Medicare/Medicaid Public Records Documents Only

Survey event #DOE0

Facility: SANDSTONE OF TUCSON REHAB

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

CATION AND TRANSMITTAL ID: DOE

	PART I - TO BE COMPLETED BY THE					STATE SURVEY AGENCY Facility ID: LTC			
1. MEDICARE/MEDICAID PROVIDER (L1) 035099 2.STATE VENDOR OR MEDICAID NO (L2) 835118		3. NAME AND ADD (L3) SANDSTONI (L4) 2900 EAST M (L5) TUCSON, AZ	E OF TUCSON R MILBER STREE	REHAB CEN		L6) 85714	4. TYPE OF ACTION 1. Initial 3. Termination 5. Validation	2. Recertification 4. CHOW 6. Complaint	
5. EFFECTIVE DATE CHANGE OF O	WNERSHIP	7. PROVIDER/SUF	PPLIER CATEGORY	Y 09 ESRD	<u>02</u> 13 PTIP	(L7) 22 CLIA	7. On-Site Visit 8. Full Survey After (9. Other Complaint	
6. DATE OF SURVEY 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPIC	CE	FISCAL YEAR ENDING	G DATE: (L35)	
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDOW 18 SNF 18/19 SN (L37) (L38) 16. STATE SURVEY AGENCY REMA An offsite revisit survey event #D	F 19 SNF (L39) RKS (IF APPLICABLE S	B. Not in Com Requirements a ICF (L42)	nce With quirements Based On: .cceptable POC pliance with Progran and/or Applied Waiv IID (L43)	ı rers:	2. 3. 4. 5. * Code: 15. FACILIT. 1861 (e) (1	Technical Personnel 24 Hour RN 7-Day RN (Rural SNF) Life Safety Code A* IY MEETS 1) or 1861 (j) (1):	e Following Requirements: 6. Scope of Ser 7. Medical Dire 8. Patient Room 9. Beds/Room (L12)	vices Limit	
17. SURVEYOR SIGNATURE For Matthew Connolly, HCCN	Л, by BKeilman	Bernadet	te Keilw 07/26/2022	ian (L19)		survey agency ap Dette Keil	\mathcal{M}_{0}	Date: 907/26/2022 (L20)	
	PART II - TO	BE COMPLETE	D BY HCFA RI	EGIONAL	OFFICE O	OR SINGLE STAT	TE AGENCY		
DETERMINATION OF ELIGIBILI	Participate		IPLIANCE WITH C HTS ACT:	CIVIL	21.		ial Solvency (HCFA-2572) Interest Disclosure Stmt (HCl	FA-1513)	
22. ORIGINAL DATE OF PARTICIPATION	23. LTC AGREEMI BEGINNING I		24. LTC AGREEME ENDING DATI		VOLUNTAR 01-Merger, O	Closure	<u>INVOLUN</u> 05-Fail to N	Meet Health/Safety	
(L24) 25. LTC EXTENSION DATE: (L27)	(L41) 27. ALTERNATIVI A. Suspension of B. Rescind Susp	of Admissions:	(L25)		03-Risk of In	action W/ Reimburseme evoluntary Termination uson for Withdrawal	OTHER	Meet Agreement r Status Change	
			(L45)						
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMAR	KS			
		00000							
	(L28)			(L31)					
31. RO RECEIPT OF CMS-1539	(1.32)	. DETERMINATION (OF APPROVAL DAT	ΓΕ (L33)	DETERNA	INATION ADDDO	N/A I		



July 26, 2022

Receipt Of This Notice Is Presumed To Be 07/26/2022 Important Notice - Please Read Carefully

Mr. Ryan Valdez, Administrator Sandstone Of Tucson Rehab Centre 2900 East Milber Street Tucson, AZ 85714

Dear Mr. Valdez:

On July 25, 2022, an offsite revisit survey was conducted for your facility by the Arizona Department of Public Health, Licensing and Certification Bureau, to determine if your facility was in compliance with federal participation requirements at the time of the follow-up investigation to Complaint #DOE012.

The enclosed Center for Medicare and Medicaid Services (CMS) form, entitled "Statement of Deficiencies and Plan of Correction" (CMS 2567) indicates, based on your Plan of Correction, that no deficiencies of participation requirements were identified during this revisit. The plan of correction was accepted for the Federal citations.

Enclosed is the **Federal Post-Certification Revisit Report**, please retain a copy for your files. If we can be of further assistance, please contact the Bureau of Long Term Care at (602) 364-2690.

Sincerely,

Bernadette Keilman

LTC Customer Service Representative IV

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\bk

Enclosure

PRINTED: 07/26/2022 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		035099	B. WING _			1	-C 25/2022
NAME OF PR	ROVIDER OR SUPPLIER		I	STR	REET ADDRESS, CITY, STATE, ZIP CODE	1 011	25/2022
SANDSTO	NE OF TUCSON REHAE	R CENTRE			0 EAST MILBER STREET		
- CANDOTO	NE OF TOOOON KENAL	JOLIVINE		TU	CSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS	3	{F 0	00}			
	An offsite follow-up s July 25, 2022. No def	survey was conducted on ficiencies were cited.					
ADODLESS		SUPPLIER REPRESENTATIVE'S SIGNATU			TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

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.

