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	11/03/2023

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 42319 Based on observations, staff interviews and facility policy, the facility failed to ensure that meals were provided to residents seated together at the same time. This practice could result in compromised dignity for the residents and a decrease of mental health. Findings include: An observation was conducted on 11/01/23 at 12:30 PM of the downstairs B hall dining room of residents seated at tables with drinks. A food cart was brought to dining room, and trays are passed to residents as they are encountered on the cart without regard to the residents seating arrangements. A corner table seating 2 residents are served first and second to last, and all other tables are provided food in a similar manner. An interview was conducted on 11/02/23 at 2:01 PM with the Food Service Director (staff #81) who said that staff are supposed to serve all persons at the table at the same time and that they did not do so. An interview was conducted on 11/02/23 at 3:26 PM with the Administrator (staff #150) who said that staff should be serving tables all at once, not sporadically, and that residents being provided their meals at different times did not meet her expectations.

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47911 Based on review of resident council minutes, resident and staff interviews, and policy and procedures, the facility was unable to demonstrate that resident council meetings were held regularly and that their response and rationale to grievances and recommendations voiced during resident council meetings were addressed. The facility census was 154. The deficient practice could result in residents' concerns, views, grievances or recommendations not being considered or acted upon by facility staff. Findings include: A review of the resident council minutes for the past 6 months, revealed no evidence of written documentation of feedback provided to residents regarding issues brought forth during resident council. A review of the grievance log revealed no evidence of written documentation that grievances had been addressed. The log denotes an open date but not a closed date. The grievance log provided by the director of social services, staff #8, revealed no evidence of any grievances logged prior to [DATE]. Additionally, after reviewing grievances for resident #95 on [DATE] and for resident #143 on [DATE], there was no evidence of written documentation that the outcome had been discussed or acknowledged by the residents. An interview was conducted on [DATE] at 2:57 P.M. with the Ombudsman, individual #148. The ombudsman stated that the most recent resident council meeting had been canceled by the facility and had not been rescheduled. She stated that 3 residents had waited to participate in the meeting, but it never occurred. She further stated that no outcomes or updates from prior concerns are ever reported back to the residents. She stated that 'they' (the residents) never know the status of what had brought up previously and that nothing ever comes to fruition. A meeting was conducted on [DATE] at 1:30 P.M. with the following residents in attendance: #18, #95, #110 and #77. Resident #77 stated that the last meeting had been canceled by the facility due to COVID. Resident #95 stated that when issues are brought forward, residents are thanked and told the facility would look into it, but no one ever reports back. The other residents present at the meeting were observed to nod in agreement. Some of the issues brought forward and not addressed per the residents included: [NAME] Flag request, quality of food, installation of grab bars, observance of allergy alerts on food slips, a resident refrigerator with expired food and dirty shelves that had not been cleaned for over 2 months and night time staffing issues. Resident # 18 stated that she had filed a grievance last year regarding a CNA but never heard back. Resident #95 stated that he also had filed a grievance in [DATE] and had not heard back. Resident #95 stated that meetings were initially scheduled the last Tuesday of every month at 2:00 P.M. yet the this is not being adhered to by the facility, adding that cancellations are driven by the facility. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on [DATE] at 7:57 A.M. with the activities director, staff #80. Staff #80 stated that she attends the resident council meetings but does not run them. She stated that the resident council president runs the meetings but the director of social services, staff #8, guides them to remain on topic. She stated that staff #8 finds out what the issues are from the residents and tries to problem solve. She stated that he additionally meets with the applicable departments contingent on the type of concern voiced to relay the expectations and attempts to find a viable solution. She reviewed the previous resident council meeting notes and stated that she did not see any documentation of feedback provided to the residents. She stated that the last resident council meeting had been canceled and that it had been canceled by a resident and not yet rescheduled. She further stated that that the [DATE] meeting had also been canceled due to a COVID-19 outbreak. Staff #80 stated that she was not familiar with the protocol of conducting resident council meetings if there is an outbreak of COVID. She did state that if she was in charge of the resident council meetings, she would meet with the council members individually if unable to meet as a group to determine what their concerns or suggestions are. She stated that the risk for not having regular meetings or communicating back to the residents on concerns raised during the meetings could lead residents to feel unheard, kept in the dark and or upset. An interview was conducted on [DATE] at 8:14 A.M. with staff #8. He stated that he had been facilitating the resident council meetings since [DATE] and essentially only acted as a scribe and provided follow-up to the residents. He stated that feedback on previous issues were only provided verbally and that there was no documentation of the follow-up. He further stated that he is also in charge of the grievance process. He stated that until [DATE] all responses to formal resident grievances were verbal. He stated that the actual grievances are kept from one survey to the next and not beyond that timeframe. He provided the grievance log that dated back to [DATE] and when asked about prior grievances, he stated he was unable to locate them. Recent grievances for resident #95 on [DATE] and for resident #143 on [DATE] were reviewed. Staff #8 acknowledged that neither grievance response had the resident's signature or documented acknowledgment in the resident's record. Staff #8 stated that the current form is being revised to ensure it includes the resident's acknowledgement (signature) of the grievance outcome/resolution. He stated the risk for not reporting back to residents either for the concerns brought forward during resident council or via the grievance process could include miscommunication and a loss of trust. An interview was conducted on [DATE] at 8:53 A.M. with the administrator, staff #63. Staff #63 stated that her expectations for resident council is that residents are listened to and then make the necessary changes, as applicable. She stated that she wants the residents to feel heard and the goal is to make sure that they have what they need. She stated that the risk for not reporting back to residents can include the residents not feeling heard. A review of the resident rights -right to organize and participate in resident groups policy dated May, 4, 2023 revealed that the facility will act promptly regarding grievances and recommendations and will be able to demonstrate the facility response and rationale for the response in relation to the expressed grievance or recommendations; however, there was no evidence of a facility response to resident council concerns. A review of the grievance policy with a revise by date of [DATE] revealed that the grievance officer with the assistance of social services, oversees the grievance process. Grievances are noted to be tracked and a written grievance decision is to be issued; however, there is no written documentation that decisions were provided to those filing the grievances.

