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	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandstone of Tucson Rehab Centre	2900 East Milber Street Tucson, AZ 85714

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 review of the clinical record, interviews, and review of the facility's policies and procedures, the facility failed to protect the rights of one resident (#6) to be free from abuse from another resident (#9). The deficient practice could lead to sustaining injuries.Findings include:Related to Resident #6-Resident #6 was admitted to the facility on [DATE] with diagnoses that includes fusion of the spine, lower back pain, and Major Depressive Disorder.Review of the quarterly Minimum Data Set (MDS), dated [DATE], revealed Resident #6 completed a Brief Interview for Mental Status (BIMS) and scored a 15 which indicated he was cognitively intact.Review of the Progress Notes in the clinical record, revealed a Nurses Note created by Registered Nurse (RN/Staff #65), dated February 2, 2026 at 7:01 P.M. The note indicated that around 6:35 P.M., Resident #6 reported that he was physically attacked by his roommate. The same note further revealed that there were visible injuries which included a skin tear on his left forearm and redness on the right side of his neck.A second Nurses Note, dated February 2, 2026 at 11:41 P.M., indicated that Resident #6 reported that his roommate (Resident #9) had the volume on his television too loud and they had a verbal disagreement and the roommate (Resident #9) then grabbed Resident #6 around the neck and shoulder area. The note also revealed that Resident #6 denied hitting Resident #9, however, Resident #9 was observed to have a minimal area raised on the left cheekbone below the eye with no discoloration or pain. The note further detailed that both residents were separated and skin checks were completed. The other resident (Resident #9) was then moved to another hall.A skin assessment, dated February 2, 2026 at 11:14 P.M. indicated that Resident #6 had a left forearm skin tear due to physical contact/aggression with (another) resident. It was also noted that wound care was done by the nurse on duty (Staff #65).Related to Resident #9-Resident #9 was admitted to the facility on [DATE] with diagnoses that includes cellulitis of the Right and Left lower limb, Cerebral Palsy, and Scoliosis.Review of the admission MDS, dated [DATE], revealed Resident #9 completed a BIMS and scored a 15 which indicated he was cognitively intact.A review of the Progress Notes in the clinical record, revealed a Nurses Note, dated February 2, 2026 at 8:10 P.M., indicated that Staff contacted a crisis center and they sent someone to the facility to evaluate Resident #9.Another Nurses Note, dated February 2, 2026 at 9:15 P.M. Resident #9 was transferred to the crisis center by crisis staff and that he was alert and oriented X4. A Nurses Note, dated February 2, 2026 at 11:12 P.M. indicated that Resident #9 reported that his roommate (Resident #6) did not believe that he had the television volume lowered which resulted in the two Residents having a verbal disagreement. The note further indicated that Resident #9 alleged that Resident #6 hit him on the left side of the face and Resident #9 then reacted to the hit by grabbing Resident #6 by the neck and shoulder area. The same note also indicated that Resident #9 had minimal area raised on left cheekbone below the eye with no discoloration or pain. Both residents were separated and had skin checks completed. Resident #9 was reassigned to another hall and received orders for a (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	crisis center evaluation.The Care Plan identified a focus on Resident #9's behavioral disturbances which were identified as physically aggressive, impulsive, verbal aggression related to poor impulse control, and a mood disorder. Interventions included 15-minute checks, reduce noise, dim the lights, and giving the resident as many choices as possible.An interview was conducted with Resident #6 on February 10, 2026 at 1:10 P.M. Resident #6 shared that his former roommate had started strangling him after he had asked him to turn down the volume on the television. Surveyor observed a quarter sized scab on Resident #6's left arm. Resident #6 indicated the scab was from a cut he sustained when he was being attacked by Resident #9 and that he also had redness on his neck. Resident #6 shared that he had gone outside to report the incident to the nurse in the hall. He also shared that he was not happy when Resident #9 called him a liar when he told the nurse that he did not hit Resident #9.An interview was conducted with Certified Nursing Assistant (CNA/Staff #6) on February 11, 2026 at 12:33 P.M. Staff #6 confirmed that she was working the unit when the altercation between Resident #6 and #9 took place. However, she shared that she did not witness the incident, only had a conversation with Resident #6 after it happened. She shared that she heard Resident #6 tell a nurse that his roommate had choked him. Staff #6 indicated that she then spoke with Resident #6 and he had told her that his roommate had choked him because he had asked him roommate to turn down the volume on the television. She further indicated that she did not see any marks on Resident #6's neck but did see some scratches on the left arm.A telephonic interview was attempted with Staff #65 twice during the survey. However, a phone call was not returned to Surveyor by the conclusion of the survey.An interview was conducted on February 11, 