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER		MULTIPLE CON	ISTRUCTIO	N						DATE (OF REVISIT
IDENTIFICATION NUMB 035099		A. Building B. Wing							Y2	7/25/2	022 _{Y3}
NAME OF FACILITY SANDSTONE OF TUC	SON RE	HAB CENTRE				2900 E	T ADDRESS, C AST MILBER S N, AZ 85714		ZIP CODE	1	
This report is complete program, to show thos corrected and the date provision number and the survey report form	e deficier such cor the identi	ncies previously rective action v	reported c	n the Colished.	MS-2567 Each de	, Staten ficiency	nent of Deficient should be ful	encies and F ly identified	Plan of Correctusing either the	tion, that ne regulat	have been tion or LSC
ITEM		DATE	ITEM				DATE	ITEM			DATE
Y4		Y5	Y4				Y5	Y4			Y5
ID Prefix F0677		Correction	ID Prefix	F0925			Correction	ID Prefix			Correction
Reg. # 483.24(a)(2)		Completed	Reg. #	483.90	(i)(4)		Completed	Reg.#			Completed
LSC		07/29/2022	LSC				07/29/2022	LSC			•
ID Prefix		Correction	ID Prefix				Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #				Completed	Reg.#			Completed
LSC		-	LSC					LSC			
ID Prefix		Correction	ID Prefix				Correction	ID Prefix			Correction
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Reg. #		Completed	Reg. #				Completed	Reg. #			Completed
LSC		-	LSC					LSC			
REVIEWED BY STATE AGENCY	REVIEV (INITIAI	VED BY LS) MC	DATE 7/25/202	22	SIGNATU	IRE OF S	SURVEYOR	 کر		DATE 7/2	25/2022
REVIEWED BY CMS RO	REVIEV (INITIAI	VED BY LS)	DATE		TITLE			<i>Y</i>		DATE	
FOLLOWUP TO SURVEY COMPLETED ON			☐ CHE	CK FOR	R ANY UNC	ORREC	TED DEFICIEN	ICIES. WAS A	A SUMMARY O	F	

6/24/2022

UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

YES NO



July 25, 2022

Mr. Ryan Valdez, Administrator Sandstone Of Tucson Rehab Centre 2900 East Milber Street Tucson, AZ 85714 NCI-2643

Dear Mr. Ryan Valdez,

Thank you for the documentation submitted with your request for informal dispute resolution regarding the Statement of Deficiencies for your survey # DOE011 conducted on June 24, 2022.

The management review team has reviewed the citations and your documentation, and has made the following decisions:

Tag #F925. §483.90.i.4 will remain as written.

Tag #Y205. R9-10-425.A will remain as written.

If we may be of further assistance, please contact the Bureau of Long Term Care at (602) 364-2690.

Sincerely,

Tom Salow

Interim Assistant Director

CB/pdh

Enclosure

CC: **CMS**

Ombudsman



July 19, 2022

Ryan Valdez, Administrator, Administrator Sandstone Of Tucson Rehab Centre 2900 East Milber Street Tucson, AZ 85714

Dear Mr. Valdez:

Enclosed please find the Statement of Deficiencies and Plan of Correction for the Complaint Investigation # **DOE011** conducted on June 24, 2022 which was submitted to the Bureau of Long Term Care on July 15, 2022.

The Plan of Correction is unacceptable for the following reasons:

Changes needed to the 2567:

- -For all Ftags/Ytags indicate the frequency of the audits that will be conducted
- -Indicate the completion date for the Plan of Correction (POC)

Supplemental Documentation:

- -For all Ftags/Ytags include evidence that staff have been in-serviced
- -For all Ftags/Ytags include some completed audits

The requested documents are required to be returned to this office no later than **July 26, 2022**, please retain a copy for your files. If the requested documents for the Plan of Correction are not received by this office on or before **July 26, 2022**, licensure action and/or civil penalties may be assessed.

Thank you for your cooperation. If you have any questions, please call the Bureau of Long Term Care at (602) 364-2690.