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents a notice of rights, rules, services and charges. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49199 Based on clinical review, staff interviews and facility policy and procedure, the facility failed to ensure that one resident (#401) was informed of their rights during their stay at the facility. The deficient practice could result in residents not understanding their rights and being able to advocate for themselves. Findings include: Resident was admitted on [DATE] with a fracture of the left patella. During the resident interview, #401 stated that she was curious about her rights as a resident. When asked if she was provided a copy of here resident rights, she replied no. An interview was conducted on November 2, 2023 at 03:22 PM, with Licensed Practical Nurse (LPN staff #44). He stated when a new resident is admitted , the nurse reviews an admission packet with the resident, and has them sign the documents in the packet. Once signature is completed, the documents go to medical records for scanning into the electronic medical record. A review of the admission packet did not reveal a copy of the resident rights. An interview was conducted on November 2, 2023 at 03:35 PM, with the Director of Nursing, (DON staff # 24) and the Assistant Director of Nursing, (ADON staff #69). Staff #69 stated, there are two admission packets for a resident upon admission. One is the clinical packet which is completed by the nurse with the resident. The second packet is completed by the ward clerk with the resident. The second packet includes non clinical, but does have basic information and resident rights information. She also stated, the facility has not had a ward clerk for a time period, but could not recall how long it has been, A new ward clerk had been hired and was completing the training . However, she did state that during the time period of not having a ward clerk, no one was completing the second admission packets and they will not begin to complete them until the new ward clerk is working. When directly asked if anyone had been giving residents a copy of their rights, staff # 69 stated, no. Staff # 24 stated, it is not a nurses' job to complete the resident rights form. Review of the policy, that is included in the admission packet, is a copy of the patient's rights along with an acknowledgement of receipt.

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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** 47341 Based on clinical record review, staff interviews and review of policy and procedure, the facility failed to ensure one was resident (51) was not physically abused by another resident (154). Findings include: Resident #51 was admitted on [DATE] with diagnoses that included dementia, major depressive disorder, and encephalopathy. Her orders included mirtazapine and trazadone to treat her depression, and donezepil and Depakote to manage dementia and behaviors. In a Minimum Data Set (MDS) assessment done on 01/26/2023 that recorded data from a 7 day look back period, Resident #51 scored an 8 on a Brief Interview for Mental Status which suggested moderate cognitive impairment. She did not display any behaviors such as aggression or wandering in the look back period. In her Care plan initiated in August 2023, Resident #51 has goals related to her disorientation and social skills with interventions that included orientating her to her environment and helping increase her comfort level and awareness. In a nursing progress note dated 2/10/2023 at 6:00 PM, Resident #51's daughter in law expressed concern that there had been three occurrences of a resident to resident altercation with her mother as the victim. Resident # 154 was admitted on [DATE] with diagnoses that included dementia and acute kidney failure. A review of her physician orders revealed no order for behavior monitoring. She was prescribed psychotropics that included Depakote, trazodone, quetiapine, and hydroxyzine. Her care plan initiated on 1/31/23 does not have any goals or interventions related to her physical aggression towards staff and other residents. According to the nursing behavior notes, the resident had incidents of acting out behaviors on 1/31/23, 2/1/23, 2/2/23, 2/4/23, 2/6/23, 2/7/23, 2/8/23, and 2/9/23. Internal incident reports were completed for acts of physical aggression by Resident #154 on 2/4/23, 2/7/23 and 2/10/23, as well as an allegation of abuse on 1/30/23 naming resident #154 as the alleged perpetrator against another resident. Certified Nursing Assistant daily task documentation for Behavior tracking was not completed for Resident #154. A nursing progress note dated 1/20/2023 at 8:35 PM, states Resident in the hallway wandering into other residents rooms. Nurse re-directed resident but she was upset and slapped nurse on left cheek. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A note dated 1/21/2023 at 12:13 PM states Resident alert. Wandering the unit. Also wanders into other resident's rooms. Needs constant supervision and redirection. This morning was seen standing in front of other residents leaning forward to her face. The other resident became upset and started yelling. [NAME] swung at her. A subsequent note dated 1/22/2023 6:44 PM states Tried hitting several residents through out the shift. On 1/26/2023 4:25 PM a note documents [Patient] punched the nurse in the left chest and then punched her in the mouth. Nurse told the pt. she absolutely could not hit any of the staff or other residents. [Patient voiced understanding] but reiteration is needed. The incident note from 1/30/2023 5:36 PM reads Resident back handed another resident in 114 B across her back. On 2/10/2023 12:07 PM the incident with resident #51 is documented in the electronic health record: Resident did hit another resident across the face today, without warning and there were no triggers. Went over residents medications with provider and he would like to change her depakote from ER to depakote IR 500mg twice a day. Provider would also like resident to be on hydroxyzine 50mg every 12 hours. Will change medication orders according to recommendations of