

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035099	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2026
NAME OF PROVIDER OR SUPPLIER Sandstone of Tucson Rehab Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 2900 East Milber Street Tucson, AZ 85714	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and review of facility documentation and policies, the facility failed to protect the rights of 1 resident (#1) to be free from verbal abuse by staff. The deficient practice could result in further abuse of residents and appropriate action not taken. Findings include:-Regarding Resident #1 (alleged victim):Resident #1 was admitted to the facility on [DATE], with diagnoses of hemiplegia, chronic kidney disease, Schizoaffective Disorder, Type 2 Diabetes Mellitus, Major Depressive Disorder, and dementia.The care plan revised on November 12, 2025, revealed that the resident was in a secured unit related to dementia with behavioral disturbance and had physical aggression towards staff. The care plan identified a behavior problem as evidenced by being verbal and physical aggression with staff and refusal of care from people of different ethnicities. The Care plan further identified that Resident #1 was at risk for altered mood state and impaired psychosocial well-being related to schizoaffective disorder, major depressive disorder, impulsivity, and periods of emotional dysregulation.The Care plan documented that Resident #1's mood could fluctuate with or without an identifiable trigger and could be exacerbated by overstimulation, particularly during personal care or other high-demand situations. During periods of distress, the resident could demonstrate ineffective communication, impulsive behaviors, difficulty maintaining positive interpersonal relationships with staff and peers. The Care plan interventions included cares in pairs, the staff to approach the resident in a calm, consistent, and non-threatening manner while minimizing environmental stimulation during care and other potentially stressful interactions, allow adequate time for processing, offer simple choices, and use clear, concise communication to reduce frustration and support effective expression of needs, monitor for changes in mood, impulsive behaviors, withdrawal, agitation, or other signs of psychiatric decompensation, promptly communicate significant changes to the interdisciplinary team and psychiatric provider, reinforce appropriate coping skills, provide positive redirection and reassurance as needed, encourage participation in preferred activities and social interactions as tolerated to promote psychosocial well-being, provide the resident with supportive care and services to promote a sense of safety, well-being and positive self-image, and if safe, allow the resident personal space. The annual Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental status (BIMS) score of 10, indicating moderate cognitive impairment. The assessment included that the resident exhibited physical and verbal behavioral symptoms and exhibited behaviors of rejection of care.A nursing progress note dated July 23, 2026, revealed that the resident was alert, compliant with his medications, and denied any pain or discomfort. Per the document, the resident had a behavior history of physical and verbal aggressions with care staff, the resident was verbally and physically aggressive during care with the certified nursing assistants (CNAs), and the resident was redirected (continued on next page)		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035099	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2026
NAME OF PROVIDER OR SUPPLIER Sandstone of Tucson Rehab Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 2900 East Milber Street Tucson, AZ 85714	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	but continued to be verbally and physically aggressive during care. A social services progress note dated July 23, 2026, revealed that the resident had an irritable mood and affect and was minimally engaged during interaction. Per the document, the resident did not recall the event related to the reported incident. -Regarding CNA (Staff #13 /alleged perpetrator):CNA (Staff #13) employee record revealed a:Hire date July 1, 2026No evidence of APS (Adult Protective Services) registry recordCertificate of Completion on Elder Justice Act and Preventing Abuse and NeglectCertificate of Completion for dementia careA written warning related to failure to appropriately de-escalate a resident interaction, for not meeting the facility's expectations for professionalism, customer service, and resident care. A facility 5-day investigation report dated July 27, 2026, revealed that the Behavioral Health Consultant (Staff #30) met with Resident #1 on July 22, 2026 and the Social Services met with Resident #1 on July 23, 2026. The resident did not recall the event. The report also revealed that CNA (Staff #7) and CNA (Staff #13) were interviewed. According to the facility's interview