Sincerely,

Megan whettey

Megan Whitby
Interim Long Term Care Bureau Chief

MW/MC:mm

Attachments

RECEIVED BLTC 7-21-22 MM

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/07/2022 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		035099	B. WING		C 06/24/2022
	ROVIDER OR SUPPLIER	B CENTRE	29	TREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST MILBER STREET UCSON, AZ 85714	00/24/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETIO
F 677	AZ00179201, AZ001 AZ00178241 was column and from June 20 thr deficiencies were cite ADL Care Provided from CFR(s): 483.24(a)(2)	complaints AZ00181681, 78373, AZ00178379, and inducted on June 17, 2022 rough 24, 2022. The following ed: or Dependent Residents	F 000	F000 This Plan of Correction is submit the requirements established by F This Plan of Correction constitute facility's demonstration of complete deficiencies cited. Submission Plan of Correction is not an admit deficiency existed or that one was cited. F677	ederal law. es this iance for n of this ssion that a
	out activities of daily services to maintain personal and oral hydring this REQUIREMENT by: Based on clinical reclarity documentation failed to provide adecresidents (#46, #136, was three residents.)	living receives the necessary good nutrition, grooming, and		A. Corrective actions: 1. Residents #46, #136, and #140 found affected by this alleged de practice. 2. Residents #46 and #136 receive and/or following facility survey, shower schedule. Resident #140 from the facility on August 6, 20 3. Documentation for showers are baths are available on electronic records and/or uploaded into residents.	red showers per facility discharged 21. ad/or bed medical
	shower schedule whi are to receive two shings and vertigo of the resident's Activitial plan revealed the resperformance deficit resunsteadiness on feet, activity intolerance from the resident intolerance from the resident intolerance from the resident intolerance from the received intole	dmitted on November 6, that included difficulty in f central origin. les of Daily Living (ADL) care ident had a self-care		B. Identify other residents 1. No other residents were found affected by the alleged deficient noted. However, all residents ha potential to be affected by the all deficient practice.	practice ve the

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 07/07/2022 FORM APPROVED

OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (Y3) DATE SLIBVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION DENTIFICATION NUMBER: COMPLETED A. BUILDING C 035099 B WNG 06/24/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2900 EAST MILBER STREET SANDSTONE OF TUCSON REHAB CENTRE TUCSON, AZ 85714 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) C. Measures F 677 Continued From page 1 participate in the fullest extent possible with each 1. n July 15th, 2022, Nurse Unit Manager interaction. in-serviced and implement the staff on the following topics but not limited to: A quarterly Minimum Data Set (MDS) assessment dated May 6, 2022 included that the a. Facility policies and procedures for ADL resident required supervision with one-person care previded for dependent residents, physical assistance for personal hygiene and including showers and hed baths extensive assistance for bed mobility. This b. Requirements for compliance regarding assessment included that bathing completion of shower sheets/bed baths and self-performance and bathing support provided post shower documentation did not occur during the 7-day look-back window of the assessment. The resident scored a 15 on c. Administrator initiated a QA tool on July the Brief Interview for Mental Status (BIMS) 12, 2022 regarding ADL Care and showers indicating he was cognitively intact and bed baths to ensure: A review of the clinical record for April through Resident are receiving showers June, 2022 included the following information and bed baths per the facility regarding showers and/or bed baths: shower schedule -0 showers/bed baths were completed for the weeks of: April 3 to 9, April 10 to 16, May 29 to Documentation following showers June 4, and June 5 to 11. and/or bed bath is completed and -1 shower/bed bath was completed for the weeks uploaded into patient's chart. of: April 17 to 23 and May 1 to 7. D. Corrective Actions -Resident #136 was admitted to the facility on 1 The administrator or designee will 7/29/12 November 19, 2019 with diagnoses of dementia continue to conduct random twice a week and hemiplegia. audits for 6 weeks to ensure that residents are receiving showers per facility schedule and that shower documentation is available The resident's ADL care plan revealed the on electronic medical records and/or resident had a self-care performance deficit uploaded into resident chart. related to decreased mobility, weakness, and hemiplegia of the right dominant side. An 2. The results of the audits completed on this intervention included to provide supervision to POC will be submitted to the Quality extensive assistance from staff for ADLS as Assurance and Performance Improvement needed. committee for review and follow up A quarterly MDS assessment dated June 8, 2022

included that the resident required physical help in part of the bathing process and required setup