Dr. [NAME]. In a follow up note on 2/10/2023 5:19 PM the facility documented that in previous conversation with the Power of Attorney, they discussed Resident #154 does enjoy doing painting. Spoke with nurse manager and she said we will implement in patients care plan to do one on one activities to stimulate residents mind. There were no goals or interventions related to activities added to the care plan. In an interview with Licensed Practical Nurse (LPN) Staff #140 on 11/1/23 at 10:15 AM, she stated that care plans should be updated after every incident and that will be done by the Unit manager and/or the Director of Nursing (DON) at the Interdisciplinary Team meeting. She stated that verbal and physical aggression should be careplanned for repeat offenders. Typical interventions for a resident that presented the way Resident #154 did would be redirecting into quiet activity or possible pain management. Careplanning is important because it reflects how the staff would move forward and know which approaches will work with the patient. In an interview with the DON, Staff #24, on 11/1/23 10:35 AM, she stated that her expectation is that physical and verbal altercations are careplanned for, and the particular interventions will depend on the individual situation, but it can include items such as engaging with social services, following up with the physician, or orders for behavior monitoring. The DON stated a combative resident would benefit from individualized careplanning, and anything specific to them should be careplanned. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In their policy entitled Freedom from Abuse, Neglect, and Exploitation- Preventing and Prohibiting Abuse last revised 11/2017, it states The facility's policy is to prohibit and prevent abuse .of residents .The facility screens prospective residents to determine if the facility has the capability and capacity to provide the necessary care and services for resident admitted to the facility. The policy goes on to address prevention stating Staff will identify, assess, develop care plan interventions, and monitor residents with needs and behaviors that might lead to conflict or neglect, such as: verbally aggressive behavior, and physically aggressive behavior, .wandering into other's room/space.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47911 1. Based on clinical record review, staff interviews, and policy review, the facility failed to ensure a referral for a PASARR (Preadmission Screening and Resident Review) level II determination was obtained timely for two residents (#56 and #38). The deficient practice could result in the resident not receiving the appropriate level of services. Findings include: Resident #56 was admitted [DATE] with diagnosis including schizoaffective disorder, unspecified bipolar disorder and epilepsy. A review of the quarterly MDS (minimum data set) dated October 18, 2023 revealed a BIMS (brief interview of mental status) score of 13, indicating the that the resident is cognitively intact. The same MDS revealed, under section I, active diagnosis including seizure disorder or epilepsy, bipolar disorder and schizophrenia. An interview was conducted on November 2, 2023 at 3:35 PM with the Director of Social Services, staff #8. Staff #8 stated that resident #56 did require a level II PASARR review and that he had sent the PASARR to the state for review in October 2023 but was unable to provide documentation that it had gone up on the date he reported or that a response had been rendered by the state. Staff #8 stated that because he had not received an email response from the state he opted to send a follow-up email dated November 2, 2023. Staff #8 was able to provide the email dated November 2, 2023 to the state for a level II PASARR review. Staff #8 stated that the risk of not sending the PASARR timely for review could include the resident not receiving the appropriate services based on the diagnosis. An interview was conducted on November 2, 2023 at 4:13 PM with the Administrator, staff #63. Staff #63 stated that the expectation is that a PASARR is conducted on admission and reviewed for accuracy. The expectation for a level II PASARR referral, based on the diagnosis, is that it is sent timely to the respective state agency. She stated that the risk of a level II referral not being sent or not being sent timely could include that a resident might not be appropriate for the setting or potentially be a risk to self or others if they do not receive the appropriate treatment based the outcome of the level II PASARR referral. A review of the resident assessment policy with a revise date of August, 2018 revealed that any resident with a newly evident of possible serious mental disorder or related condition is to be referred by the facility to the appropriate state designated mental health authority for review to ensure that residents are offered the most appropriate setting for their need and receive appropriate services for their needs. However, there was no evidence that the level II PASARR referral had been sent prior to November 2, 2023. 49199 (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Based on clinical record review, staff interviews, and policy review, the facility failed to ensure a referral for a PASARR (Pre-Admission Screening and Resident Review) level II determination was obtained timely for one resident (#38). The deficient practice could result in the resident not receiving the appropriate level of services. Findings include: Resident #38 was first admitted to the facility on [DATE]. The PASARR completed dated June 2023, reveals diagnoses of major depression, bipolar disorder, and anxiety disorder. The PASARR also revealed that resident #38 had exhibited suicidal talk, however it did not reveal a suicide attempt. Record review of admitting facility notes dated July 11, 2023 at 04:05 PM, revealed prior to his admission July 7, 2023, he was hospitalized for a suicide attempt where he cut both wrists. Record review of the history and physical (H&P), dated October 2, 2023, from the referring facility revealed that #38 was suspected to have been a drug overdose and was sent to in-patient behavioral hospitalization . Further record review revealed resident #38 had a psychiatric history with diagnoses of major depressive disorder, bipolar disorder, past history of suicidal ideation, history of suicide attempts by overdose and cutting. The PASARR level I screening dated October 3, 2023, from the hospital, revealed the resident had a diagnoses of depression, bipolar disorder, and an inpatient psychiatric hospitalization beginning on September 27, 2023, and that a PASARR level II referral was not necessary. Resident #38 was admitted again to the facility on [DATE], with admitting diagnoses of anxiety disorder, bipolar disorder, major depressive disorder, and suicidal ideation's. Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed diagnoses that included bipolar, anxiety, and depression disorder. Record review also revealed a PASARR completed by the admitting facility dated October 30, 2023, with diagnoses of major depression, bipolar disorder, and anxiety disorder. However, it is not noted that resident #38 had a inpatient psychiatric hospitalization . An interview was conducted on November 1, 2023 at 11:13 AM, with the Director of Social Services (staff #8). He stated, every resident diagnoses is reviewed, and if there is a diagnosis of dementia the PASARR is finished. He further stated, without a diagnosis of dementia, the PASARR is submitted to the MDS (Minimum Data Set) Coordinator and that individual makes the decision of a level II. He stated, the first time resident #38 was admitted in July, 2023 he was only admitted for two weeks. The PASARR for the admission of October 6, 2023, was completed on October 30, 2023. Staff #8 stated he is awaiting signature from resident #38's power of attorney, before he can submit the PASARR level II. He stated when a resident admits, there is a 30 day timeframe to complete the Level 2. The level II from the July 2023 admission was not completed because resident #38 was stable. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A second interview was conducted on November 2, 2023 at 12:48 PM, with the Director of Social Services (staff #8). He stated, he had updated resident #38's PASARR again on November 2, 2023, because it was not noted he had an inpatient psychiatric hospitalization . When author asked staff #8 if a suicide attempt would warrant a level II, he answered yes. When author asked staff #8 to review the PASARR dated June 2023, he admitted a mistake had been made in completing the PASARR, because resident #38 had an attempted suicide within the past 2 years. Review of the PASARR screening coordination policy dated August 2018 stated, residents are offered the most appropriate setting for their needs and receive the services for their needs in those settings. Any resident with newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred by the facility to the appropriate state-designated mental health or intellectual disability authority for review.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47911 Based on clinical record review, staff and resident interviews and policy review, the facility failed to ensure one resident (#114) or resident's representative was able to participate in the care planning process. The sample size was 31. The deficient practice could result in residents and representatives not participating in and understanding their plan of care. Findings include: Resident #114 was admitted on [DATE] with diagnosis including peripheral vascular disease, morbid obesity, gout, difficulty walking, weakness, hypothyroidism and hypertension. A review of the quarterly MDS (minimum data set) dated October 3, 2023 revealed a BIMS (brief interview of mental status) score of 15, indicating that the resident is cognitively intact. A review of the progress notes in the resident's electronic health record did not reveal evidence of the resident's participation in the care plan conference. A review of the IDT (interdisciplinary care conference) summary did not reveal evidence of the resident's participation in the care plan. An interview was conducted on November 2, 2023 with resident #114. The resident stated that he had not been invited to his care plan meetings for about a year. He stated that he is fairly independent and would have liked to provide input to be able to return to the community. An interview was conducted on November 2, 2023 at 12:00 PM with the director of social services, staff #8. The director of social services stated that case management conducts the initial care plans, baseline care plans are done with the MDS nurse and that he is responsible for the quarterly care plans. Staff #8 demonstrated the scheduling process, stating that he would receive notification that the care plan is due and he then opens the forms and proceeds with scheduling. He stated that invitations are sent to the team and the resident or designated person. He stated that resident participation is generally hit and miss and that he sometimes puts a note in the care plan if a resident did not attend, but not always. Staff #8 reviewed the record for resident #114 and stated that he did not see documentation where the resident had been invited, attended or had refused the invitation. Staff #8 stated on the current care conference form there is no check box to indicate resident attendance, only boxes for other team members. He further stated that he did not recall whether the resident had in fact attended the last care conference of not. He stated that the risk for not inviting a resident to their care conference goes back to facility to resident communication issues and the ability of the resident to participate in their own care. (continued on next page)

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	035099	A. Building B. Wing	11/03/2023

