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	05/07/2026

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	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 interviews, review of clinical record, and review of facility policy and procedure, the facility failed to ensure an allegation of resident-to-resident abuse was reported to the applicable and required state agencies within 2 hours, for two of four sampled residents (#50 and #40). The deficient practice could result in an allegation of abuse not being reported and investigated in a timely manner, and could result in continued harm to residents.Findings include:Resident #50 was admitted to the facility on [DATE], with diagnoses of dementia, bipolar disorder, and heart failure.A Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #50 had a Brief Interview for Mental Status (BIMS) assessment score of 7, indicating severe cognitive impairment.A Nursing Note dated May 4, 2026, at 3:43 p.m. revealed Resident #50 was observed with small discoloration / light bruising to her right outer arm. The note revealed Resident #50 stated she hit her arm on the door and was unable to recall further details regarding the injury.There was no evidence in Resident #50's medical record of documentation on May 4, 2026, regarding a resident-to-resident incident.A Nursing Note dated May 6, 2026, revealed that on May 4, 2026, at approximately 2:00 p.m., staff in Resident #50's room were assisting with the redirection of another resident during a wandering episode. The other resident was looking for a male whom he was calling by a specific name, who he thought was Resident #50. The other resident emotionally escalated and wanted to get Resident #50's attention and to get Resident #50 up out of bed. Staff continued to use verbal de-escalation and hand-on-hand redirection to distract the other resident to another object and guide the other resident out of Resident #50's room, which was ineffective. The note revealed that the other resident grabbed Resident #50's right arm and right leg while she was lying down in bed, and the other resident ended up halfway on Resident #50's bed while the other resident continued to attempt to get Resident #50's attention. Staff were able to intervene and separate the residents. The note revealed that Resident #50 was given reassurance, and that the wound nurse was in to do a skin check after the event. The nurse and the unit manager asked the resident how her bruise occurred, and Resident #50 stated that she hit it on the door. The note included that the local police responded that a report would not be completed because the police did not observe the incident.-Resident #40 was admitted to the facility on [DATE], with diagnoses of neurocognitive disorder with Lewy bodies, chronic heart disease, dementia, post-traumatic stress disorder, and acquired absence of right toe(s).An admission MDS assessment dated [DATE], revealed Resident #40 had no BIMS assessment completed due to the resident being rarely or never understood. Section E, Behavior, revealed Resident #40 had episodes of physical and verbal behavioral symptoms directed toward others, in addition to wandering behavior that occurred 1 to 3 days.A Nursing Note dated April 4, 2026, at 2:23 p.m., revealed Resident #40 was exit-seeking, combative with staff during redirection attempts, and entering other resident's rooms.Another Nursing Note dated May 4, 2026, at 3;12 p.m., revealed Resident #40 was agitated, exit-seeking, pacing the hallway and hit staff during attempts at redirection.There was no evidence of a progress note in Resident #40's medical record completed on May 4, 2026, regarding a resident-to-resident incident.A facility self-report submitted to the State Agency on May 5, 2026, at 11:44 a.m. revealed that on May (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4, 2026, at approximately 2:00 p.m., a Behavioral Health Technician (BHT / Staff #41) was attempting to de-escalate Resident #40 in the hallway. The report revealed that a code grey was called, and that Resident #40 was yelling and cursing at the BHT and a Certified Nursing Assistant (CNA / Staff #83). The report revealed Resident #40 entered Resident #50's room while Resident #50 was lying in her bed, and yelled a specific male's name, grabbed Resident #50's arm and leg. The report included that Staff #41 and Staff #83 were able to get Resident #40 from the bed area, and Resident #40 sat on the floor. The report revealed that a head-to-toe assessment was completed for Resident #50, and a bruise was found on her right arm. Additionally, the report included that Resident #50 exhibited no sign of distress.A telephonic interview was conducted on May 7, 2026, at 11:08 a.m., with a CNA (Staff #83) who stated that on May 4, 2026, after Resident #40 had received wound care, he was very agitated and was