a nurses' progress note revealed per documentation, the resident was found lying on the floor; resident verbalized she did not hit her head; vital signs taken; neuro check started; no verbalized pain; resident was (continued on next page)

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	01/28/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	advised to use walker when ambulating; walker was placed at reach for use; bed was placed at the lowest position for safety; the provider and the assistant director of nursing (ADON) were notified; and the resident's emergency contact cannot be reached.Review of the Neurological Flow Sheet revealed a neuro check was completed on August 13, 2024 through August 16, 2024. The result of the neuro checks revealed that Resident #191 was fully conscious, her pupils' reaction was brisk, her speech was clear, she moved all of her 4 extremities equally and strong, and the Resident's vital signs were also monitored.Review of the comprehensive care plan dated August 5, 2024, related to activities of daily living, self-care performance deficit related to deconditioning, and resident at risk for falls related to deconditioning and gait/balance problems revealed the care plan was not updated after Resident #191 fall incident on August 13, 2024.On August 16, 2024, a nurses' progress note revealed per documentation, the incident was unwitnessed fall; resident was seen on the floor, on prone position; forehead laceration bleeding and was controlled; left knee skin tear; resident cannot verbalize what had happened prior to fall; she appears to be confused; resident was assessed; neuro check initiated; resident was able to verbalized pain over the affected area; 911 was called; resident was transferred out to the hospital; and management, provider, and emergency contact were notified.An interview was conducted on January 28, 2026 at 8:32 AM with a certified nursing assistant (CNA/Staff #148). Staff #148 stated that fall risk was discussed with the new admission. Staff #148 stated that for a fall risk resident, the mattress is placed at the side of the bed; she is instructed to lower the bed; and when the resident arrived from the hospital, the resident have a fall risk tag. Staff #148 stated that it was important to monitor the resident closely because the impact of residents not being monitored is that they can have a fracture, or be afraid to do things after a fall, lose confidence, and get hurt.An interview was conducted with a licensed practical nurse (LPN/Staff #85) on January 28, 2026 at 9:05 AM. Regarding fall, Staff #85 stated that staff can move resident closer to the nurses' station, have call light, increase safety checks; maybe have a fall mattress. Staff #85 stated that fall has a lot of risk such as broken bones, injuries and hospitalization.An interview was conducted on January 28, 2026, at 2:29 PM with the director of nursing (DON/Staff #25). The DON stated that staff perform fall assessment to monitor and anticipate the resident's needs; get to know the resident's routine and be one step ahead so staff can partner and the resident can be more compliant; and do not wait for the resident to ask. The DON stated that fall assessment and anticipating the needs and routine of the resident was important to prevent falls; altercations; prevent complaints and issues, illness, injuries, pain; the resident will be happier; and prevention is easier. The DON stated that the impact of a resident not being assessed for fall risk and their needs unmet could lead to falls, fractures, pain, or a decline in function.An interview was conducted on January 28, 2026, at 3:31 PM with a Registered Nurse (RN/Staff #66). Staff #66 stated that if a new resident was admitted , he will do an initial assessment which includes a skin assessment, a fall assessment, especially with a history of falls, ground level fall, wandering, dementia, old age, and new residents tend to be uneasy with a new place. He said that he will inform the certified nursing assistant (CNA) about the resident's risk of falls. He said that for resident identified as having a high risk for falls, the intervention includes lowering the bed, call light within reach, ask the provider to order floor mattress, place a yellow star for fall risk signage. He stated that for an unwitnessed fall, he will assess the resident, check their vital signs, notify the provider, director of nursing, start neuro check assessment. He said that neuro assessment was needed to compare resident's baseline and current situation and be aware of any changes or any injury. Regarding Resident #191, Staff #66 stated that he does not remember caring for the resident. Staff #66 stated that the unit manager (continued on next page)

