STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035099	A. Building B. Wing	04/03/2026

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

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

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 04/03/2026
NAME OF PROVIDER OR SUPPLIER Sandstone of Tucson Rehab Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 2900 East Milber Street Tucson, AZ 85714	

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

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

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

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

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

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

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F 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** Based on interview, review of clinical record, and review of facility policy and procedure, the facility failed to ensure 1 of 24 sampled residents (#118) was protected from a preventable accident, related to a fall from the bed during brief change. The deficient practice could lead to physical injury of a resident.-Findings include:Resident #118 was initially admitted to the facility on [DATE], with diagnoses that included quadriplegia, major depressive disorder, anxiety disorder, insomnia, neuromuscular dysfunction of bladder, and other problems related to life management difficulty.A care plan revised November 3, 2023, revealed Resident #118 had limited physical mobility.An annual minimum data set (MDS) assessment dated [DATE], revealed Resident #118 had a brief interview for mental status (BIMS) assessment score of 15, indicating intact cognition. Section GG revealed the resident had limited range of motion on both sides of his upper and lower extremities. Additionally, the resident was dependent on staff for rolling left and right in bed. Section J revealed the resident had no falls since admission / entry.A Fall Scale Evaluation dated September 28, 2025, revealed Resident #118 was a high fall risk.A care plan focus for limited physical mobility revealed a new intervention dated October 23, 2025, and included for 2 staff to assist with bed mobility.A nursing note dated November 5, 2025, revealed that it was brought to the nurse's (Staff #34) attention that Resident #118 had a fall incident at approximately 11:10 a.m., and that the nurse assessed the resident immediately. The documentation included that the resident was on the floor and was assisted back to bed. The note revealed per the staff who was changing the brief, the resident was positioned on his right side with the head and body on the edge of the bed. The note included the resident slipped from this position, and fell to the floor hitting his head, with his face and body facing downward. The note included the resident was complaining of knee pain, and was alert and oriented x 4, and able to follow commands. The documentation revealed there was no head or body injury related to the fall incident noted, small scratches on the right side of the buttock, and that the resident complained of knee pain. The note included that the provider was notified and gave orders to send the resident to the hospital, and that the resident refused to go to the hospital.A physician/practitioner note dated November 5, 2025, revealed that the nurse reported the resident hit knees and head with staff present, and that the resident's right knee was worse than left, with a small abrasion less than 0.5 centimeters on the right knee.A care plan dated November 6, 2025, included that the resident had an actual fall on November 5, 2025, and that interventions included to reposition grab bars, re-educate on repositioning done with nursing staff, floor mat to right side of bed, and staff education provided for proper turning and positioning while in bed.A therapy note dated November 12, 2025, revealed that a physical therapy screen was completed, and that the resident would benefit from bilateral repositioning rail to decrease fall risk when repositioning in bed for pressure relief and/or brief changes.A late entry interdisciplinary team (IDT) note dated November 12, 2025, revealed the resident accidentally slipped during activity of daily living (ADL), and that the root cause was that the resident was repositioned to his right side during ADL and slipped, causing him to fall. Interventions included to change low air loss mattress to concave mattress for safety, 2 staff needed during turning and repositioning, turn resident to weak side of his body during ADL, and to instruct resident to use his strong side of his body to hold onto the grab bar.A nurse's note dated November 18, 2025, revealed the nurse talked with the resident and his family about the use of long side rails, and that they are considered restraints, and that a consent must be signed. Additionally, with the long siderails, broken limbs could occur if resident fell out of bed due to the fact he is on an air mattress that has a plastic cover and sheets, and he can slide off the bed. Resident #118 and his family decided to use bolster pads on both sides of the bed that are secured to the bed. The note included the nursing staff would be able to do personal care and the bolsters would not need to be removed, and he would not slide out of bed when being repositioned. (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 04/03/2026