walking around the unit. The CNA stated that the resident was calling a male's name and entered Resident #50's room, where Resident #50 was lying on her bed. The CNA stated that Resident #40 grabbed Resident #50's arm and leg and was trying to pull her off of the bed, before climbing on top of Resident #50 in the bed. The CNA stated that Resident #50 was very upset and was screaming and yelling because she did not know what was going on. The CNA stated that she then pulled Resident #40 off of Resident #50 and onto the floor.An interview was conducted with a BHT (Staff #41) on May 7, 2026, at 12:23 p.m., who stated that if there was an incident that could possibly be abuse, staff were expected to report the situation immediately to their direct supervisor and the administrator. The BHT stated that it would not be appropriate for a resident to grab another resident, and that it could possibly be considered a situation of abuse. The BHT stated on May 4, 2026, Resident #40 was agitated and wandering, and that Resident #40 pushed the BHT out of the way in the hallway as the BHT was attempting to provide redirection and de-escalation. The BHT stated that then, Resident #40 saw Resident #50 lying in her bed, and entered her room and yelled out a male's name as he grabbed Resident #50's right arm and right leg. The BHT stated that he worked together with the CNA, Staff #83, to get Resident #40 off of Resident #50, and that Resident #40 was assisted to the floor. The BHT stated that Resident #40 was surprised by the interaction, and asked the staff directly after the incident if there was any blood.A telephonic interview was conducted with the Assistant Director of Nursing (ADON / Staff #2) on May 7, 2026, at 1:22 p.m., who stated that on May 4, 2026, she heard the call for code grey and went to the unit to assist, and observed Resident #40 being assisted by staff into his wheelchair. When she asked the CNA (Staff #83) and the BHT (Staff #41) what happened, Staff #2 stated that she was informed that the staff were trying to redirect Resident #40, who entered Resident #50's room and had been trying to wake Resident #50 up and sat on Resident #50's bed. The ADON stated she did not draw any conclusions whether this was an instance of physical abuse, and that she reported the incident to the covering Administrator (Staff #7) right away.A telephonic interview was conducted on May 7, 2026, at 3:32 p.m. with the Administrator (Staff #5), who stated that she was away on vacation during the timeframe of the incident between Resident #50 and Resident #40, and that the covering Administrator for that timeframe was Staff #7. The Administrator stated that her expectation was that any allegation of possible abuse be reported in accordance with state and federal regulations, and that facility staff were mandated to report allegations of abuse to the State Agency, to Adult Protective Services (APS), and to the ombudsman within 2 hours. The Administrator stated that the importance of reporting in a timely manner was to protect residents from injury, to have staff suspended if necessary, and to protect residents from further abuse.An interview was conducted with the covering Administrator (Staff #7) on May 7, 2026, at 3:49 p.m. who stated that he was covering as Administrator during the timeframe of the incident between Resident #40 and Resident #50. Staff #7 stated that, to his knowledge, Resident #40 entered Resident #50's room, and was yelling out his old business partner's name and mistook Resident #50 for his old business partner. Staff #7 stated that Resident #40 then grabbed Resident #50's arm and leg and was attempting to wake her up when the BHT (Staff #41) and the CNA (Staff #83) separated the residents and got Resident #40 out of the room. Staff #7 stated that the incident occurred on May (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4, 2026, around 2:00 p.m., and that the report to the State Agency occurred on May 5, 2026. Staff #7 stated that the reason he waited almost a day to report the incident to the State Agency was that there was no harm done to the residents.Review of the facility policy titled Freedom from Abuse, Neglect, and Exploitation, dated November 2027, revealed the facility will provide a safe resident environment and protect residents from abuse. Physical abuse includes, but is not limited to, hitting, slapping, punching, biting and kicking. Physical abuse may be possible when a resident receives an injury that is suspicious because the source of the injury is not observed, the extent or location of the injury is unusual or because of the number of injuries either at a single point in time or over time. Regarding resident to resident abuse: cognitive impairment or mental disorder does not preclude a resident from being abusive. In determining abuse, willful (deliberate) action (not