summary for Staff #7, Staff 13 requested Staff #7's assistance with placing sling under Resident #1. While the sling was being positioned, Resident #1 punched Staff #7 in the stomach. Staff #13 blocked Resident #1's fist from striking Staff #7. Resident #1 then grabbed Staff #13's hand and pulled it toward his chest. Staff #7 reported that Staff #13 was holding Resident #1's hand tightly while Staff #13 reported that Resident #1 was holding his hand tightly and would not let go. Staff #7 described a back and forth interaction between Resident #1 and Staff #13 throughout the care encounter. According to the facility's interview summary for Staff #13, Resident #1 attempted to punch Staff #7 in the stomach. Staff #13 blocked the punch, after which Resident #1 grabbed Staff #13's hand and squeezed it tightly. Staff #13 acknowledged saying, jokingly, stop being a sissy, in reference to how Resident #1 was squeezing his hand. Staff #13 further reported that Resident #1 told him, I hope you go to hell and Staff #13 responded, that's ok, it doesn't matter. Staff #13 stated he did not recall saying or doing that could have been misunderstood by Staff #7. The facility's interview summary further documented that while Staff #13 was later wheeling Resident #1 back to his room, Resident #1 attempted to strike Staff #13 in the face. Staff #13 reported that he blocked the resident's punch. Staff #13 acknowledged that he could have used better judgement and professionalism when communicating with Resident #1. The facility 5-day investigation concluded that the allegation of abuse was not verified. An interview was conducted on July 31, 2026, at 11:04 AM, with the Staff #13. Staff #13 stated that he and Staff #7 were in Resident #1's room to place a sling under the resident and the resident punched Staff #7. Staff #13 stated that he grabbed the resident's hand before the resident could throw another punch to Staff #7. Staff #13 stated it upset him when a man hits a woman. Staff #13 stated that the resident told him hope you die and he responded by saying okay and walked out of the resident's room. Staff #13 stated he was immediately contacted by management, was sent home and subsequently reassigned to another section. Staff #13 stated that he did not feel like he did something wrong, he said that he wanted to protect Staff #7, and he also said that he got in trouble for helping an employee for not getting hit. Staff #13 stated that abuse is hurting somebody and can be verbal. Staff #13 stated that he did not intend to say it to Resident #1, but it was seen as verbal abuse. Staff #13 further stated that he took care of Resident #1 several times, and sometimes the resident was nice and sometimes the resident was mean and when the resident acted mean, he would walk away. Further, Staff #13 stated that his dementia care training involved getting down to the residents' level to make them comfortable. Staff #13 also stated that if there was a resident with behavioral outburst, he would leave them alone, he would stand away from the resident so the resident would not get more mad. An attempt was made to conduct an interview with Resident #1 on July 31, 2026, at 1:44 PM. The resident had a visitor in his room. The visitor (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035099	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2026
NAME OF PROVIDER OR SUPPLIER Sandstone of Tucson Rehab Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 2900 East Milber Street Tucson, AZ 85714	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated that she was the resident's family member, she was getting the resident down to sleep, she did not want the resident to be disturbed, and also stated for the surveyor to speak with the nurse. An interview was conducted on July 31, 2026, around 11:55 AM with a CNA (Staff #16). Staff #16 stated that Resident #1 can be pleasant, sometimes combative and it depends on how he feels. Staff #16 stated that, sometime last week, she instructed a CNA (Staff #7) to report an incident involving Resident #1 to the unit managers. An interview was conducted on July 31, 2026, at 12:03 PM with a Licensed Practical Nurse (LPN/Staff #43). The LPN stated that Resident #1 was one of their veterans, who cannot move his left arm, sometimes the resident might not be approachable, the resident used the F word, sometimes the resident might strike with his arm, the resident was in their locked unit for his behaviors, and the resident was not on any psychotropic medications. The LPN stated that Resident #1 needed to be changed, the CNA (Staff #7) was a new CNA and the other CNA (Staff #13) was rough, and he was sent home. The LPN stated that she assessed the resident and he did not have marks. An interview was conducted on July 31, 2026, at 12:45 PM with the Assistant Director of Nursing (ADON/Staff #15). The ADON stated that abuse is an act that is unwarranted to another individual and it could be financial, sexual, verbal and physical. The ADON