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.		A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		035099	B. WING		C 06/24/2022
	ROVIDER OR SUPPLIER	CENTRE		STREET ADDRESS, CITY, STATE, ZIP CODE 2900 EAST MILBER STREET TUCSON, AZ 85714	00/24/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
	A review of the clinical June, 2022 included the regarding showers and -0 showers/bed baths weeks of: April 3 to 9, 16, April 17 to 23, April 17 to 23, April 17 to 23, April 17 to 23, April 17 to 7, May 9 to 18 shower/bed bath was of: May 1 to 7, May 9 to 18 shower/bed bath was affebruary 28, 2021 with with behavioral disturb weakness. This resided 2021. The resident's ADL car resident had a self-car related to confusion and dementia and Alzheim included to monitor the in ability. A quarterly MDS assess included that this resident part of the bathing person physical assists resident scored 0 on the cognitive impairment. A review of the clinical July, 2021 included the regarding showers and -0 showers/bed baths of the clinical part of showers/bed baths of the clinical part of showers/bed baths of the clinical part of the clinical July, 2021 included the regarding showers and -0 showers/bed baths of the clinical part o	resident scored a 0 on the e cognitive impairment. I record for April through the following information d/or bed baths were completed for the April 10 to 16, April 11 to 124 to 30, and May 15 to 124 to 30, and May 15 to 15 as completed for the weeks to 14, and June 5 to 11. Idmitted to the facility on the diagnoses of demential trance and muscle and cognition from the performance deficit and impaired cognition from the resident for any changes are required physical help rocess and required 1 ance with bathing. The the BIMS indicating severe are completed for the June 13 to 19, July 4 to	F 67	7	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		035099	B WNG_			C (24/2022
	ROVIDER OR SUPPLIER	CENTRE		STREET ADDRESS, CITY, STATE, ZIP CODE 2900 EAST MILBER STREET TUCSON, AZ 85714	00/	2412022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	An interview was cond 2.36 PM with a Certific (CNA/staff #96) who sassigned to complete showers. She said that the bulletin board and one is done on the day bed two. She said that shower, then normally hopefully the next shift the shower. She said that showers are document that gets turned into the said that showers are document that gets turned into the said that showers are clinical record. She saknow that residents has sheets or computer do asked the person that An interview was cond 1.55 PM with a License (LPN/staff #72) who say the clinical record and the clinical record and the shows when the resident had a shower CNA and get confirmated. An interview was cond 12:46 PM with the interview was cond 12:46 PM with the interview bathing twice and offered bathing twice as sheets aftered bathing twice as offered bathing twice as sheets aftered bathing twice as offered bathing twice as sheets aftered bathing twice as offered bathing twice as sheets after the CNAs or if they refuse. She said that if shows when the resident had a shower CNA and get confirmated bathing twice as offered bathing twice as offered bathing twice as sheets.	as completed for the weeks and July 25 to 31. ducted on June 23, 2022 at ed Nursing Assistant aid that each day she is a certain amount of at showers are posted on broken down by shift. Bed by shift and evening does at if she cannot complete a she will tell the nurse and at will be able to complete that there are very few days ower. She said that ted on a specific paper and the nurse every day. She also documented in the id that the CNA's would not a shower without shower cumentation unless they worked that day. The provided in the idea of the provided and the nurse can go and look up the resident and dent has had a shower/bed the did not know if a then she would ask the ion. The provided in the idea of the provided and that the nurses can go and look up the resident and dent has had a shower/bed the did not know if a then she would ask the ion.	F 67			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPU A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		035099	B. WING		06/24/2022	
	RCVIDER OR SUPPLIER DNE OF TUCSON REHAE	CENTRE		STREET ADDRESS, CITY, STATE, ZIP CODE 2900 EAST MILBER STREET TUCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 677	did not meet her expensived shower and/or the facility has a show do showers, however on the floor at times. An interview was contained that she does not bathing problem or a that there is a problem. Review of the facility's February 2018, reveateanliness, provide to observe the condition of time a shower was peof the individual(s) with the shower. The policy included to time a shower was peof the individual(s) with shower. The policy resident refused the state reason(s) why and person recoding the cand include their title. Maintains Effective People (CIFR(s): 483.90(i)(4). Shaded on observation review of facility documents. This REQUIREMENT for the facility failed to maintain program to ensure the program to ensure the	ectations that the residents is bed baths. She said that wer aid who was assigned to it, they do get pulled to help ducted on June 24, 2022 at inistrator (staff #26) who it know if the facility has a documentation problem, but in. Is bathing policy, revised led a purpose to promote comfort to the residents, and on of the residents' skin in document the date and enformed as well as the title to assisted the resident with my included that if the shower, staff will document do the intervention taken. The lata ishould sign the form the sest Control Program In an effective pest control accility is liree of pests and mentation and policy, the ain an effective pest control of accility was free from a practice could result in	F 677		l ng	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 07/07/2022 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING_ CB. WING 035099 06/24/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2900 EAST MILBER STREET SANDSTONE OF TUCSON REHAB CENTRE TUCSON, AZ 85714 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 925 Continued From page 5 F 925 B. Identify other residents 1. No other residents were found to be affected by the alleged deficient practice Findings include: noted. However, all residents have the potential to be affected by the alleged A review of pest control inspections and services deficient practice. from an outside exterminator from October 13. 2021 through June 16, 2022 included: C. Measures 1. On June 23, 2022. Director of 2021 Maintenance in-serviced and implement the -October 13 - Includes rodent station install staff on the following topics but not limited -October 14 - Invoice for 7 week rodent trapping a. Facility policies and procedures for cleaning resident rooms -April 12 - Rodent bait stations some activity b. Requirements for compliance regarding -April 14 - Inspection of rodent bait stations some completion of cleaning logs activity c. Importance of utilizing the pest control -May 12 - Inspection of rodent bait stations some d. Administrator or designee initiated a QA activity tool on June 23, 2022 regarding resident -June 2 - Installed 10 traps units room cleanings to ensure: -June 9 - Inspection of rodent bait stations some Resident rooms are cleaned appropriately activity per facility policy Cleaning logs are appropriately completed Review of the facility's pest log from October 23, by housekeeping staff 2021 through June 16, 2022 included: D. Corrective Action 2021 1. The housekeeping director or designee 7/29/22 -November 20 - Nightshift reported mouse in a will continue to conduct daily random audits resident room for 6 weeks to ensure that resident rooms are appropriately cleaned and that cleaning logs 2022 are completed by facility staff -January 20 - Droppings in three resident rooms 2. The maintenance director or designee will -January 26 - Mice in two resident rooms continue to conduct random twice a week -February 4 - Mice feces in a resident room audits for 6 weeks on door seals that lead to -March 1 - Mouse in one resident room, mouse the outside caught in another resident room 3. The results of the audits completed on this -May 9 - Mice in one resident room POC will be submitted to the Quality Assurance and Performance Improvement -May 26 - Mice caught in several resident rooms committee for review and follow up