inadvertent or accidental) will be considered regardless of whether the individual intended to inflict injury or harm. The policy also revealed that each resident-to-resident altercation should be reviewed for potential abuse.Review of a facility policy titled, Resident Rights, dated May 1, 2024, revealed that it was the policy of the facility that all resident rights be followed per state and federal guidelines, as well as other regulatory agencies, and that residents had the right to be free from physical abuse.Review of the Code of Federal Regulation 42 CFR S 483.12, revealed that in response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interviews, and review of facility policy and procedure, the facility failed to ensure food was stored and prepared under sanitary conditions. The deficient practice could lead to pests in the kitchen and/or spread of infection to residents.Findings include:A blank kitchen Daily Cleaning Log revealed a list of tasks including Wash & Sanitize Prep Tables / Countertops, Wash & Sanitize Dining Room Tables, Sweep & Mop Kitchen Floor, and the log also included a blank space for staff responsible, and a check box for each day of the week.A blank Validation Checklist Kitchen Observation revealed to walk through the kitchen at the start and end of every shift. The document included a list of tasks that included Floor is clean and free of debris, Canned goods have an uncompromised seal, Bottom shelves throughout kitchen clean and sanitized, and no clutter on Bottom shelves throughout. The log included a check box for each day of the week.A formal request was submitted to the facility on May 7, 2026, for a kitchen cleaning log form, and any kitchen cleaning logs completed in the past three months. The facility provided a signed statement that for the past three months there were no completed cleaning logs.An interview was conducted with a certified nursing assistant (CNA / Staff #25) on May 6, 2026, at 10:54 a.m. who stated that she has seen an ongoing issue of lack of cleanliness coming from the kitchen. Staff #25 stated that often, she would notice that dishes such as cups coming from the kitchen as clean would have grease residue in them, and that often as she poured juice out of pitchers for residents, that she could see dirt or residue on the bottom of the inside of the pitchers. Staff #25 stated that when she noticed this, she returned the dirty dishes to the kitchen to get new ones. Additionally, Staff #25 stated that in one instance, she started to pass meal trays to residents from the meal cart that was just delivered to her hallway, and that there was an old used meal tray on the cart from a resident from a previous meal that was left on the cart with the other new meal trays that were to be delivered, and that she was concerned of the cleanliness issue for residents.An observation was conducted of the kitchen with the Dietary Manager (Staff #66) on May 6, 2026, at 11:43 p.m., who had arrived to the facility at that time to unlock the kitchen area. There were no staff working in the kitchen at that time of night. The kitchen observation revealed an area with storage racks of clean pots and pans. Underneath the pots and pans rack was a puddle of standing water approximately 2 feet long and 1 foot wide, with the puddle extending along the wall of the area. The wall was observed to function as the exterior wall of the facility on the other side. There was no sink or dishwasher or faucet anywhere in the direct vicinity of the puddle. The nearest sink was approximately 10 feet away, and there was no trail of water leading to the puddle. Additionally, the pots and pans observed on the rack were completely dry.An interview was conducted with Staff #66 at that time, who stated that when it rains heavily, water leaks into the kitchen, and that it has been an ongoing issue since he started working at the facility in November 2025. Staff #66 stated that the water was coming from behind the wall, and that it had last rained about a day and a half ago. Staff #66 stated that maintenance staff had already been alerted and were aware of the issue from before he started working at the facility. Staff #66 declined to state whether there would be any risk from water leaking from behind a wall.The observation of the kitchen continued in the dry goods storage area and at approximately 11:50 p.m., a puddle of sticky-appearing, clear, yellowish residue was observed on the floor underneath a rack of canned food. It was observed to have dripped down from a large can of fruit that had juice residue on the label of the canned fruit. There were also spattered juice residue drops on the rack, the wheel of the rack, and spattered drops surrounding the puddle of juice residue on the floor.Another interview was conducted at that time with Staff #66, who stated that the residue was coming from