stated that if she was made aware of any allegation of abuse, she would immediately notify the administrator/abuse coordinator. Regarding the incident involving Resident #1, the ADON stated that when the resident was being changed, the resident became combative so the CNAs (Staff #7 and Staff #13) had to deescalate the situation. The ADON stated that the resident was hitting and punching Staff #7 and Staff #13 attempted to deescalate by keeping the resident from hitting Staff #7 further. The ADON stated that Resident #1 was a veteran, and at baseline, he could be combative and verbally aggressive towards staff. The ADON stated that the resident's care plan included cares and pairs, making sure to take a calm approach, giving the resident space to calm down, and then re-approach. The ADON stated that their Human Resources department followed up on the Staff #7 who got punched by the resident and Staff #13 was removed from the floor pending investigation. A phone interview was conducted on July 31, 2026, at 12:54 PM with Staff #7. The CNA stated that abuse could be financial, physical, and verbal. The CNA stated that she was called by another Staff #13 to Resident #1's room to assist with the transfer lift, to get the resident up for dinner, and it happened on a Wednesday. The CNA stated that she was putting a sling under the resident and the resident started punching her. The CNA stated that she was shocked. The CNA stated that Staff #13 grabbed Resident #1's hand and pitted against his chest, assuming to stop the resident from hitting her. The CNA stated that Staff #13 started speaking to the resident by saying, fucking pussy, how dare you put hand on a woman, I should put my hands on you. The CNA stated that the resident said fuck you and hope you die. The CNA stated that Staff #13 said the same thing to the resident. The CNA stated that she went to another CNA and the CNA told her to speak with the supervisor. The CNA stated that she filled out a report after speaking with the supervisor. The CNA further stated that she considered the incident abuse on the resident. The CNA stated that the resident had a mental health problem. The CNA stated that Staff #13 was sent home. An interview was conducted with the Director of Nursing (DON/Staff #20) and present during the interview was Regional Nurse Consultant (Staff #35). The Regional Nurse Consultant stated that abuse is neglect, misappropriation, verbal, and the DON stated that abuse is also emotional. The Regional Nurse Consultant stated that verbal abuse is calling somebody asshole, and degrading them verbally. The Regional Nurse Consultant also included intimidation and physical abuse such as hitting, slapping, strangling, as examples of abuse. The Regional Nurse Consultant stated that in the dementia care unit, the residents have specific needs and it depends on their plan of care. The Regional Nurse Consultant stated that the process of (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035099	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2026
NAME OF PROVIDER OR SUPPLIER Sandstone of Tucson Rehab Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 2900 East Milber Street Tucson, AZ 85714	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	deescalating involved safety first. The DON stated that deescalating involved providing space, but not stepping away from a resident on a sling during a transfer lift. Regarding Resident #1, the DON stated that the resident was being cared for by two CNAs (Staff #7 and Staff #13), the resident became combative at some point, and Staff #13 tried to block the resident from hitting Staff #7. The Regional Nurse Consultant stated that she did not ask for a visual on how Staff #13 blocked the resident from hitting Staff #7. The Regional Nurse Consultant stated that the plan of care for a resident in the dementia care unit would include deescalating, stepping away as long as it was safe to do so, switching staff, and re-approaching. The DON stated that she would look at the resident's plan of care to determine what to do to that specific resident. The DON stated that the impact of not stepping away from Resident #1 during his behavioral outburst could make the resident continue his outburst. An interview was conducted on July 31, 2026, at 1:24 PM with the Administrator (Staff #8). The Administrator stated that abuse is any type of physical, mental, financial, sexual, technical, and infliction on a resident. The Administrator stated that a physical abuse example would be hitting a resident and handling a resident roughly. The Administrator stated that a verbal abuse example would be swearing at a resident using foul language such as using the F word and belittling the resident using the stupid word. The Administrator stated that the process of providing care to residents in a behavioral unit included having a care plan that was individually tailored for each resident so the care can be provided appropriately, using cares in pairs requiring 