-April 11 - Mice droppings in one resident room -May 27 - Mouse caught in one resident room -June 14 - Rodents heard from up above in front

PRINTED: 07/07/2022

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING_ 035099 B WING 06/24/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2900 EAST MILBER STREET SANDSTONE OF TUCSON REHAB CENTRE **TUCSON, AZ 85714** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 925 Continued From page 6 F 925 office and lobby An interview was conducted on June 17, 2022 at 2:10 PM with a resident (#6) who said that he has seen mice in his room and that one was caught last night in a trap. He said that the mice are in the bathroom as well. An observation was conducted of resident #6's bathroom immediately after the interview. Behind the toilet brush and trash can, there were small. dark brown objects that had the appearance of rodent droppings. An interview was conducted on June 17, 2022 at 2:20 PM with a resident (#72) who said little mice were running around and that he had seen one two days ago. This resident's roommate (#34) said that there was a little rat and a couple of little liny ones An observation was conducted on June 17, 2022 at 2:24 PM in resident #98's room. The resident's bed was moved out and there were small, dark brown objects that had the appearance of rodent droppings against the wall where the head of the bed would be. The room also contained a metal rodent trap under the sink. An observation was conducted on June 17, 2022 at 3:00 PM of a vacant resident room (room 213) which had a hole approximately 5 inches by 10 inches in the corner of the bathroom in the wall near the sink. This room had multiple small, dark brown objects with the appearance of rodent

feces behind the nightstand.

An observation was conducted on June 20, 2022 of a gap under and between double doors to the

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER DNE OF TUCSON REHAB	CENTRE	2900	EET ADDRESS, CITY, STATE, ZIP CODE EAST MILBER STREET SON, AZ 85714		
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F 925	outside loading dock: An observation was c at 7:23 AM of residen the floor there were signed that had the appearant corner of the dresser. An interview was conditional to the director of the dresser. An interview was conditional to the director of the dresser. An interview was conditional to the director of the dresser. An interview was conditional to the director of the director of mainten suggestions that he model to the company started pand if they see activity said that they put weadoors and that seems that he does not know having trouble with minute the director of the they bait stations. He said that they bait stations. He said that they bait stations and that they bait stations that he models come from out the areas, sometimes said that they come instead and because it is.	and waste disposal area. conducted on June 21, 2022 t #98 and #62's room. On mall, dark brown objects are of rodent feces at the closest to the sink. ducted on June 21, 2022 at ector of maintenance (staff started in this position in id that he renewed the control company that was a used them because he with the rodents. He said butting traps in the building they keep using them. He ther stripping across the to have helped. He said why the facility is still ce. the a pest control staff June 21, 2022 at 12:30 company has had a ly for the last 8 months to a ly have traps in place and that the rodents were gone bey have been back again. He said that he works with ance who does follow the lakes. He said that the iside and that if they seal they get sealed inside. He saide looking for water and	F 925			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 925	who acknowledged the outside trash area and inches at the base of twere more gaps at was these were likely cause the door. He said that door. An interview was conducted that the facility has this problem and that it said that they do have place. The facility's pest contuinsects and rodents from policy included that all tight fitting and free of shall be kept in such contents.	e gap in the door to the disaid it was about 0.5 the door. He said there list and chest high and that ed by delivery people hitting e were bait stations outside the would fix the gaps in the districted on June 24, 2022 at inistrator (staff #26) who is spent a lot of money on they are trying to fix it. She a pest control program in the rol policy, dated November repose to prevent or control or spreading disease. This building openings shall be breaks, and that the facility ondition and cleaning event the harborage or	F 9:	25		



July 7, 2022

Receipt Of This Notice Is Presumed To Be -07/07/2022 Important Notice - Please Read Carefully

Mr. Ryan Valdez, Administrator Sandstone Of Tucson Rehab Centre 2900 East Milber Street Tucson, AZ 85714

Dear Mr. Valdez:

On June 24, 2022, a Medicare abbreviated survey #DOE011 was conducted at your facility by the Department of Health Services, Bureau of Long Term Care to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. During this survey, complaints investigations may have also been conducted.

- [] This survey found the most serious deficiency(ies) in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the attached form 2567 whereby corrections are required (D).
- [X] This survey found the most serious deficiency(ies) in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the attached form 2567 whereby corrections are required (E).
- [] This survey found the most serious deficiency(ies) in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the attached form 2567 whereby corrections are required (F).

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Douglas A. Ducey | Governor D

Don Herrington | Interim Director

Sandstone Of Tucson Rehab Centre July 7, 2022 Page Two

Plan of Correction

A Plan of Correction (PoC) for the deficiencies must be submitted by **July 17, 2022**. You must include all pages of the Statement of Deficiencies when submitting your PoC.

Failure to submit an acceptable PoC by July 17, 2022 may result in the imposition of remedies.