a damaged can of tropical fruit, and Staff #66 then picked up the can and disposed of it.Another observation of the kitchen was conducted on May 7, 2026, at 11:42 a.m., with Staff #66 in the dry goods storage area. In the same area where the juice residue was observed from the leaking can of tropical fruit from the previous evening, there was observed residual (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dried, sticky-appearing droplets on the floor. Additionally, there were marks on the floor that indicated some of the residue had been wiped up and smeared; however, there was still sticky appearing juice residue on and around the wheel of the rack, and still some remaining droplets on the floor.An interview was conducted with Staff #66 at that time, who stated the residue on the floor was from the leaking can of fruit from the previous evening, and that he cleaned up the mess, but that he had missed some. When Staff #66 was asked if he had any kitchen cleaning logs, Staff #66 showed a copy of a blank Validation Checklist Kitchen Observation, and stated that he had none that were completed. Staff #66 stated that the facility's process for ensuring the kitchen is cleaned was that a lot of the kitchen staff have worked at the facility for years and that they know to clean the kitchen if it gets dirty. Staff #66 stated that usually staff clean the kitchen after every meal, and that additional cleaning is done after the dinner meal in the evening. Regarding the water puddle under the pots and pans storage rack from the previous evening, Staff #66 stated that he had talked to maintenance staff this morning and that the maintenance staff said it was an ongoing issue and that it is not a quick fix.An interview was conducted with the Maintenance Director (Staff #11) on May 7, 2026, at 12:00 p.m. who stated he had received a work order this morning to address the water puddle under the pots and pans storage rack from the previous evening. Staff #11 stated that he believed the water was coming from a sink that was approximately 10 feet away from the puddle area, and that he had fixed the issue this morning. Additionally, Staff #11 stated that staff had not informed him of any water puddles in the kitchen or leaks from the sink prior to this morning. Staff #11 also stated that the water puddle could have come from drips of water coming from pots and pans that staff had put away on the rack while still wet. Staff #11 declined to state whether it would meet his expectation for kitchen staff to leave a standing puddle of water on the floor of the kitchen through the night.A telephonic interview was conducted with the Administrator (Staff #5) on May 6, 2026, at 11:14 a.m., who stated that the kitchen staff have a process to ensure the kitchen is kept clean and that food is prepared under sanitary conditions. The Administrator stated the process included that staff should be wiping down counters, cleaning the floor routinely, sanitizing dishes, waiting until dishes are dry before putting them away, emptying used cleaning buckets, checking the sanitizing chemicals to ensure they are at the right level, ensuring used rags are cleaned, and cleaning meal carts between meals. Staff #5 stated that Staff #66 was responsible for ensuring the kitchen was kept clean and food was stored and prepared under sanitary conditions, and that she believed he kept cleaning logs to ensure cleanliness. Staff #5 stated that it would not meet her expectation for the kitchen to have food residue or spilled food left overnight in the kitchen, and that she would expect it were cleaned after the meal. Staff #5 stated that spills or food residue left overnight could pose a risk for infection control issues and pests in the kitchen.Review of the facility policy titled Food and Nutrition Services, dated July, 2018, revealed the facility will store, prepare, and serve food in a manner to minimize the potential for biological contamination and taking into consideration factors which may influence the growth of bacteria. Additionally, the facility will adhere to practices to minimize the potential of physical contamination of food. Dry foods and goods will be handled and stored in a manner that maintains the integrity of the packaging until they are ready to use. Dry foods will be stored in closed containers and supplies will be rotated.Review of the facility policy titled Water Supply - Disruption Due to Repairs or Emergencies, dated May 2024, revealed in the event of sewage system flooding or failure, the facility will evaluate infection control risks to the residents and implement appropriate measures including possible transfer of residents as needed, and in accordance with current CDC/HICPAC guidelines and state and local health department requirements. Regardless of the original source of water damage (e.g., flooding, water