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	01/28/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	initiates the baseline care plan; and he did not find a baseline care plan for resident #191 in the electronic medical record.A follow-up interview was conducted on January 28, 2026, at 5:11 PM with the director of nursing (DON/Staff #25). The DON stated that a fall assessment includes identifying diagnoses, history of falls, use of medications, any behaviors that can cause a fall, the resident's mobility, and orientation. The DON stated that if the resident was assessed as having a high risk for falls, she said to monitor, observe, check the resident, and report the high risk for falls to the staff. In addition, the DON stated other interventions such as, if a room was available to place the resident near the nurses' station, lower the bed, make sure the mattress does not slide out, have grab bars, call light within reach, anticipate the resident's needs, answer the call light promptly, and offer food and toileting before the resident goes to bed. Regarding Resident #191, who had 3 fall incidents, the DON stated that the resident has a fall care plan that did not have the resident at high risk for falls as indicated in the resident's fall assessment; she said that after the resident's fall incidents, the care plan was not updated. The DON stated that a resident's care plan is an interdisciplinary team approach because a care plan needs feedback from different disciplines, such as from dietary, rehab, or social services.A review of facility policy titled Fall Prevention adopted on May 1, 2024, revealed that it is the policy of this facility that the Fall Prevention Program is designed to ensure a safe environment for all residents. Each resident will be evaluated upon admission, quarterly, and as needed by an RN/LPN to assess his/her individual level of risk. The Interdisciplinary Team will review the Fall Risk Assessment completed by the nursing department, and if appropriate, a fall prevention protocol will be initiated. The purpose of the policy was to identify residents at risk in a timely manner; to gather accurate, objective, and consistent data for the purpose of implementing an individualized Plan of Care designated to meet the resident's needs; to ensure consistency in the implementation of preventive measures to assist with the reduction of falls; and to evaluate outcomes. The policy procedure include a licensed nurse will complete a Fall Risk Assessment within 24 hours of admit to determine the resident's risk factors associated with the potential for falls; the Interdisciplinary Team will be responsible for reviewing the Fall Risk Assessments, if assessed to be a high risk and/or is appropriate they will initiate fall prevention interventions; and the Director of Nursing/designee will be responsible for ensuring that residents who have been identified at risk or who have experienced a recent fall have all recommended interventions in place as well as current assessments and documentation reflecting notification of applicable disciplines, resident's physician and resident's family/responsible party.

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	01/28/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews, facility documentation, policy and procedures, the facility failed to identify elopement risks, and plan for effective supervision for resident one of three sampled residents (#888) related to risk factors for cognitively intact residents, and to ensure that one resident (#511) was supervised during activity sessions, and that activities were conducted safely. The deficient practice could result in avoidable accidents.Findings Include: -Regarding Resident #511 Resident #511 was readmitted to the facility on [DATE], with diagnoses that included type 2 diabetes mellitus, factitious disorder imposed on self, borderline personality disorder, major depressive disorder, anxiety disorder, and Huntington's disease (is an inherited disorder, and develop uncontrollable dance-like movements (chorea) and abnormal body postures, as well as problems with behavior, emotion, thinking, and personality). The Resident's Clinical Resident Profile revealed that she was her own responsible party/representative. A review of the annual Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15.0, indicating that the Resident was cognitively intact. The assessment also revealed that behavioral symptoms were not exhibited. The quarterly MDS assessment dated [DATE], revealed a BIMS score of 15.0, indicating that the Resident was cognitively intact. The assessment also revealed that physical and verbal behavioral symptoms occurred, and the Resident exhibited rejection of care and wandering behaviors. A review of care plan revised on January 15, 2025, revealed that the Resident demonstrates significant problems with leisure skill and time planning related to Borderline personality disorder manifested by cognitive and neurological impairment; and at risk for harm to self or others as evidence by pulling out her hair and throwing it to the ground, throwing food, tray covers, empty drink bottles at staff and will hit her hand on the arm of her chair. The goal was that the Resident would not harm themselves or others. The interventions included assisting the Resident to activity of choice; if her behaviors become disruptive in group activities, the Resident will be escorted back to her hall until she calms down, she may return to the group function to participate; care in pairs; have supervisory personnel observe care delivery, as possible, and in accordance with privacy and dignity considerations. An activity observation was conducted on January 26, 2026, at 1:59 PM, held in the first-floor dining room. Resident #511 was observed sitting in her wheelchair on one end of the table, slightly away from the tables where other residents were seated. Resident #511 was interacting with a staff member who was holding a cellphone displaying images of products from the cellphone to Resident #511. About 3 other residents were also seated on the other side of the table, opposite/facing Resident #511. Some residents who were seated in front of the tables were singing along with the music. Several other residents who were seated in front of a table were holding a green colored play gun with foam darts aiming at a couple of balloons placed in front of the tables and the residents. The residents were engaged with the activity being provided. Resident #511 was playing with the toy gun with foam (continued on next page)

