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	04/03/2026

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 - 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, facility documentation, and staff interviews, the facility failed to protect the rights of two of four sampled residents (Residents #16, #45) to be free from abuse by another resident (#26 and #121). The universe was 117. The deficient practice could lead to additional resident-to-resident altercations, creating an unsafe environment.Findings Include: -Regarding Resident #45 and Resident #121 A facility-reported incident form dated March 31, 2026, revealed that Resident #121 stated that she overheard Resident #45 speaking to someone on the phone and was speaking negatively of the facility, and called Resident #121 a bad name. The report included that Resident #121 proceeded to get out of her bed and went over to Resident #45, and said 'What did you say about me?' Resident #121 said Resident #45 made a slapping motion towards her, Resident #121 blocked the motion, and then Resident #121 grabbed Resident #45's wrist and struck Resident #45 with a closed fist on the cranial/facial area. The Report revealed a statement from Resident #45 who reported that she was on the phone 'complaining,' but she did not recall calling Resident #121 a 'bad name'. The Incident Report continued, revealing that Resident #45 acknowledged that Resident #121 made physical contact but was unable to recall additional details or to identify what precipitated the event, even with prompting. The report included that the allegation was verified by evidence collected during the investigation. -Resident #45 Resident #45 (alleged victim) was initially admitted on [DATE], and re-admitted on [DATE], with the diagnosis that included major depressive disorder, vascular dementia, psychotic disturbance, mood disturbance, anxiety, and unspecified symptoms and signs involving cognitive functions and awareness. A care plan focus related the following: Initiated on August 12, 2024: May present in a problematic manner, in which the resident's actions were characterized by ineffective coping skills; in relation to anxiety and agitation, as evidenced by pulling out her hair. The care plan revealed interventions that included not invading the personal space of Resident #45. Initiated on February 26, 2026: Resident utilizes antidepressant medication related to depression, as evidenced by self-isolation, with interventions to provide calm reassurance and empathy. A quarterly MDS (minimum data set) assessment dated [DATE], revealed that a BIMS (brief interview (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	of mental status) score of 05, which indicated severe cognitive impairment at the time of the assessment. An March 10, 2026, provider order was written for one 125 mg sertraline HCl tablet one time a day for depression, as evidenced by isolation and poverty of speech. A nursing progress note dated March 26, 2026, revealed that at approximately 6:50 PM, staff heard a resident yelling out and, upon entering the room, the nurse found Resident #45 lying on the floor next to her bed with blood on her face. Another resident was found standing near her bed. The other resident was redirected out of the room and placed on 1:1 monitoring. The nurse assessed Resident #45 and found 2 hematomas on the back of the head, a small laceration approx. 0.5 cm by 0.2 cm by 0.1 cm to the right of the face, in between the upper lip and lower nose, and the nose bleeding. The note revealed that Resident #45 reported nothing occurring before the incident, and the other resident (#121) walked up to Resident #45 while she was sitting on her bed and pulled her hair, causing Resident #45 to slide to the floor, and that Resident #121 hit Resident #45 in the face several times. The note further revealed that Resident #45 was assisted to sit on the edge of her bed, her face was cleaned, and emotional support was provided. The note relayed that orders were received for laboratory testing, urinalysis, psychiatric evaluation, and that Resident #45 was sent to the emergency department for imaging. A skin assessment dated [DATE], revealed that the resident had been assessed with a bump on the left side and on the right side of her head with a cut approximately 1 cm in length on the right side of resident's upper lip. The assessment also revealed that the resident stated that there had been an altercation with another resident. An order dated March 26, 2026, was received to send the resident to the hospital for further evaluation. An order dated March 26, 2026, from the provider for change of condition monitoring for three days following an altercation. A neurological evaluation flow sheet dated March 26, 2027 through March 27, 2026, revealed that the resident had been evaluated every fifteen minutes for the first two hours after the initial evaluation, then every thirty minutes after the first two hours. The evaluation flow sheet also revealed that Resident #45 had been sent out to the emergency department after the first four hours, and evaluations resumed after the first eight hours of the initial evaluation. An emergency room report dated March 27, 2026, revealed Resident #45 had been brought in by ambulance after being assaulted by another resident. The report also revealed that no signs of a serious problem were evident, which would require an extended hospital stay. The report also revealed the presence of a small 5 mm shallow abrasion of the upper lip, not involving the [NAME] border, and otherwise atraumatic. The report also revealed mild tenderness of the left knee without any overlying skin changes or palpable effusion. A CT (Computed Tomography) scan report of the head and brain without contrast for assault, dated March 27, 2026, revealed no acute intracranial abnormality and noted to be within the limits of motion degradation. A CT scan report of the cervical spine without contrast for assault, dated March 27, 2026, revealed no (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	acute fracture or traumatic malalignment of the cervical spine. An X-ray (x-radiation) report of the chest for assault, dated March 27, 2026, revealed no displaced rib fracture identified. An X-ray report of the left knee for assault, dated March 27, 2026, revealed mild soft tissue edema about the knee, and no acute fracture or dislocation of the left knee. -Resident #121: Resident #121 was admitted to the facility on [DATE], with the diagnosis that included hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side; unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; major depressive disorder, recurrent, unspecified. An order dated November 28, 2025, revealed Resident #121 required behavior tracking related to intrusive behaviors crossing other residents' boundaries and wandering. A quarterly MDS assessment dated [DATE], revealed a BIMS score of 07, which indicated severe cognitive impairment at the time of the assessment. The assessment revealed no evidence of behavioral symptoms present at the time of the assessment. A progress note dated March 26, 2026, revealed that at approximately 6:50 PM, staff heard a resident yelling out and, upon entering the room, the nurse found another resident lying on the floor next to her bed with blood on her face. Resident #121 was standing near her bed. Resident #121 was redirected out of the room and immediately placed on 1:1 monitoring. The progress note relayed that Resident #121 stated that her roommate (Resident #45) accused her of cheating with her roommate's husband, then proceeded to hit her roommate (Resident #45) in the face several times. The note reported that an assigned sitter escorted Resident #121 to a new room assignment, and orders were received for laboratory testing, urinalysis, and psychiatric evaluation. Provider orders for Change of condition monitoring for three days following an altercation and a room move were ordered on March 26, 2026. A skin assessment dated [DATE], revealed that Resident #121 had been assessed with no new skin issues. A behavior note dated March 26, 2026, revealed that Resident #121 reported hitting Resident #45. A care plan focus with the initiation date of March 31, 2026, revealed the following focus areas: Behavioral disturbances, which included but are not limited to intrusive behaviors, poor boundaries, pacing, delusional thoughts, physical aggression related to dementia, major depressive disorder, and poor impulse control. The care plan focus also revealed that Resident #121 had an altercation with a peer on March 26, 2026. On March 31, 2026, at 11:00 AM, an interview was conducted with Resident #45. Resident #45 stated that her previous roommate had pulled her and had hit her face. Resident #45 also stated that she ended up on the ground and bled on her face. Resident #45 also stated that she had gone to the (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	hospital after the incident and came back the next day. Resident #45 stated she had some facial pain, but has medications for any pain she may be experiencing. Resident #45 stated feeling safe at the time of the interview and glad she had not interacted with the resident since the altercation. On April 2, 2026, at 9:33 AM, an interview was attempted with Resident #121; however, Resident #121 is Spanish-speaking only, and there had not been any Staff on the hall at the time of the interview to assist with interpretive assistance. However, when asked about a previous roommate, the name of Resident #45 prompted Resident #121 was observed to scrunch of her nose and shaking her head no, while swatting at the air in front of her. No additional interview attempts were made with Resident #121. On April 2, 2026, at 9:36 AM, an interview was conducted with a CNA (Staff #91), who stated that she was made aware of the resident-to-resident altercation between Resident #45 and #121, and that Resident #45 stated something had provoked Resident #121 before the physical contact. The CNA stated that she had been privy to both Residents #45 and #121, and stated that the day before, March 25, 2026, Resident #45 expressed paranoid thoughts regarding staff and residents attempting to poison her, and that paranoid behaviors were Resident #45's baseline. Staff #91 also stated that there had not been any skin conditions observed on Resident #45, and that the skin conditions observed on Resident #45 on March 26, 2026, had to have been a direct result of the resident-to-resident altercation. On April 2, 2026, at 9:40 AM, an interview was conducted with another CNA (Staff #150), who stated that a nurse overheard yelling coming from the shared room of Residents # 45 and #121, Resident #121 was observed in the middle of the hallway in front of her room with blood on her right fist. The CNA stated that she was asked to speak to the residents and translate what happened in the room and that Resident #121 reported that Resident #45 had been speaking to Resident #121 about the husband of Resident #45, so she proceeded to hit Resident #45. The CNA