2 staff member to provide care in repositioning the resident; during transferring the resident; or maybe due to resident being abusive to make sure that the resident and the staff remain safe, and due to residents making false allegations. The Administrator also stated that the process of deescalating a resident with a behavioral outburst included encouraging everyone to back away, ask the residents what they needed, and for the staff to wait until the resident calms down before the staff continue to engage with the care. Regarding Resident #1's incident, the Administrator stated that their Behavioral Consultant Nurse (Staff #30) interviewed the staff member involved in the incident. The Administrator stated that she did not consider Resident #1 incident abuse because the CNA (Staff #13) was trying to protect the other CNA (Staff #7) from Resident #1. The Administrator stated that the CNA (Staff #13) statement was that he did not strike or hold the resident. The Administrator stated that Staff #1 saw the incident differently, and stated that the Staff #13 was the one being held by Resident #1 by holding his hand. The Administrator stated that Staff #13 put his hand in between the other CNA (Staff #7) and Resident #1 and then Resident #1 squeezed Staff #13's hand. The Administrator also stated that Staff #13 said that it was more of a joking like interaction with Resident #1 when the Staff #13 said to quit squeezing his hand. The Administrator stated that Staff #13 and Resident #1 were bantering back and forth and that Staff #13 does that in a none abusing way but in a conversation that would distract Resident #1. An interview was conducted on July 31, 2026, at 1:48 PM with the Behavioral Health Consultant (Staff #30). The Behavioral Health Nurse Consultant stated that her responsibilities included assisting with training and consulting. The Behavioral Health Nurse Consultant stated that Resident #1 baseline behavior included being aggressive, striking at a staff, and his care plan intervention included 2 to 1 staff when providing care. The Behavioral Health Nurse Consultant stated that she interviewed Staff #13 and during the interview, Staff #13 described Resident #1 as aggressive, trying to strike at a female small CNA (Staff #7), Staff #13 blocked Staff #7 from getting punched, the resident grabbed the Staff #13 arm while he was trying to block Staff #7 from getting hit. The Behavioral Health Nurse Consultant stated that the CNA (Staff #13) jokingly deescalated the resident by saying don't be a sissy. The Behavioral Health Nurse Consultant stated that she would not say don't be a sissy to a resident because it is not a term she would use. The Behavioral Health Nurse (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035099	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2026
NAME OF PROVIDER OR SUPPLIER Sandstone of Tucson Rehab Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 2900 East Milber Street Tucson, AZ 85714	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Consultant stated that she would use other techniques to distract a resident during a conversation. The Behavioral Health Nurse Consultant stated that the impact of saying to a resident don't be a sissy would depend on the resident and the relationship between the CNA and the resident. The Behavioral Health Nurse Consultant stated that the resident used the F word often, and if the resident used the F word in front of her, she would just smile because she would not take it personally. The Behavioral Health Nurse Consultant stated that later on when the Staff #13 took Resident #1 back to his room by himself, the resident tried to strike Staff #13 face, which happened shortly after the incident. The Behavioral Health Nurse Consultant stated that she checked on the resident after Staff #13 was sent home. The Behavioral Health Nurse Consultant stated that she was present while Staff #7 was being interviewed by her manager, and she did not interview nor take CNA (Staff #7) statement. A review of the facility policy titled, Abuse and Neglect, with an adopted date of May 1, 2024, revealed that it is the policy of the facility to provide professional care and services in an environment that is free from any type of abuse, corporal punishment, involuntary seclusion, misappropriation of property, exploitation, neglect, or mistreatment. This includes but is not limited to freedom from any physical or chemical restraint not required to treat the resident's medical symptoms. The facility follows the federal guidelines dedicated to prevention of abuse and timely and thorough investigations of allegations. Physical abuse includes but is not limited to infliction of injury that occurs other than by accidental means. Examples: hitting, slapping, kicking, squeezing, grabbing, pinching, punching, poking, twisting, roughly handling. Verbal abuse includes but is not limited to the use of oral, written or gestured language. This definition includes communication that expresses