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	01/28/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	darts while seated at one side of the table and pointing at the balloons. At one point during the activity, a foam dart landed on Resident #511. Resident #511 picked the foam dart and inserted into the play gun she was holding. At 2:33 PM, the only activity aide (Staff #192) during the activity wheeled a resident out of the dining/activity room. There were no other staff in the dining/activity room. At 2:34 PM, the activity aide (Staff #192) returned to the dining/activity room. An interview was conducted on January 26, 2026, at 2:56 PM with an activity aide (Staff #192). Staff #192 stated that his responsibilities included escorting and entertaining residents by providing activities to occupy their time, distributing mails and packages, and he handling residents' smoke breaks. He stated that the activity today was an exercise for eyesight, target practice, coordination, and karaoke/music therapy. Regarding the target practice coordination activity using a toy gun and foam darts, he stated that the potential for hitting someone would not cause an injury. He said that he had used this activity in the past, and the residents were good at not targeting each other because they were being supervised. He added that verbal arguments happened in the past, like whose turn it is, and they were de-escalated immediately. He also said that the residents who attended the activity were from the long-term care unit and the behavioral health unit. Regarding Resident #511, he said that Resident #511 was seated on one side; Resident #511 likes to sit with her own table, and there was no way to lower Resident #511's wheelchair so she could sit in front of the table alongside the larger group. He stated that Resident #511 seating location was accommodated based on the resident's choice. He also said that Resident #511 was from the behavioral unit, and Resident #511 would be confrontational. Further, he stated that the residents from the behavioral unit are 100 percent supervised during activities. He stated that today, his coworkers were busy, so he stepped out and escorted out one resident. The activity director (Staff #15) was interviewed on January 28, 2026, at 9:12 AM. The activity director stated that during activity sessions, they can have residents from the behavioral unit, memory care unit, and the open unit. She said that she has activity games with prizes; this week the activity involved using a play gun and foam darts; and the game was about target practice by hitting the balloons. She said that the balloons were placed opposite of the tables; the residents should be 2 to 3 feet apart from facing the balloons, and the residents should be lined up across/in front of the balloons so no one could get hurt by preventing a resident from getting hit with the dart. She also said that if a resident was seated on one side and another resident was seated on the other side, the resident could be hit with the dart, and can trigger a behavior. She said that the activity aide should have moved the residents to where they should have been placed in one line in front of the balloons. Further, she stated that the residents who attended the Monday activity were all from the behavioral long-term unit; one staff per activity; the staff has to be there all the time as long as there are residents in the activity room; the staff can't leave the room; if the staff needed assistant, the staff should have called her or a certified nursing assistant (CNA). The activity director stated that if there was no staff with the residents during an activity session, the residents could have behaviors, the residents could wonder in the kitchen, or go out to the hall, and it was not safe for the residents. The activity director stated that the staff were supposed to call using their facility system connect or use their own personal phone or message her if needing to bring a resident back. -Regarding Resident #888: Review of Resident #888's hospital records prior to admission revealed that he was admitted to the hospital on [DATE], with diagnoses that included abscess of the left thumb, left arm cellulitis, drug use, amphetamine use, moderate fentanyl dependence, and suicidal ideation. Discharge medications (continued on next page)

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	01/28/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	included daptomycin 400 mg in 0.9% normal saline, 20 mL IV. The records documented that the resident reported feeling improved and inquired about obtaining medical marijuana upon hospital discharge. Resident #888 was admitted to the facility on [DATE], with diagnoses that included cellulitis of the left upper limb, cellulitis of the left finger, bronchitis, iron deficiency anemia secondary to blood loss, stimulant abuse, in remission, opioid dependence, suicidal ideations, unspecified lack of coordination, and need for assistance with personal care. Review of the Brief Interview for Mental Status (BIMS) assessment dated [DATE], revealed that Resident #888 had a BIMS score of 14, indicating that the resident was cognitively intact. Review of a psychosocial evaluation dated January 9, 2026, revealed that Resident #888 reported diagnoses of bipolar disorder and schizophrenia. The evaluation further revealed that the resident had served approximately 20 years in prison and was currently on parole. Review of a smoking evaluation for resident #888 dated January 9, 2026, revealed that Resident #888 was a smoker and preferred to smoke in the mornings and afternoons. Further, the evaluation revealed that Resident #888 had no limitations regarding his ability to smoke independently and could light his own cigarettes. Resident #888 was considered a safe smoker and could access smoking materials consistent with the facility's policy with frequent monitoring. Review of a wandering/elopement risk assessment dated [DATE], revealed that Resident #888 had a score of 5.0, indicating low risk for wandering or elopement. The assessment evaluated mobility, mental status, speech, and history of wandering; however, it did not address psychosocial, behavioral health, or substance-use-related risk factors. A nursing progress note dated January 9, 2026, revealed that at 6:45 p.m., Resident #888 requested to shower. His right arm peripherally inserted central catheter (PICC) line and left arm wound dressing were covered, and he showered independently. At 7:10 p.m., staff informed the resident that the PICC line and wound dressing required changing. The resident requested that the dressing change occur after the 7:30 p.m. smoking break. At approximately 7:40 p.m., the on-duty receptionist (Staff #35) reported observing Resident #888 get into a black car and leave the facility following the smoking break. The provider was notified, and 911 was called. On January 10, 2026, an Against Medical Discharge (AMA) release form was entered into the clinical record for resident #888. The document revealed that on January 9, 2026, at 7:40 p.m. during smoking break, Resident #888 got in a black car and left the facility. The physician and administrator were notified, and 911 was called. Attempts to contact Resident #888 by telephone were made on January 26, 2026, at 8:40 a.m. and 12:21 p.m., and January 27, 2026, at 11:56 a.m. No answer was received, and staff were unable to leave voicemail messages. Attempts to contact Staff #35 by phone were made on January 27, 2026, at 12:41 p.m., 3:45 p.m., and 4:51 p.m. Voicemail messages were left each time, and no return calls were received. On January 27, 2026, at 12:29 p.m., an interview was conducted with a receptionist (Staff #9). Staff #9 stated that staff receive training on how to respond to elopement events and how to communicate with staff and law enforcement. Staff #9 further stated that residents are monitored during smoking (continued on next page)