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on November 2, 2023 with the administrator, staff #63. Staff number #63 stated that a care plan should be reflective of the patient's care and that care plans should be updated as changes occur. She stated that everyone on the interdisciplinary team, to include the resident, are participants and invited to attend. She further stated that if the resident is alert and oriented, then they would be asked if they would want to attend or have a family member attend, but the expectation is that the invitation is extended to the resident or representative as applicable. She stated that the risk of not rendering an invitation, for the resident or respective representative/ family members, to attend the care conference could include that the resident would not know what is on their care plan and understand what is being done for them and with them. A review of the care plan policy dated November, 2017 revealed that the resident and or family member would be notified in advance of the care plan meeting to facilitate attendance and if the resident is unable to attend, then the facility will document in the medical record the reasons and steps taken to facilitate participation; however, resident #114 stated that he was not invited to care plan meetings for the past year, and no documentation of advance notification, attendance or declination were evident in the medical record.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49325 Based on review of clinical records and policy, observations, and staff interviews the facility failed to ensure that at least one medication was not administered as ordered for three residents # 448, # 38, and # 99 out of five residents observed. The deficient practice of incorrect medication administration does not align with accepted professional standards of practice and may result in undesirable medication-induced harm due to residents receiving medications that were not ordered or incorrect doses of prescribed medications. Findings include: 1) Resident # 448 admitted into the facility on [DATE] with diagnoses of Type 2 Diabetes Mellitus (DM2) with Hyperglycemia, Hypothyroidism, and Essential (Primary) Hypertension, had a medication order of Insulin Detemir: Insulin Detemir Subcutaneous Solution 100 unit/ml (Insulin Detemir) Inject 65 unit subcutaneously every morning and at bedtime for DM2. On November 2, 2023 at 7:46 AM, a medication administration observation was conducted with Licensed Practical Nurse (LPN/Staff # 44) on the 2nd floor A wing. Staff # 44 was observed administering Resident # 448 the incorrect medication: Insulin Glargine Subcutaneous Solution 100 unit/ml 65 unit -- instead of Insulin Detemir Subcutaneous Solution 100 unit/ml 65 unit. An interview was conducted on November 2, 2023 at approximately 9:00 AM with Staff # 44 regarding the medication administration error. Staff # 44 stated did not realize it was the wrong medication, would immediately contact the doctor and let the resident know about the error. On November 02, 2023 at 3:52 PM an interview with Director of Nursing (DON/Staff # 24) was conducted. DON stated that administering Glargine instead of Detemir was not appropriate and did not meet facility standards. DON stated action to be taken next is to educate, let the patient know, and write a report about it. DON stated if the medication given to Resident # 448 were not in the same classification it could have resulted in adverse reactions. 2) Resident # 38 admitted into the facility on [DATE] with diagnoses of Chronic Obstructive Pulmonary Disease, Anxiety Disorder, and Opioid Dependence had a medication order of Nicotine Patch: Nicotine Patch 24 Hour 21 Mg/24 hr. Apply 1 patch transdermally one time a day for Smoking Cessation apply daily and remove previous patch. On November 2, 2023 at 7:57 AM, a medication administration observation was conducted with Registered Nurse (RN/Staff # 17) on the 2nd floor A wing. Staff # 17 was observed administering Resident # 38 the incorrect medication: Nicotine Patch 24 Hour 7 Mg/24 -- instead of Nicotine Patch 21 Mg/24 hr. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on November 2, 2023 at approximately 9:00 AM with Staff # 17 regarding the medication administration error. Staff # 17 stated that the patch given was not the correct one after reviewing medical records. On November 02, 2023 at 3:52 PM an interview with DON/Staff # 24 was conducted. DON stated that the nicotine patch given might not have adverse effects, however this medication administration did not meet facility standards because the resident did not receive the correct dose. 3) Resident # 99 admitted into the facility on [DATE] with diagnoses of Cognitive Communication Deficit, Adult Failure to Thrive, and Cachexia, had a medication order of Aspirin Oral Capsule: Aspirin Oral Capsule 81 Mg give 1 capsule by mouth one time a day for tachycardia. On November 2, 2023 at 8:46 AM a medication administration observation was conducted with LPN/Staff # 56 on the 2nd floor C wing. Staff #56 was observed administering Resident # 99 the incorrect medication: Aspirin Oral Tablet Chewable 81 Mg -- instead of enteric-coated (EC) Aspirin oral capsule 81 Mg. An interview was conducted on November 2, 2023 at approximately 9:00 AM with Staff # 56 regarding the medication administration error. Staff # 56 figured that giving a tablet chewable instead of the oral capsule was okay because there were none in the medication cart. Staff # 56 proceeded to update the changes on the medical records regarding the medication that was given to the resident. On November 02, 2023 at 3:52 PM an interview with DON/Staff # 24 was conducted. DON stated that the appropriate action if not found in the medication cart is to do an in-house check, then a call is appropriate if it is not available. DON stated that giving the resident an oral tablet chewable instead of an oral capsule does not meet facility standards and it is a learning experience saying staff should always confirm with the provider in this matter. Review of the facility's Clinical Services Policy and Guidelines for Implementation #759 titled, Pharmacy Services Medication Administration (revised 08/2018) revealed that, medications will be administered following the six (6) rights of medication administration: a. The right order (valid prescriber order); b. The right resident; c. The right time; d. The right dose; e. The right route; f. The right practices (correct, accepted standards of practice and manufacturer's specifications).