stated that she observed Resident #45 on the ground with a bloody face, and when asked, Resident #45 reported that Resident #121 hit her in the face and pulled her hair. The CNA relayed that she could not believe what she witnessed. The CNA further stated that Resident #45 had a bloody nose and lip, a couple of bumps on her head and that and that Resident #45 was crying. On April 2, 2026, at 10:21 AM, a telephone interview was attempted with the RN on shift (Staff #138); it was unsuccessful. On April 2, 2026, at 10:43 AM, an interview was conducted with the Nurse Consultant (Staff #13). The Nurse Consultant also stated that for resident-to-resident altercations, staff is expected to separate the residents to ensure their safety. Staff #13 also stated that once everyone is separated from the situation, then she would tell the nurse supervisor and the abuse coordinator, who is the administrator. Staff #13 further stated that it was reported to her that Resident #121 struck Resident #45 in the face with a closed fist and pulled her hair. Staff #13 further stated that Resident #45 lost her balance during the altercation and fell to the floor. The Nurse Consultant further stated that Resident #45 had been assessed with a small laceration above her lip, just under her nose, and had been observed with a bloody nose and two hematomas next to each other on the head of Resident #45, and was sent to the hospital for evaluation of the hematomas. Staff #13 stated that within her role, she provided emotional support to both Residents #45 and #121, assisted with the move of rooms for Resident #121, provided interview assistance to staff and residents, notified the family and power of attorneys as applicable, and ensured the risk management assessments for the residents were completed. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On April 2, 2026, at 11:44 AM, a joint interview with the Director of Nursing (DON/Staff #200) and the Administrator (Staff #166) was conducted. The Administrator stated that at approximately 6:50 PM, one of the nurses heard a resident yelling in the shared room, and upon entry, observed Resident #45 on the floor. A CNA was called in to assist with determining what happened, and obtained information that a physical altercation took place. The interpretation provided was that Resident #121 stated Resident #45 yelled at her and accused her of cheating with the husband of Resident #45, and Resident #121 stated she physically assaulted Resident #45, which caused Resident #45 to lose her balance and fall to the floor. The Administrator stated that Resident #121 was removed from the room and put with a 1:1 sitter, and Resident #45 was assessed, provided medical treatment, administered pain medication was assisted to her bed. The Administrator further stated that Resident #45 had a scrape under her nose, and per a physical assessment, she had two bumps on her head, which led to the decision to send her to the hospital for further medical attention. The Administrator further stated that the determination of the of abuse between Resident #45 and #121 was verified. -Regarding Resident #16 and Resident #26 Review of the facility's investigation report dated March 31, 2026, revealed that resident #16 was interviewed by the Social Service (SS/staff #127), and reported that resident #26 started hitting her for no reason and stated, she hit me twice on the arm, you can see the bruises. The resident further reported that the other resident started to cuss me out. Staff #127 asked for specific details and direct quotes, but the resident was not able to provide them. The resident was also not able to recall events verbatim and required redirection to remain focused on the interview. The investigation also included a Social Service's (SS/staff #127) interview with the alleged perpetrator (Resident #26), who stated that she was in the hallway when the other resident approached her and began being rude. Social Services reported that Resident #26 was not able to provide direct quotes, but stated that Resident #16 told her to Shut the F--k up. The Social Services interview included that Resident #26 denied any physical contact or altercation with Resident #16, stating that there was no hitting and that the other resident, and that was all she could recall of the incident. Additional review of the facility's investigation revealed that Licensed Practical Nurse (LPN, Staff #35) witnessed the incident and stated that on March 31, 2026, at 12:10 PM, stating that Resident #16 approached Resident #26 and yelled, get out of the way which startled Resident #26, who reacted by saying Fuck loudly and extending her left leg up, making brief contact with Resident #16's right forearm. The LPN intervened at the same time as this was occurring, immediately separating residents and assisting resident #16 to the front of the hall. -Regarding Resident #26: Resident #26 (alleged perpetrator) was admitted to the facility on [DATE], with diagnoses that included schizoaffective disorder, major depressive disorder, dementia without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, and epileptic seizures. The care plan revealed the following areas of focus: Used psychotropic medications related to behavior management secondary to diagnosis of schizoaffective disorder as evidenced by verbal/physical aggression, revised January 22, 2025. Interventions included to monitor/record occurrence of target behavior symptoms and document per facility protocol, revised January 18, 2020. Psychosocial wellbeing, revised