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	05/09/2025

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 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** 42319 Based on clinical record review, staff interviews, and facility policy, the facility failed to ensure one resident (#3) was provided with adequate supervision. Findings include: Resident #3 was admitted to the facility on [DATE] with diagnoses of cerebral infarction, encephalopathy, other stimulant abuse with intoxication and schizophrenia. An admission minimum data set (MDS) dated [DATE] included the resident's BIMS (Brief Interview of Mental Status) score of 3 that show that the resident #3 has severely impaired cognition and also included that the resident was exhibiting physical behaviors, rejection of care and wandering. A care plan dated March 30, 2025 included that this resident was an elopement risk/wanderer and included a goal that the resident would not leave the facility unattended. A wander risk scale dated March 30, 2025 included that this resident was at risk for wandering/elopement. A behavior notes dated April 1, 2025 included that resident frequently gets agitated screaming out and forgetting she has a left clavicle fracture, and resident was wandering around room frequently and coming into the hallway. A behavior note dated April 5, 2025 included resident frequently walking down the hallway without walker and yelling out for staff and that the resident was frequently wandering. This note included that the resident was unsteady on her feet and was educated to use walker while she is walking. A behavior note dated April 12, 2025 included that the resident was noted to have anxiety behaviors including attempting to leave the room exposed and wandering the hall attempting to open each door including the medication cart. Resident expressed frustration as evidenced by foul language and throwing/slamming walker towards wall. A progress note dated April 17, 2025 included that the resident went out for the afternoon with family and that when she got back she was upset that she was not being discharged and that the resident eloped trying to go outside. (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
	035292	A. Building B. Wing	05/09/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An activity note dated April 23, 2025 at 9:46 included that the resident was highly agitated and yelling about discharge and stated that she would walk out. This note includes that staff were able to deescalate the resident. A social services note dated April 23, 2025 at 10:13 included that the resident was screaming No I can't stay here anymore! and I cant take it anymore! This note also included that staff were able to deescalate the resident. A nurse's note dated April 24, 2025 included the activity director noticed this resident's wheelchair sitting outside front doors to the facility and resident was not around. This note included that a search was performed and that this resident was found at a bus stop. A communication with family note dated April 24, 2025 included that staff contacted family to obtain consent to place the resident on the secured unit following the elopement and included that since this resident had found out about NOMNOC (Notice Of Medicare Non-Coverage), she has been trying to leave facility and was in a very agitated mood. An interview was conducted on May 8, 2025 at 3:27 P.M. with a Certified Nursing Assistant (CNA/staff #87) who said that this staff had not personally lost a resident because this staff keeps an eye on the residents who have mentioned it. This staff said that this resident would scream and say she just wanted to go. This staff said that staff would make sure that this resident did not get on the elevator and that when she did that they would follow her and she would say, I just have to get out of here. This staff said that this resident attempted to get out of the second floor window but that it would not open enough for her to get out. This staff said that the day the resident eloped, she was very agitated and saying she was going to leave. This staff said that it was suggested to move this resident to the behavioral unit due to the wandering but that it did not happen. An interview was conducted on May 8, 2025 at 3:15 P.M. with a Certified Nursing Assistant (CNA/staff #17) who said that this resident did not want to be in the facility. This staff said that this resident was unstable on her feet and that staff knew that she was a runner and would watch her closely. This staff said that the facility gets residents who want to elope every now and then, but that normally management will catch on and move them to the behavioral unit but this was not done for this resident. An interview was conducted on May 9, 2025 at 11:30 A.M. with a Licensed Practical Nurse (LPN/staff #26) who said that if they have residents who are attempting to wander, they try to redirect them back to their room, try to keep an extra eye to make sure they don't go downstairs or in someone's room. This nurse said that if a resident told her that she wanted to leave, she would talk to them to find out why, notify the ADON and the DON, put it in a progress notes and let the nurse on the next shift know and if the resident seems adamant that she would let the receptionist know. This nurse said that resident #3 did not want to keep her sling on and just wanted to get out of here. This nurse said that the resident would wander all day long, passing her repeatedly while she was passing medications in the hall. This nurse said that she heard that this resident walked out the front. (continued on next page)

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	05/09/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on May 9, 2025 at 10:26 with the Assistant Director of Nursing (LPN/staff #22) who said that the management received the call that resident #3 was not in her room, noticed her wheelchair at the front and initiated the code [NAME] for elopement. This staff said that this resident would often scoot around the facility in a manual wheelchair, so when they found it, the management called the code green, had floor staff do an interior search and had the department heads do a search in a radius around the community. This staff said that resident #3 was found at a bus stop near a hospital which was on the other side behind a whoesale grocery store. This staff said that she was a little warm and thirsty but not in distress, and that she came back willingly. This staff said I believe she was looking for a cigarette. An interview was conducted on May 9, 2025 at 10:35 with the Receptionist (staff #74) who said that her responsibilities included to greet people, make sure they sign in and out and watch the front door, direct people where they need to go and the front paperwork. This staff said that there should always be someone watching the front door and that the facility locks to door at 8 P.M. when there is no one to watch it. This staff said that if she needed to step away from the door, she would call somebody to watch the door for her. This staff said that if she sees someone leaving who is a resident, that she will redirect them, and if that does not work she will call in the nurse chat and put Urgent and if the resident is still trying to leave that she will follow them out. This staff said that it's for safety in the roads and parking lot and also because we are in the desert and they can dehydrate so quickly. An interview was conducted on May 9, 2025 at 11:32 A.M. with the prior Director of Nursing (DON/staff #31) who said that prior to coming to the facility, resident #3 was homeless and using illicit substances and was found on the ground before before she was admitted to the facility and that the resident's behaviors were worse at night and included aggression and wandering. This staff said that the resident wandered normally but was not attempting to leave but that when she was given the Notice of Medical Non Coverage (NOMNC), that she became agitated. This DON said that not long afterward the staff were looking for her to follow up on some information they had discussed with family, the resident was not in the facility. This DON said that the resident's wheelchair was found by the front door, so a search was performed and that the resident was found unharmed but that she wanted extra water. This DON said that the receptionist did not see this resident leave. This DON said that after this resident #3 was really antsy and wanted to go and that the family approved the secured unit and over the weekend the family picked her up. This staff said that they did not want to initially put her in the secure unit because they were trying to do the least restrictive thing and maintain her dignity and rights. An interview was conducted on May 9, 2025 at 12:00 P.M. with the current Director of Nursing (DON/staff #9) who said that her expectations were that residents did not elope and are kept safe and secure by using the elopement assessment and making sure to utilize the tools at their disposal. A policy adopted May 1, 2024 titled Elopement revealed that all residents who are at risk for possible elopement/wandering shall be accompanied by staff or responsible party when leaving the facility grounds.