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	035099	A. Building B. Wing	11/03/2023

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the activities program is directed by a qualified professional. 49199 Based on personnel file review, staff interviews, and the job description, the facility failed to ensure the activities program was directed by a qualified professional. Findings include: A review of the personnel file for the Activity Director (staff #80), revealed she was hired for the Activities Director position on February 28, 2023. Further review of the file did not reveal any evidence staff #80 had the qualifications for the position. An interview was conducted on November 2, 2023 at 01:30 PM, with the Director of Human Resources, (staff #58). She stated staff #80 transferred from another facility in Utah that is also a Sandstone property. At the time of her transfer, she did not have the training course for Activity Directors and the owners and Administrator (staff #63) knew that . The intention was to have staff #80 complete the training course at some point. However, as of now, there has not been any further discussion about it. She did state she will be following up on this. Review of the job description for the Activity Director revealed, the Activity Director provides an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. The description revealed the qualifications are satisfactory completion of a training course for Activity Directors and 2 years minimum of experience in a social or recreational program. Staff #80 signed the job description but it is not dated.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49325 Based on review of clinical records and policy, observations, and staff interviews the facility failed to ensure the environment for Resident # 58 remained free of accident hazards existing from medications at bedside and a potential risk of medication self-administration. The deficient practice of medication at bedside may result in undesirable medication-induced harm. Findings include: Resident # 58 was admitted initially into the facility on [DATE] and readmitted on [DATE] with diagnoses of Gram-negative Sepsis, Type 2 Diabetes Mellitus, and Major Depressive Disorder. The Annual Minimum Data Set assessment of Resident #58 dated October 29, 2023 reveals a Brief Interview for Mental Status score of 15 indicating the resident is cognitively intact. Review of medical records reveals no evidence of any medication self-administration assessment, request, or approval order by IDT (interdisciplinary team) for Resident # 58. Room observation of Resident # 58 was conducted twice on October 30, 2023 at 9:03 AM and October 31, 2023 at 1:05 PM which revealed the following medications at bedside and at reaching distance of resident: 1) Zinc Oxide 20% Ointment. 2) Antifungal Powder Miconazole Nitrate 2%. 3) Medicated Body Powder Menthol 0.15%. 4) Maximum Strength Pain and Itch Relief Cream Lidocaine HCl 4%. On October 31, 2023 at 2:40 PM an interview was conducted with LPN (Licensed Practical Nurse) Staff # 56 who stated that prescribed orders, including OTC (over the counter) Medications, constitute medications. When asked about self-administering medication policies, Staff # 56 mentioned that the process requires approval by the doctor after a comprehensive evaluation of the resident is performed. On October 31, 2023 at 2:55 PM an interview was conducted with Assistant Director of Nursing (ADON/Staff # 69) in the presence of Resident # 58 about whether the medications should be at bedside. At this time, Resident # 58 stated that the antifungal (medication 2) was left behind by a staff member who was previously applying the medication. At this time, Staff # 69 took the medication bottle and enclosed it with the worn gloves prior-to discarding. Staff # 69 walked over to a nearby computer, reviewed previous medication orders of Antifungal Powder Miconazole Nitrate 2% for Resident # 58, and verified that it had been discontinued on October 16, 2023 by the provider. (continued on next page)

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	035099	A. Building B. Wing	11/03/2023

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with LPN Staff # 131 on November 01, 2023 at 1:13 PM to confirm whether Resident #58 is able to self-administer medications which replied, no, on my side I don't have any patient like that. When asked about any risks associated with medication at bedside replied, yes, patient could take it at the wrong time, taking it off-time and double dosing. On November 02, 2023 at 9:55 AM an interview with Director of Nursing (DON/Staff # 24) was conducted. The DON confirmed that all four items found at bedside are considered medications. When asked about risks of medications at bedside stated it is not ideal and there is always risk of interactions for any medications. When asked if the expectation is to have had these medications at bedside replied, if it was discontinued it should not have been left there and if no self-administration form is present, the expectation is not to have any medications at bedside; its required to have doctor's awareness of it. Review of the facility's Clinical Services Policy and Guidelines for Implementation #554 titled, Resident Rights Right to Self-Administration Medication (revised 07/2018) revealed that a resident may self-administer medications after the interdisciplinary team has determined which medications may be self-administered and appropriate documentation of the determinations will be documented in the resident's medical record and care plan.