on March 27, 2025, indicated that the resident had the potential to be (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	physically aggressive related to a history of physical harm to others. Interventions initiated on November 27, 2019, included to monitor/document/report PRN any signs symptoms of resident posing danger to self and others; When the resident becomes agitated to intervene before agitation escalates, guide away from source of distress, engage calmly in conversation. A behavior problem, including but not limited to (yelling/screaming/cursing at staff and peers, will often have outbursts unprompted), call light abuse, non-compliance with care and treatment, and instigating behaviors. The resident was noted to refuse alternate activities, care, would kick, hit, pinch, scratch, spit, bite, and use abusive language targeting both residents and staff, revised September 5, 2025. Interventions revised on January 23, 2026 included that the resident has outbursts and antagonizes staff and peers, redirect and orient as needed. Potential for behaviors, exhibits disruptive interpersonal behavior among peers, which can escalate tensions within the facility dynamic, revised January 22, 2026. An annual Minimum Data Set (MDS) assessment dated [DATE], revealed that the resident has a BIMS Score of 11, indicating moderate impairment. A March 20, 2026 psychiatric follow-up note revealed that the resident experienced intermittent agitation but remained redirectable, indicating good behavioral control and that staff reported no new behavioral issues and confirmed medication compliance. On March 31, 2026 a nursing progress note revealed that at 12:10PM Resident #26 was yelled at by Resident #16, and subsequently Resident #26 extended her left legs, contacting Resident #16's right forearm. The note indicated that the residents were separated, skin checks were performed. The note also relayed that Resident #16 utilized an extra-large bariatric chair and had difficulty independently propelling/maneuvering the wheelchair in the hallway, limiting personal space for others in the immediate area. A March 31, 2026 Behavior Observation form, revealed that physical and verbal behavioral symptoms directed towards others occurred 1 to 3 days, and that the behavior was defensive/reactive to stimuli that occurred. The form included that the resident's family and provider were notified. A skin assessment dated [DATE], revealed no new skin issues observed. A progress notes dated March 31, 2026, stated that fifteen-minute checks for twenty-four hours started for the resident. Further review of the care plan revealed no evidence of review or update of interventions regarding the March 31, 2026 incident. -Resident #16: Resident #16 (alleged victim) was initially admitted to the facility on [DATE] with diagnoses that included Borderline Personality Disorder, Major Depressive Disorder, Generalized Anxiety Disorder, Huntington's Disease. A care plan revealed the following areas of focus: (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Potential risk for alteration in mood state and psychosocial well-being related to panic disorder and paroxysmal anxiety, Initiated August 15, 2023, revised on January 15, 2025. Potential for behaviors including to acting in a problematic manner characterized by verbal/physical aggression, intrusiveness toward residents, exhibits disruptive interpersonal behavior characterized by initiating or exacerbating conflicts among peers. Further review of the resident's care plan included that the resident was admitted to the secured unit, due to physical and verbal aggression, such as yelling at staff, and throwing items at staff. Initiated October 1, 2025, revised March 26, 2026. An annual Minimum Data Set (MDS) assessment dated [DATE] revealed a BIMS (Brief Interview for Mental Status) score of 15, which indicated intact cognition. A nursing progress note dated March 26, 2026, revealed that the resident attended afternoon activities but was unable to participate due to continued yelling. A psychiatric follow-up progress note dated March 26, 2026, revealed that the patient was experiencing increased agitation and behavioral issues requiring active monitoring and potential medication adjustments. A nursing progress note dated March 31, 2026 at 6:41 PM, revealed that an incident occurred on March 31, 2026 at 12:10 PM in which Resident #16 was self-propelling to the front of the hallway to wait for activities, and as Resident #16 approached Resident #26, who was sitting in front of her room in the doorway, Resident #16 yelled out, get out of the way, which startled Resident #26. The note revealed that Resident #26 reacted by saying Fuck loudly and extending her left legs up, making brief contact with the right forearm of Resident #16. The floor nurse intervened at the same time as this was occurring, immediately separating the residents and assisting Resident #16 to the front of the hall. Further review of the resident's records revealed no evidence that the care plan was reviewed/revised regarding the incident that occurred on March 31, 2026. A review of the skin assessment dated [DATE], stated that a skin check was done on Resident #16's upper body which included observations of small old bruises noted on her bilateral hands and forearms, with no new discoloration, swelling or redness noted. An interview was conducted with a Certified Nursing Assistant (CNA, Staff #67) on April 3, 2026, at 8:25 AM. The CNA stated that she did not witness Resident #26 hitting Resident #16 