2026 with the Director of Nursing (DON/Staff #22) at 12:47 P.M. When asked to explain the resident to resident altercation between Resident #6 and #9, Staff #22 indicated that, according to the report, the residents were in their room and were having issues with the television being loud. They had gotten into an argument and she was not sure who grabbed who on the neck. Staff #22 then check the clinical chart and shared that Resident #9 had gotten close to Resident #6 and grabbed Resident #6 around the neck. She indicated that she believes there was redness in the neck area. She also shared that both residents were separated and Resident #9 was moved to another hall to prevent another incident. When asked if this situation would be considered abuse, she initially indicated that for her, it was not abuse but it was a behavior because residents were mad. She further explained that the residents were emotional; the altercation was a spur of the moment thing when you're trying to stop the person from coming closer to you. Staff #22 indicated that abuse was a big word and is an intentional act- she was not there so she did not know if the situation was intentional. Staff #22 acknowledged that both residents were alert and oriented. She then acknowledged that the situation could probably be abuse.An interview was conducted on February 11, 2026 at 2:56 P.M. with the Administrator/Staff #29. Staff #29 explained that Resident #6 had told Resident #9 to turn down the television and then they had an argument. Resident #9 reported that Resident #6 punched him and then Resident #9 went after Resident #6's neck with both hands. She shared that Resident #6 had red marks on his neck and a skin tear on his arm. She further shared that Resident #9 had a red mark on his left cheek. Staff #29 also added that it was a very aggressive altercation because Resident #9 went under the curtain, in the room, and he was very angry and admitted that he was angry. Staff #29 further added that Resident #6 has been at the facility for a long time and he has never had an altercation with other residents before. Staff #29 shared that she would categorize this incident as abuse as it was an abusive situation towards Resident #6.Review of the facility's 5-day report indicated that based on the facility's investigation of the incident, they had verified the allegation of resident to resident abuse. The 5-day report included a signed statement from Staff #65. The (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	statement indicated that Staff #65 was exiting another resident's room around 6:35 P.M. when she was approached by Resident #6. The statement further indicated that Resident #6 reported that he was physically attacked by his roommate (Resident #9). Resident #6 explained that he was strangled around the neck and grabbed on the arm which resulted in a skin tear to the left forearm. The statement also shared that Resident #6 was moved closer to the medication cart for his safety and that he had called 911 himself. His injuries were treated and a skin assessment was completed. It further shared that redness was observed on the right side of his neck. The statement continued to indicate that Staff #65 then went into the room to check on Resident #9 and he stated that he was punched on the left side of the face by Resident #6. The statement also indicated that the incident occurred following a disagreement about the television volume.Review of the facility's policy, titled, Abuse and Neglect, indicated that it was adopted on May 1, 2024. The policy indicated that the facility will provide an environment that is free from any type of abuse. It defined abuse as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish. It also identified the 7 types of abuse with physical abuse being one of them.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to ensure a signed consent was obtained before starting a new psychotropic medication for one resident, #4. The deficient practice could lead to a resident's responsible party not being informed of the risk and benefits of a resident's medications. Findings include:Resident #4 was admitted to the facility on [DATE] with diagnoses that included Dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; Urinary Tract Infections (UTI); and repeated falls.Review of the admission Minimum Data Set (MDS), dated [DATE], revealed Resident #4 underwent a Brief Interview for Mental Status (BIMS) and scored a 02 which indicated the resident was cognitively impaired. The same MDS further revealed that Resident #4 exhibited behaviors such as physical, verbal, and other behavioral symptoms that are not directed towards others, however it did significantly interfere with her care and participation in activities. It also noted that Resident #4 also exhibited rejection of care and wandering.Review of the resident's orders revealed that Resident #4 had an order put in on February 3, 2026 for Hydroxyzine. The order indicated Resident #4 was to be administered 1 tablet by mouth, 50 milligrams (mg), every 6 hours as needed for Anxiety as evidenced by calling out.Resident #4's Medication Administration Record for February 2026 indicated that she received four doses of hydroxyzine between February 3, 2026 and February 7, 2026.Review of the Progress Notes in the clinical record revealed a Psych Evaluation note, dated February 3, 2026 at 10:45 A.M. The note indicated that Resident #4 was to start Hydroxyzine 50 mg by mouth every 6 hours as needed for anxiety.Review of a second progress note, dated February 7, 