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49325 Based on observation, interview and record review, the facility failed to ensure medication error rate was below 5% after 3 medication errors were observed during a combined 27 randomly selected medication administration opportunities by four licensed nurses for residents # 448, # 38, # 99. The facility's medication error rate was 11.11% as a result of three of four licensed nurses having at least one medication administration error upon individual observation. The deficient practice of medication errors at or exceeding 5% may result in undesirable medication-induced harm. Findings include: 1. Resident # 448 admitted into the facility on [DATE] with diagnoses of Type 2 Diabetes Mellitus (DM 2) with Hyperglycemia, Hypothyroidism, and Essential (Primary) Hypertension, had a medication order of Insulin Determine: There was an order for Insulin Determine Subcutaneous Solution 100 unit/ml (Insulin Determine) Inject 65 unit subcutaneously every morning and at bedtime for DM 2. On November 2, 2023 at 7:46 AM, a medication administration observation was conducted with Licensed Practical Nurse (LPN/Staff # 44) on the 2nd floor A wing. Staff # 44 was observed administering Resident # 448 the incorrect medication: Insulin Glargine Subcutaneous Solution 100 unit/ml 65 unit -- instead of Insulin Determine Subcutaneous Solution 100 unit/ml 65 unit. 2. Resident # 38 admitted into the facility on [DATE] with diagnoses of Chronic Obstructive Pulmonary Disease, Anxiety Disorder, and Opioid Dependence had a medication order of Nicotine Patch: Nicotine Patch 24 Hour 21 Mg/24 hr. Apply 1 patch transdermal one time a day for Smoking Cessation apply daily and remove previous patch. On November 2, 2023 at 7:57 AM, a medication administration observation was conducted with Registered Nurse (RN/Staff # 17) on the 2nd floor A wing. Staff # 17 was observed administering Resident # 38 the incorrect medication: Nicotine Patch 24 Hour 7 Mg/24 -- instead of Nicotine Patch 21 Mg/24 hr. 3. Resident # 99 admitted into the facility on [DATE] with diagnoses of Cognitive Communication Deficit, Adult Failure to Thrive, and Cache, had a medication order of Aspirin Oral Capsule: Aspirin Oral Capsule 81 Mg give 1 capsule by mouth one time a day for stockyard. On November 2, 2023 at 8:46 AM a medication administration observation was conducted with LPN/Staff # 56 on the 2nd floor C wing. Staff #56 was observed administering Resident # 99 the incorrect medication: Aspirin Oral Tablet Chewable 81 Mg -- instead of enteric-coated (EC) Aspirin oral capsule 81 Mg. On November 02, 2023 at 4:29 PM, an interview with Director of Nursing (DON/Staff # 24) was conducted. The DON stated that this medication error rate does not meet expectations, it is the highest it has ever been, and would like it to be at 0%. (continued on next page)

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	035099	A. Building B. Wing	11/03/2023

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Clinical Services Policy and Guidelines for Implementation #759 titled, Pharmacy Services Medication Administration (revised 08/2018) revealed that, The facility will maintain a medication error rate less than five (5) percent. The Guidelines state, Medications will be prepared and administered in accordance with: Prescriber's order.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49325 Based on observation, staff interview, and policy review, the facility failed to ensure that expired medications and devices were not readily accessible for use in the medication supply room and medication cart according to professional standards. The deficient practice may result in the use of expired supplies against manufacturer recommendation resulting in undesirable harm or alterations in effectiveness of medications and devices. Findings include: During a medication storage observation conducted on November 2, 2023 at 7:46 AM with a Licensed Practical Nurse (LPN/Staff # 44), a random inspection of expiration dates was performed of supplies stored in the 2nd floor medication storage supply room. Upon close inspection of enteral feeding supplies, 13 tube feeds tubing entraflo H2O safety spike connectors 1000 ml water bag pump sets were found to be expired. The expiration date on the 13 devices was written as July 28, 2023 on the outside of each of the sealed plastic bags. Staff # 44 confirmed expiration dates on the 13 tube feeds confirming that they were expired and all products in the medication storage supply room are expected to be checked weekly. During a medication storage observation conducted on November 3, 2023 at 8:55 AM with LPN/Staff # 147 a random inspection of expiration dates was performed of medications stored in medication cart B2 on the 2nd floor B wing. Upon a random inspection of medication expiration dates, 100,000 USP Nystatin Units Per Gram topical medication inside the drawer had an expiration date of May/2023 written on the box. Staff # 147 stated that due to the medication being expired it is evident that it will not be given to residents. Staff # 147 stated that the expired medication would be discarded and not be placed back in the drawer. An interview was conducted on November 02, 2023 at 4:29 PM with the Director of Nursing (DON/Staff # 24). DON stated that medications and supplies which are out-of-date should be removed and then discarded. Regarding having expired medications, DON stated it does not meet expectations because the facility had recently performed an audit of the medication carts and expected that all medications that were expired not to be present. Review of the facility's Clinical Services Policy and Guidelines for Implementation # 759 titled, Pharmacy Services Medication Administration (revised 08/2018) revealed that, Medications will be prepared and administered in accordance with: Manufacturer's specifications and The right practices (correct, accepted standards of practice and manufacturer's specifications).

