STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035292	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandstone Estates Rehab Centre	2040 North Wilmot Road 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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51124 Based on clinical record review, staff interviews, facility documentation, and facility policy, the facility failed to ensure one resident (#420) was free from misappropriation of resident medications. The deficient practice could result in further incidents of misappropriation. -Findings Include: Resident #420 was admitted to the facility on [DATE] with diagnoses that included Parkinson's disease, major depressive disorder, post-traumatic stress disorder, and heart failure. A physician order dated January 26, 2023, for Oxycodone HCl Oral Tablet 20 mg to give 1 tablet by mouth every 3 hours as needed for pain. The order was placed by a licensed practical nurse (LPN/Staff #220) and discontinued the same day by the same LPN. An additional order dated February 02, 2023 revealed Morphine Sulfate Oral Tablet 15 MG to give 1 tablet by mouth every 3 hours as needed by pain. The order was placed by the LPN (Staff #220) and was also discontinued that same day by the same LPN. Review of the personnel file for the LPN (Staff #220) revealed a Disciplinary Action document dated December 9, 2022, for a probationary period for failure to follow departmental policy and procedure when dispensing narcotics. Employee signs out narcotics in narc book but fails to document in eMAR (electronic medical administration record). An additional 30-Day Performance Improvement Plan dated December 09, 2022 indicated, as a corrective action step, that the LPN (Staff #220) would be required to have the oversight of an LPN who must cosign the dispense of the narcotic and accompany the employee to administer the narcotic to the patient. The Improvement Plan also indicated to follow up with employee every 7 days and record development below. However, the spaces provided by the form were left blank. (continued on next page)

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

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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An additional Disciplinary Action document dated February 08, 2023, for the LPN (Staff #220), revealed that the type of action was termination. The details indicated an investigation for narcotic diversion, and that the supervisor met with employee, she had no answers as to investigation outcome, and that the facility's investigation was substantiated. The supervisor's name was listed as the DON at that time (Staff #55). A review of the SA incident reporting system revealed a Reportable Event Record submitted by the facility dated February 06, 2023, revealed that on February 03, 2023, it was identified that a nurse was possibly diverting narcotics. The nurse in question was suspended pending investigation on February 03, 2023, and the investigation was initiated. The Reportable Event Record indicated that the interventions implemented after the incident were that the nurse was suspended and terminated, the pharmacy will no longer accept scripts printed from the electronic medical record, the physicians must E-prescribe, call the pharmacy themselves, or write the narcotic scripts on their own script pad, and that the DON or designee will obtain the daily narcotic logs and match them with what was ordered and delivered in the cart. Review of the state reporting system revealed that the facility's Administrator at that time (Staff #82) filed a Self-Report form dated February 06, 2023 at 7:24 PM for an allegation of misappropriation (narcotic diversion) for Resident #420. A Complaint Form dated February 08, 2023 to the state board of nursing revealed that the DON at that time (Staff #55) filed a complaint against the LPN (Staff #220). The complaint specified that during the facility's investigation of possible narcotic diversion by the LPN, that the facility identified over 34 orders that had been started and discontinued in the same shift that she worked and that each prescription (was) the physical prescription with identical handwriting/DEA#/signature with different patient information in the middle. If you look at the top right if the prescription you will see a faint line where the new patient's information was overlaid on the existing signed prescription. Later during the same shift (Staff #220) would receive the medication from the pharmacy and discontinue the medication from the medical record so there was (no) evidence of it being ordered. We did verify with all physicians for attached and signed prescriptions that they did not sign or prescribe them. The complaint specified that no harm occurred to the patients involved, that the LPN was terminated, and that authorities were notified. A telephonic interview was conducted on October 23, 2024 at 10:47 AM with the Director of Nursing (DON/Staff #55), who was no longer employed at the facility. When asked to describe the incident of the LPN (Staff #220) diverting narcotics, the DON stated that she suspended the nurse immediately when she knew about the missing medications. She stated that initially, her Assistant Director of Nursing (ADON) had identified that morphine was missing. According to the investigation, it was the DON's understanding that the LPN would order medications at the beginning of her shift, the medications would be delivered from the pharmacy, and then the LPN would discontinue the order from the computer. The LPN had an old prescription form from a patient that was printed and signed by one of the facility's providers. The LPN would then fold the new prescription with the new details over the old signed prescription paper, and there was a faint line on all of her orders that signified where she folded the paper. The DON stated that she verified with the provider that he did not write those prescriptions. The DON stated that after the incident, that the facility put in place interventions to prevent recurrence of narcotic diversion, including using strictly prescription pads or computer orders and daily cross checks with the pharmacy. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A telephonic interview was conducted on October 23, 2024 at 11:04 AM, with the Administrator (Staff #82), who was no longer employed by the facility. The Administrator stated that the incident was first noted by the ADON at the time, who noticed a missing bottle of morphine. An investigation started and it was discovered that the LPN (Staff #220) was printing orders, falsifying the signature, sending the script to the pharmacy, and getting medications delivered. The Administrator stated that is was hundreds of pills that were diverted, and that the employee was terminated. The facility policy titled Freedom from Abuse, Neglect, and Exploitation: Preventing and Prohibiting Abuse, revised May 04, 2023, revealed that it is the facility's policy to prohibit and prevent abuse, neglect, exploitation of residents, and misappropriation of resident property.