STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035151	A. Building B. Wing	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sabino Canyon Rehabilitation & Care Center	5830 East Pima Street Tucson, AZ 85712

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, interviews, and review of facility policies, the facility failed to ensure a discharge summary was completed for one resident (#64). The deficient practice could result in an unsafe discharge for residents.Findings include:Resident #64 was admitted to the facility on [DATE] with diagnoses of foot drop of the left foot, wrist drop of the left wrist, and a fracture of the lower end of the left radius. Review of the discharge Minimum Data Set (MDS), dated [DATE] indicated that Resident #64's return was not anticipated. The same MDS indicated staff assessed her cognitive skills for daily decision making as independent.Review of the clinical chart revealed a progress note, dated December 10, 2025 at 2:38 P.M., indicated that a referral was sent to another facility per the request of the resident's family member.A second progress note, dated December 11, 2025 at 7:30 P.M., indicated that the receiving facility had received authorization through the resident's health insurance and had accepted the resident. It also stated Transfer scheduled for (December 12, 2025).The last progress note, dated December 12, 2025 at 3:49 P.M., revealed that a report was called to staff at the receiving facility and the resident was sent with her belongings and medications on hand.Further review of the clinical record did not reveal a discharge summary on file.An interview was conducted on February 4, 2026 at 12:11 P.M. with Social Services (SS/Staff #44). Staff #44 explained that discharge summaries are completed by the nurse who does the assessment and then social services will complete another section of it. Information such as home health agencies or any durable medical equipment (DME) that the resident is needing, future provider appointments, the Ombudsman's office and the facility's contact information is included in the summary. However, Staff #44 included that they do not do discharge summaries for residents who transfer out of the facility and nothing is documented in the chart. She added that they typically send a packet, via e-mail, with medication information, provider notes, health & physical information, therapy notes, medication list and a transfer order to the receiving facility. Staff #44 described Resident #64 as being transferred because she went to another facility.An interview was conducted on February 4, 2026 at 12:44 P.M. with the MDS Coordinator/Unit Manager/Licensed Practical Nurse (LPN/Staff #10). Staff #10 described a resident discharge as when a resident leaves the building. A transfer would be when they go to another facility or hospital and we expect them to come back. Staff #10 looked at Resident #64's MDS list in the clinical record and shared that she was discharged and her return was not anticipated. She added that this would be considered a discharge. Staff #10 shared that social services would open the discharge process and identify any resources that a resident might need such as home health services. Then the nurses will do the clinical portion of the discharge process. Staff #10 further added that she was not able to locate a discharge summary in Resident #64's clinical record. Staff #10 reviewed the progress notes in the clinical chart and shared that social services had sent the resident's referral on (December) 10th and the insurance was accepted on (December) 11th, while the resident (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	left the faciity on (December) 12th. She added that she assumed the discharge summary was not opened up because she was going to another facility.An interview was conducted on February 4, 2026 at 1:09 P.M. with the Social Services Director (SSD/Staff #13). Staff #13 described a discharge as when a person leaves the facility to go home and a transfer is when a patient is moved from one facility to a different facility. She also explained that a discharge summary is done when a person is discharging from the facility to their place of residence. She further explained that the facility does not do discharge summaries for residents who transfers to another facility. The discharge summaries have a nursing section for clinical information in addition to a section where home health and DME information can be added. The transfer information is sent to the receiving facility over the phone via a nursing report.A request was made on February 4, 2026 at 1:25 P.M. for the facility's discharge summary policy. At 1:50 P.M., the Administrator/Staff #1 informed surveyor that the facility did not have a policy related to this.A policy titled, Discharge Planning Process indicated it was last revised in September 2023. The policy stated that It is the policy of this Facility that the discharge planning process focuses on the resident's discharge goals, involving the residents as active partners. The discharge process should effectively transition them to post-discharge care, and minimize clinical or other factors which are related to the possibility of a readmission. The policy did not have language related to a Resident's Discharge Summary.