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	01/28/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	breaks and that posted smoking times were 6:30 a.m., 9:30 a.m., 12:30 p.m., 4:00 p.m., 7:30 p.m., and 10:00 p.m. daily. On January 27, 2026, at 12:57 p.m., an interview was conducted with the case manager (staff #6). Staff #6 stated that newly admitted residents are assessed for cognition, psychosocial needs, and wandering/elopement. Staff #6 stated that the wander assessment focuses on cognition and assesses residents for both wandering and elopement. The hospital records reveal diagnoses and conditions that could indicate higher risks for elopement than the wandering/elopement screening at the facility. Upon review of the hospital discharge documentation for resident #888, Staff #6 stated that suicidal ideation, homelessness, and drug use could indicate a higher risk of elopement, and a resident with these concerns should be referred to behavioral health. On January 27, 2026, at 1:59 p.m., an interview was conducted with the Director of Nursing (DON, Staff #25). Staff #25 stated that hospital records are reviewed upon admission and that narcotic use, homelessness, and suicidal ideation are risk factors for elopement. After reviewing the wandering/elopement assessment for Resident #888, Staff #25 stated that the assessment did not adequately evaluate the resident's risks and did not capture his needs and concerns. Staff #25 further stated that the wandering/elopement assessment for Resident #888 did not provide sufficient information to accurately evaluate his elopement risk. Staff #25 stated that potential risks for the resident included self-harm, suicide, illegal drug use, and infection related to the PICC line and open wound, and that newly admitted residents should be closely monitored. Staff #25 stated that Resident #888's life was at risk. Staff #25 stated that leaving against medical advice (AMA) differs from elopement, as AMA requires that the resident be informed of the risks and sign documentation prior to leaving. Staff #25 stated that Resident #888's departure should have been considered an elopement, not an AMA discharge. On January 27, 2026, at 4:54 p.m., an interview was conducted with the on-duty receptionist (Staff #45). Staff #45 stated that staff rotate responsibility for monitoring residents in the smoking area and that the receptionist is responsible for monitoring residents during the 6:30 a.m. and 7:30 p.m. daily smoking times. On January 27, 2026, at 5:03 p.m., a telephone interview was conducted with the resident's only listed emergency contact. The family member stated that she lived out of state and was unable to be present to monitor the resident's care or behaviors. She stated she was informed that Resident #888 eloped from the facility on January 9, 2026, but was not informed of why he left or who transported him. The family member stated that the resident's whereabouts were unknown until he was located by police and was currently incarcerated. On January 28, 2026, at 6:55 a.m., observation revealed three residents smoking outside the facility without staff supervision. The receptionist on duty was observed seated inside the building at the reception desk. Review of the facility policy titled Policy/Procedure – Nursing Administration, Subject: Elopement, adopted May 1, 2024, revealed that the facility policy required all residents to receive adequate supervision to ensure the safest environment possible and required that residents be assessed for behaviors or conditions that place them at risk for wandering or elopement. (continued on next page)

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	01/28/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy titled Activity/Recreation Therapy Program revised in August 2023, revealed that activities/recreation therapy programs are provided in coordination with the resident's comprehensive assessment.