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

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The note revealed that Resident #118 required care for all ADLs, and that the bolsters would be ordered and applied as soon as they arrived.An interview was conducted on March 31, 2026, at 11:15 a.m. with Resident #118, who stated that there was an incident a few months ago where staff were changing him and he fell off the edge of the bed and hurt his knee and his head.An interview was conducted on April 1, 2026, at 1:41 p.m. with a certified nursing assistant (CNA / Staff #48), who stated that some residents require 2 staff to assist with rolling the resident on the side in bed for changing. Staff #48 stated that if the resident was at a dependent-level for care, then likely 2 staff would be needed, unless the staff was a large person and the resident was small. Additionally, Staff #48 stated that if the resident were paralyzed, then 2 staff would be needed to safely roll the resident in bed. Regarding Resident #118, Staff #48 stated that she was familiar with caring for the resident, and that he was paralyzed and needed two staff to roll the resident in bed. Regarding the fall incident, Staff #48 stated that she was present for the incident. Staff #48 stated that Resident #118 was unable to move himself at all, and that she and another CNA (Staff #14) were changing the resident, with one CNA positioned on each side of the bed, and were attempting to roll the resident onto his side facing Staff #48. Staff #48 stated that the other CNA (Staff #14) may have moved too quickly, and that the resident was positioned too close to the edge of the bed nearest to Staff #48. Staff #48 stated that maybe we overturned him a little, and the resident suddenly fell off the side of the bed onto the floor. Regarding the cause of the fall, Staff #48 stated that there was not enough room for the resident to be rolled onto his side, and that the CNAs should have moved him over in the bed to the opposite side first, before attempting to roll him, and that it should have been done more slowly. Staff #48 stated that it was an accident, and that she felt awful that it happened.An interview was conducted with a CNA (Staff #14) on April 2, 2026, at 7:18 a.m., who stated that she and the other CNA (Staff #48) were changing Resident #118, and that the resident was too close to the edge of the bed before they started to roll him. Staff #14 stated that when she went to roll him over, and the other CNA (Staff #48) was pulling the resident toward her as well, the resident then slipped off the edge of the bed quickly and fell to the floor onto his stomach. Staff #14 stated that the resident was yelling, the nurse came in to assess the resident, and afterward, the resident refused to go to the hospital for evaluation. Staff #14 stated that if the CNAs had pulled the resident more toward the opposite side of the bed prior to rolling him, then that could have prevented the accidental fall from the bed. Staff #14 stated that they received training after the incident to position the resident adequately before providing assistance with rolling, and training on fall prevention.A telephonic interview was conducted with a licensed practical nurse (LPN / Staff #34) on April 2, 2026, at 10:15 a.m., who stated that she was the floor nurse on the day of Resident #118's fall incident. Staff #34 stated that the CNAs were turning the resident in bed and that the resident accidentally slipped off the edge of the bed and fell to the floor. Staff #34 stated that she did not recall the resident complaining of pain after the incident. After the incident, Staff #34 stated that there were interventions placed so that there were always two CNAs when changing and rolling the resident, and one CNA would always have their hands on the resident holding him to ensure he does not fall.An interview was conducted on April 2, 2026, at 10:35 a.m. with a unit manager and LPN (Staff #86) who stated that for a paralyzed resident or one who is dependent for care, that the procedure for rolling or turning that resident in the bed included to use a draw sheet to move the resident so that there is no pulling or jerking on the resident which could cause injury. Additionally, Staff #86 stated that if there were two staff, that it would be necessary for them to communicate to coordinate their movements at the same time, such as counting 1,2,3 before moving the resident, that way all parties would be ready. When rolling a resident to the side, Staff #86 stated that a resident would be pre-positioned to the opposite side of the bed so that the resident could have room to be rolled without rolling off the side of the bed. Regarding Resident #118, Staff #86 stated that she had heard about the fall incident, that the resident was being changed and accidentally slid off the edge of the bed during care with the staff. Staff #86 stated that she did not know any further details, and that she believed the resident did not sustain any injuries.An interview (continued on next page)

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	035099	A. Building B. Wing	04/03/2026

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was conducted with the Director of Nursing (DON / Staff #200) on April 3, 2026, at 8:45 a.m., who stated that the facility staff prevent accidents by following protocol and policies. The DON stated that the procedural steps of safely turning / rolling a dependent resident in the bed included to take into consideration the resident's care plan interventions, to have one staff positioned on each side of the bed, to lift and move the resident more toward the opposite side of the bed (than the side rolling toward) in order to provide adequate space for rolling, and then to assist the resident with rolling. The DON stated that if those steps were not completed, then the resident could fall from the edge of the bed and get injured. The DON stated that she was not familiar with Resident #118's fall incident because it happened before she was employed at the facility. The clinical record was reviewed, and the DON stated that it appeared from the documentation as if the CNA had the resident positioned on his right side and on the edge of the bed, and that the resident slipped from that position and fell to the floor. The DON stated that it would not meet her expectation as far as following safe procedure to prevent a fall.An interview was conducted with the Administrator (Staff #166) on April 3, 2026, at 9:01 a.m. who stated that regarding Resident #118's fall incident, that she believed there were two CNAs assisting the resident at the time. She further stated that after the incident, several interventions were put into place including ordering of mobility bars for the resident's bed, immediate education provided to the two CNAs, and ordering bolsters for the resident's bed which he later declined. The Administrator stated that improved bed mobility assistance from the CNAs, in addition to the mobility bar, would have helped to prevent the accident.Review of the facility policy titled Moving Resident in Bed, dated May 1, 2024, revealed that if turning the resident toward you: reach over resident and firmly grasp the resident's shoulder and hip that are farthest from you, and shift your weight from the forward leg to the backward leg as you roll the resident toward you. If turning resident away from you: move resident to side nearest you, place arms under each area of body and move slowly and gently, flex arm nearest you across the resident's chest and flex nearest knee, slide one arm under resident's shoulder and back and other arm under hips, and pull your arms toward you while rolling resident onto side.Review of the facility policy titled Fall Risk Assessment, dated May 1, 2024, revealed it is the policy of this facility to identify the resident who is at risk for potential falls, and to initiate a preventative plan of care to reduce fall occurrence. The purpose of the policy was to ensure that the facility identifies each resident at risk for accidents and/or falls, and adequately plans care and implements procedures to prevent accidents.