2026 at 12:20 P.M., revealed that the provider was contacted related to an increase in Resident #4's behaviors. A new order was received to increase Hydroxyzine from 50 mg to 75mg every 6 hours as needed.A third progress note, dated February 7, 2026 at 6:24 P.M. revealed that after the provider had a conversation with Resident #4's family member, her Hydroxyzine was put on hold by the provider pending a re-evaluation.Further review of the clinical record did not reveal a signed consent by the responsible party for the Hydroxyzine 50 mg.An interview was conducted on February 11, 2026 at 10:43 A.M. with Licensed Practical Nurse (LPN/Staff #10). Staff #10 explained that consents for psychotropic medications are received by the nurse working the floor when the resident is admitted . She further explained that the consent needs to be signed by the resident or responsible party prior to administering the medication. She added that if the family is not able to come in to sign the form, they can provide verbal consent as well. Staff #10 confirmed that she was familiar with Resident #4 and that she was receiving Hydroxyzine. After looking in the clinical record, Staff #10 shared that she was unable to locate a signed consent for the Hydroxyzine. Staff #10 explained that the medication should not have been administered without consent however, she added that the family member knew the Hydroxyzine was being administered. Staff #10 added that she had asked the family member to sign the consent form because she had agreed to Resident #4 taking the medication during the care plan meeting but the family member had decided, at the last minute, to not sign the form. When asked if Staff #10 attended the care plan meeting, she acknowledged that she did not but the family member had told her that it was discussed at the meeting.An interview was conducted on February 11, 2026 at 11:46 A.M. with the Behavioral Health Unit Manager (LPN/Staff #37). Staff #37 explained that her nurses will do the admissions paperwork and this also includes obtaining consents for psychotropic medications. She indicated that she was familiar with Resident #4 and added that there should be signed consents for her psychotropic medications in the chart. However, she was not able to locate the signed consent for Hydroxyzine. Staff #37 stated that she would check with medical records to see if the form had been uploaded. After a (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	few minutes, Staff #37 shared that medical records confirmed that they did not have the form as well. Staff #37 explained that nurses are not to administer Hydroxyzine without a signed consent so she would need to look at the Medication Administration Record (MAR) to see if it was administered. After reviewing the MAR, Staff #37 shared that the Hydroxyzine was administered on February 4, 5, 6, and 7. She added that it looks like the Hydroxyzine was administered without the signed consent which was not protocol and it did not meet her expectations.An interview was conducted on February 11, 2026 at 1:37 P.M. with LPN/Staff #86. Staff #86 explained that Resident #4 came into the facility with Mirtazapine and when she had spoken with the family member, the family member reported that Resident #4 was on Seroquel when she was in the hospital and the family member did not want Resident #4 on Seroquel while she was at the facility. Staff #86 recalled telling the family member that Resident #4 was hitting staff and they were getting injured. This has led the psychiatrist wanting to do labs to rule out any underlying causes of the increase in behaviors. Staff #86 further recalled that the family member was okay with the lab work being done but she wanted to ensure that non-pharmacological interventions were being tried first. Staff #86 acknowledged that the facility would need a signed consent before administering Hydroxyzine, which Staff #86 explained was for Anxiety. She was not able to locate a signed consent and stated that it might not have gotten signed. Staff #86 also confirmed that Resident #4 was administered Hydroxyzine four times. She added that nursing staff were not following protocol for administering psychotropics. She also added that Staff #37 was putting together an education on consents and that she was overseeing all provider orders to prevent this situation from happening again.An interview was conducted on February 11, 2026 at 2:04 P.M. with the Director of Nursing (DON/Staff #22). Staff #22 explained that the nurse getting an order, containing psychotropic medications, and putting it into the system is responsible for getting the consent. If a Nurse Practitioner puts the order in, a nurse still needs to verify the order and obtain the consent. She added that prior to administering psychotropic medications, nurses need to go into the system to look for the signed consent. Then they would be able to administer the medication. Staff #22 was not able to locate a signed consent form for Hydroxyzine and identified that the medication was administered to Resident #4, four times. She added that staff should not have administered the medication before the consent was signed. She added that it looked like the nurses did not check the system for the signed consent and assumed that it was done. Staff #22 shared that it was important to have signed consent for residents who are taking psychotropic medications so the family/resident are aware of the medications the resident is taking as well of the side effects of those medications.Review of the facility's policy and procedure, titled Psychoactive Drug Use, dated May 1, 2024, indicated the purpose of the policy was to ensure communication of risks and benefits concerning the need of chemical restraints to residents and responsible parties. The policy and procedure's section 8 stated that all residents and/or responsible parties will be asked to make an informed choice concerning the use of a psychoactive drug. In order for an informed choice to be made, potential negative outcomes (risks) and benefits of the drug use will be explained.