The POC must be signed and dated by an official facility representative. Please send your POC by email to the following:

ltc.licensing@azdhs.gov

SUBJECT LINE: the name of your facility and POC

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice, on both a temporary and permanent basis, including the date the correction will be accomplished;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the
 deficient practice does not recur; and,
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and the title, or position, of the person responsible for implementing/monitoring the corrective action.
- The signature and date you approve the Plan of Correction on the first page.
- Please provide all in-service records to include:
 - What was taught
 - When it was taught
 - Sign-in sheets of those who attended
 - Any copies of monitoring adults being done up to your Allegation of Compliance date

Allegation of Compliance

Your properly signed Plan of Correction constitutes your credible allegation of compliance. We may accept the Plan of Correction and presume compliance until substantiated by a revisit or other means.

To ensure that this office has time to confirm compliance before mandatory remedies are imposed, the Bureau of Long Term Care recommends that an allegation of compliance date be within one week of August 8, 2022.

Sandstone Of Tucson Rehab Centre July 7, 2022 Page Three

If, upon a subsequent revisit, your facility has not achieved substantial compliance, the Bureau of Long Term Care will recommend that remedies be imposed by the CMS Regional Office or the State Medicaid Agency and continue until substantial compliance is achieved.

Recommended Remedies

The remedies which will be recommended if substantial compliance is not achieved include the following:

Recommending to CMS Civil Money, effective June 24, 2022 Recommending to CMS Denial of Payment for New Admission

Mandatory Remedies

Your current period of noncompliance began on June 24, 2022. If you do not achieve substantial compliance within three months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions. The CMS Regional Office must terminate your provider agreement if substantial compliance has not been reached by **December 21, 2022**.

Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate). A change in the seriousness of the deficiencies may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

Notice for Statutory Denial of Payment for New Admissions (DPNA)

Based on deficiencies cited during this survey and as authorized by CMS San Francisco Regional Office, we are giving formal notice of imposition of statutory Denial of Payment for New Admissions effective September 22, 2022. This remedy will be effectuated on the stated date unless you demonstrate substantial compliance with an acceptable plan of correction and subsequent revisit.

This notice in no way limits the prerogative of CMS to impose discretionary DPNA at any appropriate time. CMS Regional Office will notify your intermediary and the Medicaid Agency. If effectuated, denial of payment will continue until your facility achieves substantial compliance or your provider agreement is terminated. [Facilities are prohibited from billing those Medicare/Medicaid residents or their responsible parties during the denial period for services normally billed to Medicare or Medicaid} The Medicare and Medicaid programs will make no payment for residents whose plans of care begin on or after the DPNA effective date.

FILING AN APPEAL

If you disagree with the determination of noncompliance (and/or substandard quality of care resulting in the loss of your Nurse Aide Training and Competency Evaluation Program (NATCEP), if applicable), you or your legal representative may request a hearing before an

Sandstone Of Tucson Rehab Centre July 7, 2022 Page Four

administrative law judge of the U.S. Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in 42 CFR §498.40, et. seq. You may appeal the finding of noncompliance that led to an enforcement action, but not the enforcement action or remedy itself. A request for a hearing should identify the specific issues, and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You may have counsel represent you at a hearing (at your own expense). Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted unless you do not have access to a computer or internet service. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than 60 days from the date of receipt of this letter.

When using DAB E-File for the first time, you will need to create an account by a) clicking Register on the DAB E-File home page; b) entering the requested information on the Register New Account form; and c) clicking Register Account at the bottom of the form. Each representative authorized to represent you must register separately to use the DAB E-File on your behalf.

The e-mail address and password given during registration must be entered on the login screen at: https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he/she is a party or an authorized representative. You can file a new appeal by a) clicking the File New Appeal link on the Manage Existing Appeals screen; then b) clicking Civil Remedies Division on the File New Appeal screen; and c) entering and uploading the requested information and documents on the File New Appeal-Civil Remedies Division form.

The Civil Remedies Division (CRD) requires all hearing requests to be signed and accompanied by the notice letter from CMS that addresses the action taken and your appeal rights. All submitted documents must be in Portable Document Format (PDF). Documents uploaded to DAB E-File on any day on or before 11:59p.m. ET will be considered to have been received on that day. You will be expected to accept electronic service of any appeal-related documents filed by CMS or that the CRD issues on behalf of the Administrative Law Judge (ALJ) via DAB E-File. Further instructions are located at: https://dab.efile.hhs.gov/appeals/to_crd_instructions. Please contact the Civil Remedies Division at (202) 565-9462 if you have questions regarding the DAB E-Filing System. If you experience technical issues with the DAB E-Filing System, please contact E-File System Support at OSDABImmediateOffice@hhs.gov or call (202) 565-0146 before 4:00p.m. ET.

If you do not have access to a computer or internet service, you may call the Civil Remedies Division at (202) 565-9462 to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

Douglas A. Ducey | Governor Don Herrington | Interim Director

150 North 18th Avenue, Suite 440, Phoenix, AZ 85007-3247 P | 602-364-2690 F | 602-324-0993

W | azhealth.gov

Sandstone Of Tucson Rehab Centre July 7, 2022 Page Five

In addition, please email a copy of your request to Western Division of Survey and Certification-San Francisco at ROSFEnforcements@cms.hhs.gov.