because she was assisting another resident in a different room when she heard screaming in the hallway. When she stepped out of the room, she saw Residents #16 and #26 still yelling at each other. The CNA reported that Resident #16 was consistently anxious and sensitive and did not understand when staff asked her to be more patient. She stated that if Resident #16 wanted something, she expected staff to respond immediately, or she would continue to cry until she got her way. The CNA also relayed that she had never observed Resident #26 exhibiting aggressive behavior toward another resident, as she usually sees resident #26 being pleasant and smiling at both residents and staff. She stated that Resident #26 may have been frightened when Resident #16 yelled at her. The CNA also stated that there are often resident-to-resident altercations in the behavioral unit, and when such incidents occur, staff are trained to separate the residents immediately and monitor the situation. She also indicated that she received abuse training quarterly since she primarily works in the dementia and behavioral unit. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	An interview was also conducted with a Licensed Practical Nurse (LPN, Staff #42) on April 3, 2026, at 8:34 AM, who explained that abuse can take many forms, including verbal, physical, misappropriation, neglect, and sexual abuse. The LPN stated that if any type of abuse is witnessed, unwitnessed, or reported, staff are expected to notify her or any nurse present on the floor. She stated that any allegations of abuse must be reported to management immediately to ensure prompt investigation, as delays can put residents at risk. The LPN stated that in the case of resident-to-resident altercations, staff are responsible for separating the residents to safeguard their well-being. She stated that all staff receive abuse training quarterly and annually. The LPN stated that she was off duty when the incident between Residents #16 and #26 occurred. She stated that upon reading the report the following day, she was not surprised at the incident, as Resident #16 tends to fixate on things and will cry until she gets what she wants, demonstrating a lack of emotional control. A joint interview with the Director of Nursing (DON, Staff #200) and the Administrator (Staff #166) was conducted on April 2, 2026, at 11:44 AM. The Administrator stated that the facility provided consistent training on Abuse and Neglect, covering the types of abuse, the reporting process for allegations, and the actions to take if abuse is suspected. The Administrator stated that at 12:10 PM, Resident #16 was seen self-propelling down the hallway to wait for activities. When she approached the room of Resident #26, who was sitting just past the door threshold, Resident #16 yelled, Get out of the way, which startled Resident #26, who responded by exclaiming Fuck! loudly and making brief contact with Resident #16's right forearm using her left leg. The Administrator stated that the floor nurse intervened, immediately separating the two residents and assisting another resident to the front of the hallway, a skin check was performed on Resident #16, and no injuries were noted. The Administrator also stated that Resident #26, previously from the behavioral unit, was transferred to the dementia unit on Thursday, April 2, 2026. During the above interview conducted on April 2, 2026, at 11:44 AM with the Director of Nursing (DON, Staff #200) and the Administrator (Staff #166), the DON stated that staff are expected to report any incidents of abuse immediately to the DON, the nurse supervisor, and the administrator, to protect the residents. The DON further stated that Resident #26 was transferred to the dementia unit on Thursday, April 2, 2026. A policy titled 'Resident Rights: Abuse and Neglect', adopted on May 1, 2024, revealed that abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. The policy also revealed that physical abuse includes, but is not limited to, the infliction of injury that occurs other than by accidental means, with examples that include, but are not limited to, hitting and punching.

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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** Based on interview, review of clinical record, and review of facility policy and procedure, the facility failed to ensure an allegation of misappropriation was reported to mandated entities and within the required timeframe for 1 of 24 sampled residents (#42). The deficient practice could lead to allegations of misappropriation not being investigated thoroughly and timely. -Findings include:A complaint received by the state agency on February 11, 2026, revealed that it was reported a couple of weeks prior, that Resident #42 was missing his wallet with $2,000.00, a bank card and identification. The complaint also revealed that the resident's son reported that there was a reoccurring charge on the account for about $800.00 a month. The complaint revealed that the facility helped cancel the bank card.However, review of facility records revealed that the incident was initially reported on December 16, 2025.