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to ensure an allegation of abuse for one resident (#4) was reported to the State Agency (SA) within the timeframe established by regulations. The deficient practice could lead to continued abuse of residents.Findings include:Resident #4 was admitted to the facility on [DATE] with diagnoses that included Dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; Urinary Tract Infections (UTI); and repeated falls.Review of the admission Minimum Data Set (MDS), dated [DATE], revealed Resident #4 underwent a Brief Interview for Mental Status (BIMS) and scored a 02 which indicated the resident was cognitively impaired. The same MDS further revealed that Resident #4 exhibited behaviors such as physical, verbal, and other behavioral symptoms that are not directed towards others, however it did significantly interfere with her care and participation in activities.Review of the care plan indicated that Resident #4 had the potential for behaviors which required staff to allow the resident time to respond to directions or requests due to her dementia.A facility self-report complaint was received by the SA on February 9, 2026 at 4:31 P.M. The self-report indicated that the alleged abuse had taken place on the evening of February 8, 2026 and was not reported sooner, to the administrator, because the staff member had stated that she was in shock. The staff member reported the alleged abuse to the administrator on February 9, 2026.A telephonic interview was conducted with Licensed Practical Nurse (LPN/Staff #34) on February 11, 2026 at 9:13 A.M. She explained that she often gets training on abuse and knows that she is to report it to the Administrator. She said, except when you have a lot going on, the reporting might be delayed but she knows that she is to report it soon. She indicated that she did not report the alleged abuse to the administrator when it happened on February 8, 2026 because she was in shock when she saw it and there was a lot going on. Staff #34 recalled that the alleged abuse took place on Sunday night which was February 8, 2025 between 11:30 P.M. and midnight. She was working the 6:00 P.M. to 6:30 A.M. shift. She had gone home without reporting it because she was in shock and after thinking about the situation, she decided to go to the facility and report it the next day. Staff #34 explained that when the situation happened, she was unaware that allegations of alleged abuse needed to be reported to the administrator right away and that she was sorry for not reporting it sooner. Staff #34 explained that the risk of not making a report sooner, was that the residents could continue to get hurt.An interview was conducted on February 11, 2026 at 10:43 A.M. with LPN/Staff #10. She shared that they get training on abuse weekly or every two weeks. Once the training is done, they have to complete a test. Staff #10 explained that allegations of abuse is to be reported to her supervisor and the Administrator immediately. If it was not reported immediately, there would be a risk of harm to the resident. She added that they could be penalized or fired for not reporting right away because it was their job to report suspected abuse.An interview was conducted with the Administrator/Staff #29 was conducted on February 11, 2026 at 1:22 P.M. Staff #29 explained that Staff #34 was reported the suspected abuse to her around 2:00 P.M. on February 9, 2026. She further explained that the staff member had gone home after her shift and then came back to the facility and reported the suspected abuse. Staff #29 shared that Staff #34 thought she had 24 hours to report the suspected abuse and that Staff #29 told her that she had 2 hours to report, not 24 hours.An interview was conducted with the Director of Nursing (DON/Staff #22) on February 11, 2026 at 2:04 P.M. She explained that suspected abuse is to be reported to the administrator, who is the abuse coordinator, within 2 hours. She further explained that the risk to the residents, for not reporting abuse in a timely manner, could be emotional distress, they could become depressed, and the resident's safety would be compromised. Staff #22 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	added that you have to protect the person that is being abused, not the abuser. It has to be handled right away. When asked if the delay in reporting suspected abuse of Resident #4 met her expectations, she indicated that it did not.Review of the facility's policy and procedure titled Abuse and Neglect, indicated that it was adopted on May 1, 2024. The procedure indicates that if abuse/neglect is suspected, the facility will notify the appropriate/designated organization/authority (State Agencies) that an investigation is being initiated immediately following intervention for the resident's safety. It also indicates that all allegations and/or suspicions of abuse must be reported to the Administrator immediately. If the Administrator is not present, the report must be made to the Administrator's Designee.