leaks), wet, absorbent, structural items (e.g., carpeting, wallpaper, wallboard) and cloth furnishings will be assessed for possible replacement if they are not thoroughly dried within 72 hours and are considered to present continuing sources of contamination.Review of the facility policy titled Sanitation - Dietary Services, dated May 2024, revealed it is the policy of the facility that food service area shall be maintained in a clean and (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sanitary manner. All kitchens, kitchen areas and dining areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies and other insects. Kitchen wastes that are not disposed of by mechanical means shall be kept in clean, leakproof, nonabsorbent, tightly closed containers and shall be disposed of daily. Kitchen and dining room surfaces not in contact with food shall be cleaned on a regular schedule and frequently enough to prevent accumulation of grime. The Food Services Manager will be responsible for scheduling staff for regular cleaning of kitchen and dining areas. Food service staff will be trained to maintain cleanliness throughout their work areas during all tasks, and to clean after each task before proceeding to the next assignment.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of clinical record, and review of facility policy and procedure, the facility failed to ensure the medical record was complete and accurate for one of four sampled residents (#20) regarding a fall. The deficient practice could result in care team members not being fully aware of a resident's condition and could cause missed care and treatment.Findings include:Resident #20 was originally admitted to the facility on [DATE], with diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, dementia, anemia, difficulty in walking, and anxiety disorder.A care plan focus initiated on October 21, 2018, revealed that Resident #20 was at risk for falls due to dementia causing confusion, poor safety awareness, incontinence, and hemiplegia to the right dominant side. There was no evidence of revisions or additions to the care plan focus following a fall incident on April 24, 2026.Another care plan focus initiated on October 21, 2018, revealed Resident #20 had an ADL self-care performance deficit with decreased mobility, weakness, and hemiplegia of right dominant side. The focus revealed an intervention initiated on December 15, 2025, that included assistance of 1 staff member for bathing and showering. The intervention was revised on April 27, 2026, to include 2 staff for bathing and showering.A quarterly minimum data set (MDS) assessment dated [DATE], revealed the resident had a brief interview for mental status (BIMS) assessment score of 0, indicating severe cognitive impairment. Additionally, Section J revealed the resident had 1 fall since admission, reentry, or prior assessment.A nurse's note dated April 24, 2026, at 4:12 a.m. revealed the resident was alert and compliant with care and medications. The note included that the resident took his scheduled shower and no new skin issues were observed, and that the resident was seen lying in bed with respirations even and unlabored.An Alert Note dated April 24, 2026, at 4:45 a.m. revealed bathing had not been completed, and additionally, that the resident took his scheduled shower during the night shift. The note revealed no information about a fall.An incident report dated April 24, 2026, at 5:00 a.m. revealed that the Registered Nurse (RN / Staff #79) was called by the certified nursing assistant (CNA) in the shower room. As per the CNA, the resident leaned forward and hit his head on the shower handlebar while the CNA was busy putting shampoo on the towel. The report revealed that the resident sustained a cut (about 4 cm) and 1 cm deep on his right forehead. Immediate pressure was put on the resident's cut to stop the bleeding, a neuro check was done, and vital signs were taken, and were within normal limits. The report also included that the resident was unable to describe the incident. Additionally, the report revealed there were no predisposing environmental or physiological factors contributing to the cause of the incident; however, predisposing situational factors revealed that the CNA was busy putting shampoo on the towel. The documentation revealed that the on-call provider was immediately notified, and included the time of notification as April 24, 2026, at 7:00 a.m. (approximately 2 hours after the incident), and that the physician ordered the resident to be sent to the hospital for further evaluation and treatment.A physician's order dated April 24, 2026, at 5:45 a.m. included the resident may be to the hospital for further evaluation and treatment.A nurse's note dated April 24, 2026, at 6:47 a.m. revealed that the nurse (Staff #79) was called by the CNA in the shower room. The note also