disparaging and derogatory terms to residents within their hearing/seeing distance. Examples: name calling, swearing, yelling, threatening harm, trying to frighten the resident, racial slurs, etc. A review of the facility policy titled, Resident Rights, with an adopted date of May 1, 2024, revealed that it is the policy of the facility that all resident rights be followed per state and federal guidelines as well as other regulative agencies. The Resident has the right: To be treated with consideration, respect, and full recognition of his or her dignity and individuality. To be free from verbal, sexual, mental or physical abuse, corporal punishment, involuntary seclusion and any physical or chemical restraint imposed for purposes of discipline or convenience or for other than treating medical symptoms. A review of the facility policy titled, Care Planning, with an adopted date of May 1, 2024, revealed that it is the policy of the facility that the interdisciplinary team (IDT) shall develop a comprehensive care plan for each resident. A review of the facility policy titled, Care Planning - Baseline, with an adopted date of May 1, 2024, revealed that (3.) The baseline care plan will be used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered care plan. (4.) The resident and their representative will be provided a summary of the baseline care plan that includes but is not limited to: The initial goals of the resident; A summary of the resident's medications and dietary instructions; Any services and treatments to be administered by the facility and personnel acting on behalf of the facility; and Any updated information based on the details of the comprehensive care plan, as necessary.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035099	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2026
NAME OF PROVIDER OR SUPPLIER Sandstone of Tucson Rehab Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 2900 East Milber Street Tucson, AZ 85714	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and review of facility documentation and policies, the facility failed to follow 1 resident (#1) care plan during a behavioral episode. The deficient practice could place the residents safety at risk. Findings include: Resident #1 was admitted to the facility on [DATE], with diagnoses of hemiplegia, chronic kidney disease, Schizoaffective Disorder, Type 2 Diabetes Mellitus, Major Depressive Disorder, and dementia. A care plan revised on November 12, 2025, revealed the following focus areas that included: Behavior problem as evidenced by being verbally and physically aggressive with staff and refusing care from people of different ethnicities; Risk for altered mood state and impaired psychosocial well-being related to schizoaffective disorder, major depressive disorder, impulsivity, and periods of emotional dysregulation. His mood may fluctuate with or without an identifiable trigger and can be exacerbated by overstimulation, particularly during personal care or other high-demand situations. During periods of distress, the resident may demonstrate ineffective communication, impulsive behaviors, difficulty maintaining positive interpersonal relationships with staff and peers, and reduced ability to cope with environmental stressors. Interventions included: cares in pairs, staff to approach the resident in a calm, consistent, and non-threatening manner while minimizing environmental stimulation during care and other potentially stressful interactions allow adequate time for processing, offer simple choices, and use clear, concise communication to reduce frustration and support effective expression of needs, provide positive redirection and reassurance as needed, provide the resident with supportive care and services to promote a sense of safety, well-being and positive self-image, and if safe, allow the resident personal space. A review of the annual Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental status (BIMS) score of 10, indicating cognitive moderate impairment. The assessment included that the resident exhibited physical and verbal behavioral symptoms and exhibited behaviors of rejection of care. A nursing progress note dated July 23, 2026, revealed that the resident was alert, compliant with his medications, and denied any pain or discomfort. Per the document, the resident had a behavior history of physical and verbal aggressions with care staff, the resident was verbally and physically aggressive during care with the certified nursing assistants (CNAs), and the resident was redirected but continued to be verbally and physically aggressive during care. A facility 5-day investigation report dated July 27, 2026, revealed that a Certified Nursing Assistant (CNA staff # 7) reported to the Assistant Director of Nursing (ADON/staff #15) that while she was assisting CNA (staff #13) transfer Resident #1, the resident punched her in the stomach and staff #13 held the resident's hand tightly and would not let go. The report included