Informal Dispute Resolution

In accordance with §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, an explanation of why you are disputing those deficiencies along with supporting information that shows that the facility was in compliance at the time of the survey to Diane Eckles, Bureau Chief, Bureau of Long Term Care, 150 North 18th Avenue, Suite 440, Phoenix, Arizona 85007. This request must be sent during the same 10 days you have for submitting a PoC for the cited deficiencies.

An informal dispute resolution process will not delay the effective date of any enforcement action. Please note: Facilities requesting an Informal Dispute Resolution must submit separate requests, one for State deficiencies cited and one for Federal deficiencies cited, if applicable.

Retain a copy of the PoC for your files. If the PoC is not received by this Office by July 17, 2022, licensure and/or recertification may be denied. If you have any questions concerning the instructions contained in this letter, please contact the Bureau of Long Term Care at (602) 364-2690.

Sincerely,

Diane Eckles Bureau Chief

seare Eokles

DE:bk

RECEIVED BLTC 7-16-22 MM

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 07/07/2022 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING_ B. WING 035099 06/24/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2900 EAST MILBER STREET SANDSTONE OF TUCSON REHAB CENTRE **TUCSON, AZ 85714** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) **INITIAL COMMENTS** F 000 F 000 This Plan of Correction is submitted to meet the requirements established by Federal law. The investigation of complaints AZ00181681, This Plan of Correction constitutes this AZ00179201, AZ00178373, AZ00178379, and facility's demonstration of compliance for AZ00178241 was conducted on June 17, 2022 the deficiencies cited. Submission of this and from June 20 through 24, 2022. The following Plan of Correction is not an admission that a deficiencies were cited: deficiency existed or that one was correctly ADL Care Provided for Dependent Residents F 677 F 677 SS=E CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry F677 out activities of daily living receives the necessary A. Corrective actions: services to maintain good nutrition, grooming, and 1. Residents #46, #136, and #140 were not personal and oral hygiene; found affected by this alleged deficient This REQUIREMENT is not met as evidenced practice. Based on clinical record reviews, staff interviews. 2. Residents #46 and #136 received showers facility documentation, and policy, the facility and/or following facility survey, per facility failed to provide adequate showers for three shower schedule. Resident #140 discharged residents (#46, #136, and #140). The sample size from the facility on August 6, 2021. was three residents. The deficient practice could result in residents with unmet hygiene needs. 3. Documentation for showers and/or bed baths are available on electronic medical Findings include: records and/or uploaded into resident charts. Review of facility documentation revealed a shower schedule which included that residents **B.** Identify other residents are to receive two showers per week. 1.No other residents were found to be affected by the alleged deficient practice -Resident #46 was admitted on November 6. noted. However, all residents have the 2021 with diagnoses that included difficulty in potential to be affected by the alleged walking and vertigo of central origin. deficient practice. The resident's Activities of Daily Living (ADL) care

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

plan revealed the resident had a self-care performance deficit related to weakness, unsteadiness on feet, difficulty walking, and activity intolerance from respiratory failure. An intervention included to encourage the resident to