revealed that, according to the CNA, resident leaned forward and hit his head on the shower handlebar while the CNA was busy putting shampoo on the towel. The note revealed the resident sustained a cut (about 4 cm) and 1 cm deep on his right forehead, and that immediate pressure was put on the resident's cut to stop the bleeding, a neuro check was done, and vital signs were taken and were within normal limits. The documentation included that the on-call provider was immediately notified and ordered the resident to be sent to the hospital for further evaluation and treatment.There was no evidence of a fall incident or completion of a head-to -toe assessment.A Nurse Practitioner Progress Note dated April 24, 2026, at 2:47 p.m. revealed that Resident #20 had an accident in the shower this morning and had (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fallen forward and hit his head on the shower bar, which caused a large gash on his forehead. The note revealed that the resident was sent to the hospital emergency department for possible sutures, and the resident was still at the hospital.A hospital History and Physical Note dated April 24, 2026, revealed that the resident presented to the hospital after a ground-level mechanical fall while taking a shower. The note included that Resident #20 hit his head and suffered right facial laceration and hematoma, and additionally that x-rays revealed an acute right hip fracture.A hospital physician's progress note dated April 25, 2026, revealed that Resident #20 presented after a mechanical ground-level fall with a head strike, and that the exam revealed right hip tenderness. The note revealed that imaging was significant for right femur trochanteric fracture, and that the resident was to undergo an operation for a right hip intramedullary nailing procedure.A nurse's note dated April 27, 2026, revealed the resident was re-admitted to the facility after hospitalization for diagnoses of right forehead laceration and right hip fracture.An insurance provider Registered Nurse (RN) Follow-Up note dated May 4, 2026, revealed that Resident #20 had a recent fall with a right femur fracture, and a healed laceration to the right side of the forehead from the same incident.A written statement provided May 7, 2026, by the Director of Nursing (DON / Staff #90), revealed that the DON spoke to Staff #20 on April 28, 2026, at 2:34 a.m. to get his statement regarding the incident on April 24, 2026, when Resident #20 was sent to the hospital. The statement revealed that Staff #20 stated that during the shower, while Staff #20 was soaping up the washcloth, the resident tipped forward and hit his head on the bar of the shower, and that as the resident's head and knees were against the bar and wall, Staff #20 was able to catch the resident's body and the chair to prevent the resident from contacting the ground. The statement also revealed that Staff #20 was emphatic that no part of the resident ever touched the ground.An interview was conducted with a Licensed Practical Nurse (LPN / Staff #37) on May 7, 2026, at 9:39 a.m., who stated that she came to the facility in the morning just after the fall incident occurred on April 24, 2026. Staff #37 stated that she was told through report that Resident #20 was in the shower with a CNA, when the resident lurched forward quickly, and that the resident fell out of the shower chair and sustained a right hip fracture and had to have surgery. Staff #37 stated that normally, before the fall incident, Resident #20 had poor safety awareness, very bad vision, and behaviors of leaning forward suddenly.A telephonic interview was conducted on May 7, 2026, at 2:29 p.m. with a CNA (Staff #20) who stated that he was the staff member who was showering Resident #20 when the fall incident occurred on April 24, 2026, and that there was nobody else present in the shower room. Staff #20 stated that Resident #20 cannot see very well and has impulsive behaviors. Staff #20 stated that Resident #20 was seated in a shower chair in the shower stall, and that the brakes of the shower chair were locked. Staff #20 stated he turned slightly to put soap on a washrag, and he saw out of his peripheral vision that Resident #20 quickly reached for the water hose of the shower. Staff #20 stated that when the resident reached forward suddenly, the shower chair quickly tipped forward, the resident fell forward, the resident's face hit the wall, and the resident's knees hit the floor. Staff #20 stated that the shower chair was positioned behind the resident's backside and on top of the resident. Staff #20 stated that as the resident fell forward, Staff #20 reached his arm out to try to catch the resident, and when the resident hit the wall with his head and the floor with his knees, that Staff #20's arm was under the resident's chest and abdomen area. Staff #20 then stated