that CNA (staff #13) lightheartedly told the resident to stop being a sissy. The facility 5-day investigation report revealed a conclusion that the allegation of abuse was not verified. A facility 5-day investigation report dated July 27, 2026, revealed that the Behavioral Health Consultant (Staff #30) met with Resident #1 on July 22, 2026 and the Social Services met with Resident #1 on July 23, 2026. The resident did not recall the event. The report also revealed that CNA (Staff #7) and CNA (Staff #13) were interviewed. According to the facility's interview summary for Staff #7, Staff 13 requested Staff #7's assistance with placing sling under Resident #1. While the sling was being positioned, Resident #1 punched Staff #7 in the stomach. Staff #13 blocked Resident #1's fist from striking Staff #7. Resident #1 then grabbed Staff #13's hand and pulled it toward his chest. Staff #7 reported that Staff #13 was holding Resident #1's hand tightly while Staff #13 reported that Resident #1 was holding his hand tightly and (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035099	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2026
NAME OF PROVIDER OR SUPPLIER Sandstone of Tucson Rehab Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 2900 East Milber Street Tucson, AZ 85714	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would not let go. Staff #7 described a back and forth interaction between Resident #1 and Staff #13 throughout the care encounter. According to the facility's interview summary for Staff #13, Resident #1 attempted to punch Staff #7 in the stomach. Staff #13 blocked the punch, after which Resident #1 grabbed Staff #13's hand and squeezed it tightly. Staff #13 acknowledged saying, jokingly, stop being a sissy, in reference to how Resident #1 was squeezing his hand. Staff #13 further reported that Resident #1 told him, I hope you go to hell and Staff #13 responded, that's ok, it doesn't matter. Staff #13 stated he did not recall saying or doing that could have been misunderstood by Staff #7. The facility's interview summary further documented that while Staff #13 was later wheeling Resident #1 back to his room, Resident #1 attempted to strike Staff #13 in the face. Staff #13 reported that he blocked the resident's punch. Staff #13 acknowledged that he could have used better judgement and professionalism when communicating with Resident #1. Despite, Resident #1's comprehensive care plan interventions which included for the staff to approach the resident in a calm, consistent, and non-threatening manner while minimizing environmental stimulation during care and other potentially stressful interactions, allow adequate time for processing, offer simple choices, and use clear, concise communication to reduce frustration and support effective expression of needs, provide the resident with supportive care and services to promote a sense of safety, and if safe, allow the resident personal space, the incident on July 22, 2026, revealed that CNA (Staff #13) did not follow the resident's care plan interventions. Instead, per the 5-day investigation report dated July 27, 2026, the summary interview of Staff #7 revealed that Staff #7 believed that CNA (Staff #13) was holding Resident #1's hand tightly. Per the summary report, CNA (Staff #13) said jokingly, stop being a sissy, about how the resident was squeezing his hand. An interview was conducted on July 31, 2026, at 11:04 AM, with the CNA (CNA/Staff #13) who stated that his dementia care training involved getting down to the residents' level to make them comfortable. Staff #13 also stated that if there was a resident with behavioral outburst, he would leave them alone, he would stand away from the resident so the resident would not get more mad. An interview was conducted on July 31, 2026, at 12:03 PM with a Licensed Practical Nurse (LPN/Staff #43) who stated that Resident #1 needed to be changed, the CNA (Staff #7) was a new CNA and the other CNA (Staff #13) was rough, and he was sent home. The LPN stated that she assessed the resident and he did not have marks. An interview was conducted on July 31, 2026, at 12:45 PM with the Assistant Director of Nursing (ADON/Staff #15) who stated that the resident was being changed, the resident became combative so the CNAs (Staff #7 and Staff #13) had to deescalate the situation. The ADON stated that the resident was hitting and punching the CNA (Staff #7) and the other CNA (Staff #13) attempted to deescalate by keeping the resident from hitting the other CNA (Staff #7) further. The ADON stated that the resident's care plan included cares and pairs, making sure to take a calm approach, giving the resident space to calm down, and then re-approach. A phone interview was conducted on July 31, 2026, at 12:54 PM with a CNA (Staff #7). The CNA stated that abuse could be financial, physical, and verbal. The CNA stated that she was called by another CNA (Staff #13) to Resident #1's room to assist with the transfer lift, to get the