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 42319 Based on resident and staff interviews, a food test tray, and policy review, the facility failed to ensure food was provided that was palatable and at an appetizing temperature. The deficient practice has the potential for residents who disliked a meal to experience nutritional problems or dissatisfaction with their meals. Findings include: Review of resident council meeting minutes found 3 of 4 months included food complaints. An interview was conducted on 10/30/23 at 2:57 PM with the ombudsman who said that food had been brought up on several occasions as a concern. An interview was conducted on 10/30/23 at 10:27 AM with resident #95 who said that the food is not hot when it is supposed to be hot. An interview was conducted on 10/31/23 at 8:19 AM with resident #49 who said that the food is not good and often cold. An observation was conducted on 11/01/23 at 12:42 PM of a test tray. The test tray temperatures were taken by staff as follows: - beans 123 F - rice 106 F -taco meat 103 F An interview was conducted on 11/01/23 03:25 PM with resident #77 who said that the taco meal temperature was not ok and that the temperatures of the food had not been ok for a week. An interview was conducted on 11/01/23 03:30 PM with resident #110 who said that the food was cold. An interview was conducted on 11/1/23 at 3:35 PM with resident #19 who said that she did not even try the tacos because almost every meal is a lost cause and that if she tries to get hot food at the kitchen they say they are cleaning and cannot help her. An interview was conducted on 11/02/23 at 3:26 PM with the Administrator (staff #150) who said that hot food should be served at 120 F. She said that food should meet resident but that it's individualized. She said that this does meet her expectations but that she understands that the food is not what they want. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy titled Food and Nutrition Services: Food and Drink dated 7/2018 revealed that it is the purpose of this facility to provide residents with food and drink that is nutritive, appealing and meets their needs. This document included food will be served at an appetizing temperature, taking into consideration the type of food.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42319 Based on observations, staff interviews and facility policy, the facility failed to ensure that a unit refrigerator was maintained to ensure food items were dated, expired foods were not available for consumption, and that foods were distributed in a manner to prevent illness. Findings include: An observation was conducted on [DATE] at 12:54 PM of an uncovered cart loaded with uncovered cakes brought from the kitchen and into a downstairs B hall dining room. Some trays were not served in the dining room and drinks including coffee and juice were added to the remaining trays. The drinks and cakes were not covered and were pushed down B hall, past COVID-19 isolation rooms before being served to the residents. An observation was conducted on [DATE] at 3:14 PM of a upstairs resident refrigerator/ freezer. A notice was posted on the outside of the refrigerator/ freezer to please make sure items are clearly marked with the resident's name, room number and date. The inside of the refrigerator door was marked with a brown spatter. This refrigerator included a fruit plate dated ,d+[DATE] with browning apples, a carton of milk with a best by of 9/ ,d+[DATE] which appeared coagulated, and all other items undated which included an open bag of chicken fajita meat with something smeared on the bag, tortillas, a pizza, cream cheese, personal bags of food with names but no date, Silk almond milk, V8 juice, Healthy Greens juice. The freezer side was full with no dates observed on any items. An interview was conducted on [DATE] at 1:30 PM with resident #77 who stated that the resident refrigerator is stained and filthy, contains spilled food and that some food items are not dated. This resident said that he has been complaining for 2.5 months regarding the condition of the resident refrigerator. An interview was conducted on [DATE] at 3:19 PM with the Assistant Director of Nursing (ADON/staff #69) who said that housekeeping or dietary cleans the resident's refrigerator. She then observed this refrigerator and the milk inside and said that the items were not dated and confirmed the milk's best by date was [DATE]. An observation was conducted on [DATE] at 4:03 PM of the same refrigerator/freezer. The freezer section was full and contained undated and open boxes of taquitos, corn dogs, ice cream and various unopened re-heatable foods which were also not dated. An interview was conducted on [DATE] at 2:01 PM with the Food Service Director (staff #81) who said that food should be covered when going out of the kitchen. She said that not covering drinks and cake did not meet her expectations. She said that food items should be stored with an expiration date and that food items should be dated when placed in the refrigerator. (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	11/03/2023

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on [DATE] at 3:26 PM with an Administrator (staff #150) who said that the expectation is that refrigerators are cleaned once a week, food maintained to regulatory standards of food safety including being dated and marked. She said that the refridgerator/freezer's undated food items didn't meet her expectations and that's why it had to be cleaned. She said that Dietary and Housekeeping are in charge of keeping it. She said that food items should be covered on the way to resident rooms and that it does not meet her expectations that food and drinks were not covered. A policy titled Food and Nutrition Services: Food Safety dated ,d+[DATE] revealed that it is the policy that food items will be stored, prepared, distributed and served in accordance with professional standards for food service safety. This policy included that food, including leftovers, will be labeled and dated in the refrigerator.