he put his other arm behind the shower chair and with his arm on the resident's chest and his other arm behind the shower chair, Staff #20 lifted the resident along with the shower chair back upright into a sitting position. Staff #20 was asked to repeat whether the resident hit the floor when he fell, and Staff #20 reiterated that the resident did fall to the floor with his knees contacting the floor and his face against the wall of the shower. Staff #20 stated that after he assisted the resident back to sitting in the shower chair, he called out for the nurse (Staff #79), who came to the shower room and assessed the resident, who was bleeding from his forehead at that time. Staff #20 stated that he repeated exactly what happened, including that the resident contacted the floor with his knees, to the nurse (Staff # 79), and to management when they asked him about 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	05/07/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incident.An interview was conducted with the Director of Nursing (DON / Staff #90) on May 7, 2026, at approximately 3:00 p.m., who stated that if a fall or accident were to occur to a resident, a CNA would be expected to notify the nurse right away to assess the resident. Staff #90 stated that the nurse would be expected to perform a complete head-to-toe assessment of the resident, and that the incident and assessment would be documented in the clinical record. Staff #90 stated that she was involved in investigating the incident regarding Resident #20 and that initially, she had received information that the resident had tipped forward in the shower chair and hit his head on the bar in the shower, and then later had received information from the hospital that Resident #20 had sustained a hip fracture. The DON stated that based on the information she received, the resident never hit the floor.A telephonic interview was conducted with an RN (Staff #79) on May 7, 2026, at 4:06 p.m., who stated that he was the nurse on duty at the time of Resident #20's shower incident on April 24, 2026. Staff #79 stated that he was preparing morning medications when Staff #20 notified him of an incident, and that the RN went to assess the resident. Staff #79 stated that Resident #20 was sitting in the shower chair and had an obvious head injury with a cut on the right side of his forehead that was bleeding. Staff #79 stated that Staff #20 told him that the resident leaned forward and was falling off the shower chair, and that the CNA was trying to explain to him what happened, but that Staff #20 was concerned and focused on what was going on with the resident's head. Staff #79 stated that Staff #20 did not tell him that the resident contacted the ground. Staff #79 stated he did not do a full head-to-toe assessment of the resident's body because he was focused on the resident's head injury. Staff #79 stated that he immediately called the provider and was ordered to send the resident to the hospital. Staff #79 stated he later found out the resident had a hip fracture from the incident.A telephonic interview was conducted with the Administrator (Staff #5) on May 7, 2026, at 3:32 p.m., who stated that her expectation for staff to document a fall or accident involving a resident would be to follow the facility's guidelines on documentation, and that staff would complete an incident report and progress note, and any following neuro checks. The administrator stated that if an incident or accident were not documented accurately, that something could be missed. Regarding the incident with Resident #20 in the shower, the Administrator stated that to her knowledge, the resident never hit the floor.Review of the facility policy titled Change in a Resident's Condition or Status, dated May 1, 2024, revealed that the nurse will notify the resident's attending physician or physician on call when there has been an accident or incident involving the resident, a significant change in the resident's condition, or a need to transfer the resident to a hospital. The policy also revealed that prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information to the provider. The nurse will record in the resident's medical record information relative to changes in the resident's medical / mental condition or status.Review of the facility policy titled Charting and Documentation, dated May 1, 2024, revealed that all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. The following information is to be documented in the resident medical record: objective observations, medications administered, treatments or services performed, changes in the resident's condition, events, incidents or accidents involving the resident, and progress toward or changes in the care plan goals and objectives. The policy also revealed documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.