resident up for dinner, and it happened on a Wednesday. The CNA stated that CNA (Staff #13) started speaking to the resident by saying fucking pussy, how dare you put hand on a woman, I should put my hands on you. The CNA stated that the resident said fuck you and hope you die. The CNA stated that the other CNA (Staff #13) said the same thing to the resident. An interview was conducted with the Director of Nursing (DON/Staff #20) and present during the interview was Regional Nurse Consultant (Staff #35). The Regional Nurse Consultant stated that abuse is neglect, misappropriation, verbal, and that in the dementia care unit, the residents have specific needs and it depends on their plan of care and that the process of deescalating involved safety first. The DON (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035099	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2026
NAME OF PROVIDER OR SUPPLIER Sandstone of Tucson Rehab Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 2900 East Milber Street Tucson, AZ 85714	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated that deescalating involved providing space, but not stepping away from a resident on a sling during a transfer lift. Regarding Resident #1, the DON stated that the resident was being cared for by two CNAs (Staff #7 and Staff #13), the resident became combative at some point, and one of the CNAs (Staff #13) tried to block the resident from hitting the other CNA (Staff #7). The Regional Nurse Consultant stated that the plan of care for a resident in the dementia care unit would include deescalating, stepping away as long as it was safe to do so, switching staff, and re-approaching. The DON stated that she would look at the resident's plan of care to determine what to do to that specific resident. The DON stated that the impact of not stepping away from Resident #1 during his behavioral outburst could make the resident continue his outburst. An interview was conducted on July 31, 2026, at 1:24 PM with the Administrator (Staff #8). The Administrator stated that abuse is any type of physical, mental, financial, sexual, technical, and infliction on a resident. The Administrator stated that a physical abuse example would be hitting a resident and handling a resident roughly. The Administrator stated that the process of providing care to residents in a behavioral unit included having a care plan that was individually tailored for each resident so the care can be provided appropriately, using cares in pairs requiring 2 staff member to provide care in repositioning the resident; during transferring the resident; or maybe due to resident being abusive to make sure that the resident and the staff remain safe, and due to residents making false allegations. The Administrator also stated that the process of deescalating a resident with a behavioral outburst included encouraging everyone to back away, ask the residents what they needed, and for the staff to wait until the resident calms down before the staff continue to engage with the care. Regarding Resident #1's incident, the Administrator stated that their Behavioral Consultant Nurse (Staff #30) interviewed the staff member involved in the incident. The Administrator stated that the process starts on admission with a baseline care plan, then the full care plan would be developed by each discipline and modified as changes in the resident's condition occur, as when events such as accusation of abuse occur, and the care plan would be updated quarterly and annually. The Administrator stated that the care plans should be followed to assure care was provided appropriately for the resident. The Administrator further stated that if a resident's care plan was not followed, the impact on the resident could potentially result in the resident receiving inappropriate care. An interview was conducted on July 31, 2026, at 1:48 PM with the Behavioral Health Consultant (Staff #30) who stated that the CNA (Staff #13) jokingly deescalated the resident by saying don't be a sissy. The Behavioral Health Nurse Consultant stated that she would not say don't be a sissy to a resident because it is not a term she would use, and that she would use other techniques to distract a resident during a conversation. The Behavioral Health Nurse Consultant stated that the resident used the F word often, and if the resident used the F word in front of her, she would just smile because she would not take it personally. A review of the facility policy titled, Care Planning, with an adopted date of May 1, 2024, revealed that it is the policy of the facility that the interdisciplinary team (IDT) shall develop a comprehensive care plan for each resident. A review of the facility policy titled, Care Planning - Baseline, with an adopted date of May 1, 2024, revealed that (1.) to assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within 48 hours of admission. The baseline care plan will be used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered care plan.		