-Regarding Resident #42Resident #42 was first admitted to the facility September 08, 2024, and re-admitted on [DATE], with diagnoses that included vascular dementia, mild, with psychotic disturbance, delirium due to known physiological condition, other gram-negative sepsis, type 2 diabetes mellitus with hyperglycemia, type 2 diabetes mellitus with foot ulcer.An admission minimum data set (MDS) assessment dated [DATE], revealed a brief interview for mental status (BIMS) assessment score of 03, which indicated severe cognitive impairment.Review of the progress notes revealed no evidence regarding the missing funds initially reported on December 16, 2025. Review of the facility grievances dated from April 2025 to January 2026 revealed no evidence related to the resident's missing funds initially reported on December 16 2025.A late entry Social Service note dated February 10, 2026, revealed that Social Services was notified of concerns regarding a missing wallet and bank card. The note included that in accordance with mandatory reporting requirements, Adult Protective Services (APS) intake was completed. However, there was no evidence that the state agency was notified regarding misappropriation.The facility provided a type written report dated February 10, 2026, titled Social Services Incident Timeline. The report revealed that on December 16, 2025, Resident #42's son met with Social Services (SS/staff #109) and reported concerns regarding financial charges appearing on the resident's account of which he was unaware. The report indicated that Social Services contacted the Business Office for clarification regarding potential facility-related charges. The report relayed that the Resident's son intended to cancel the debit/credit card associated with the questioned transactions. The report relayed that an interdisciplinary discussion was conducted, during a clinical team meeting due to the reported unexplained charges and lack of supporting documentation despite multiple requests. The report indicated that the potential financial exploitation would be reported to APS. However, there was no evidence in the resident's clinical record that the state agency, or that the Administrator were notified regarding the incident on December 16, 2025.A joint interview was conducted on April 2, 2026, at 11:44 AM with the Director of Nursing (DON/Staff #200) and the Administrator (Staff #166). The Administrator stated that the facility provided consistent training on Abuse and Neglect, covering the types of abuse, that included misappropriation, the reporting process for allegations, and the actions to take if abuse is suspected. The Administrator (Staff #166) stated that for misappropriation, the social services department typically takes the report and staff will start the search in the resident's room, expanding outward if necessary. She also stated that the Department of Health Services, Ombudsman, and Adult Protective Services should be notified to start the investigation process, summarize the data, and submit the five-day report. The Administrator further stated that she would start the initial report and the investigation, notify the family and physician just like with abuse or neglect. The Administrator relayed that she has a tracker for all types of abuse, including misappropriation, which is reviewed at Quality Assurance (AQ) meeting every month to see if there are trends/multiple grievances. The Administrator stated that Resident #42's son reported a misappropriation of funds in December 2025, (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	04/03/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and she was not aware of the incident. She added that the resident doesn't have a history of missing items, as far as she remembers, and had only been at the facility for a year. She added that she's not really sure what happened because they learned about the missing items when the son spoke to the social worker, and the social worker asked whether there were any charges on the card, since Resident #42's son stated that the card had been canceled and that the card was in the resident's possession the whole time. She added that when the facility asked for a card statement, the family failed to provide it. Both the Administrator and DON (Staff #200) stated that failing to report an incident delays the response and investigation process.During the joint interview conducted on April 2, 2026 at 11:44 AM the DON (Staff #200) stated that staff are expected to report any incidents of abuse immediately to the DON, the nurse supervisor, and the administrator, to protect the residents.A policy titled, Resident Rights: Abuse and Neglect, adopted on May 1, 2024, revealed that it is the facility policy to provide professional care and services in an environment that is free from misappropriation of property. The facility follows the federal guidelines dedicated to prevention of abuse and timely and thorough investigation of allegations, that include the seven federal components of prevention and investigation. Financial abuse includes misappropriation, exploitation or otherwise taking advantage of a resident's money or property temporarily or permanently. If abuse is suspected the facility will notify the appropriate/designated organization/authority (state agencies) that in investigation is being initiated immediately following intervention for the resident's safety. Take actions related to resolving resident and family issues/concerns/allegations and record. Report the investigation findings to the appropriate state agencies, notify law enforcement authorities if indicated. All allegations and/or suspicions of abuse will be reported to the Administrator immediately, and will be reported to the appropriate state agencies immediately after the initial allegation is received, a final investigation report will be submitted to the appropriate state agency within 5 working days.