(X6) DATE

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.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 677	participate in the fulle interaction. A quarterly Minimum assessment dated Maresident required supphysical assistance for extensive assistance assessment included self-performance and did not occur during the formation of the assessment. The Brief Interview for indicating he was cognowed as the compact of the clinical June, 2022 included the regarding showers and showers/bed baths weeks of: April 3 to 9, June 4, and June 5 to 1 shower/bed bath word: April 17 to 23 and 17 resident #136 was a November 19, 2019 wand hemiplegia. The resident's ADL caresident had a self-carelated to decreased the hemiplegia of the righ intervention included extensive assistance needed.	Data Set (MDS) ay 6, 2022 included that the ervision with one-person or personal hygiene and for bed mobility. This that bathing bathing support provided the 7-day look-back window are resident scored a 15 on Mental Status (BIMS) initively intact. If record for April through the following information addor bed baths: If were completed for the April 10 to 16, May 29 to 11. It was completed for the weeks May 1 to 7. Indmitted to the facility on with diagnoses of dementia	F	677	C. Measures 1. On July 15th, 2022, Nurse Unit Managin-serviced and implement the staff on the following topics but not limited to: a. Facility policies and procedures for Acare provided for dependent residents, including showers and bed baths b. Requirements for compliance regarding completion of shower sheets/bed baths a post shower documentation c. Administrator initiated a QA tool on J 12, 2022 regarding ADL Care and show and bed baths to ensure: Resident are receiving showers and bed baths per the facility shower schedule Documentation following show and/or bed bath is completed a uploaded into patient's chart. D. Corrective Actions 1. The administrator or designee will continue to conduct random audits for 6 weeks to ensure that residents are received showers per facility schedule and that shower documentation is available on electronic medical records and/or uploaded into resident chart. 2. The results of the audits completed on the POC will be submitted to the Quality Assurance and Performance Improvement committee for review and follow up.	the ADL Ing and fully ers s wers and his	
	included that the resid	dent required physical help process and required setup					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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	A review of the clinica June, 2022 included the regarding showers and -0 showers/bed baths weeks of: April 3 to 9, 16, April 17 to 23, April 17 to 23, April 17 to 23, April 17 to 23, April 17 to 7, May 9 to 18 decision of: May 1 to 7, May 9 to 19 decision of: May 1 to 19 decisi	e resident scored a 0 on the e cognitive impairment. I record for April through the following information d/or bed baths: were completed for the April 10 to 16, April 11 to il 24 to 30, and May 15 to as completed for the weeks to 14, and June 5 to 11. Idmitted to the facility on the diagnoses of demential ance and muscle and muscle and muscle and muscle and muscle are performance deficit and impaired cognition from the resident for any changes assent dated July 23, 2021 ent required physical help rocess and required 1	F 6			
	resident scored 0 on the cognitive impairment. A review of the clinical July, 2021 included the regarding showers and -0 showers/bed baths with the resident of the company of the compan	l/or bed baths: were completed for the , June 13 to 19, July 4 to				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		NG	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 677	-1 shower/bed bath w of: June 27 to July 3 a An interview was cond 2:36 PM with a Certifi (CNA/staff #96) who sassigned to complete showers. She said that the bulletin board and one is done on the dabed two. She said that shower, then normally hopefully the next shift the shower. She said she cannot get to a she cannot get to a showers are document that gets turned into the said that showers are clinical record. She saknow that residents has sheets or computer do asked the person that An interview was cond 1:55 PM with a Licens (LPN/staff #72) who so sheets after the CNAs or if they refuse. She so to the clinical record a it shows when the resident had a shower CNA and get confirma An interview was cond 12:46 PM with the interview was cond 12:46 PM with the interview bathing twice as offered bathing twice as sheets aftered bathing twice as offered bathing twice as sheets aftered bathing twice as offered bathing twice as sheets aftered bathing twice as offered bathing twice as sheets aftered bathing twice as offered bathing twice as sheets aftered bathing twice as offered bathing twice as sheets aftered bathing twice as offered bathing twice as sheets aftered bathing twice as offered bathing twice as sheets after the CNAs or if they refuse. She said that if sheets after the CNAs or if they refuse.	as completed for the weeks and July 25 to 31. ducted on June 23, 2022 at ed Nursing Assistant said that each day she is a certain amount of at showers are posted on broken down by shift. Bed y shift and evening does to she will tell the nurse and to will be able to complete at she will tell the nurse and to will be able to complete that there are very few days shower. She said that there are very few days shower. She said that the curse every day. She also documented in the identity of the day worked that day. Bucted on June 23, 2022 at ed Practical Nurse and that she signs shower have bathed the resident said that the nurses can go and look up the resident and dent has had a shower/bed he did not know if a then she would ask the tion.	F	677			

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SANDSTONE OF TUCSON REHAB CENTRE 2900 EAST MILBER STREET TUCSON, AZ 85714					2900 EAST MILBER STREET		
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did not meet her expectations that the residents missed shower and/or bed baths. She said that the facility has a shower aid who was assigned to do showers, however, they do get pulled to help on the floor at times. An interview was conducted on June 24, 2022 at 1:30 PM with the administrator (staff #25) who said that she does not know if the facility has a bathing problem or a documentation problem, but that there is a problem. Review of the facility's bathing policy, revised February 2018, revealed a purpose to promote cleanliness, provide comfort to the residents, and to observe the condition of the residents, and to observe the condition of the residents, and to observe the condition of the resident with the shower. The policy included that if the resident refused the shower, staff will document the reason(s) why and the intervention taken. The person recoding the data should sign the form and include their title. F925 SS=E CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and review of facility documentation and policy, the facility failed to maintain an effective pest control program to ensure the facility was free from rodents. The deficient practice could result in ongoing rodent problems.	F 925 SS=E	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 did not meet her expectations that the residents missed shower and/or bed baths. She said that the facility has a shower aid who was assigned to do showers, however, they do get pulled to help on the floor at times. An interview was conducted on June 24, 2022 at 1:30 PM with the administrator (staff #26) who said that she does not know if the facility has a bathing problem or a documentation problem, but that there is a problem. Review of the facility's bathing policy, revised February 2018, revealed a purpose to promote cleanliness, provide comfort to the residents, and to observe the condition of the residents' skin. The policy included to document the date and time a shower was performed as well as the title of the individual(s) who assisted the resident with the shower. The policy included that if the resident refused the shower, staff will document the reason(s) why and the intervention taken. The person recoding the data should sign the form and include their title. Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and review of facility documentation and policy, the facility failed to maintain an effective pest control program to ensure the facility was free from rodents. The deficient practice could result in			A. Corrective actions: 1. No residents were found to be affected the alleged deficient practice. 2. Residents #6, #72, #34, #98, #62 had rooms cleaned at the time of survey, and were all deep cleaned following survey 3. Gap underneath double doors to loading dock was fixed at time of survey. Vacant room 213 gap in wall was patched and rooms 213 gap in wall was patched.	ng t	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
			A. BUILDING		С				
035099			B. WING_						
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE					
SANDSTONE OF TUCSON REHAB CENTRE			2	900 EAST MILBER STREET					
SANDSTO	THE OF TOOSON KENAB	CENTRE		T	UCSON, AZ 85714				
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	SHOULD BE COMPLETION			
F 925	from an outside extern 2021 through June 16 2021 -October 13 - Includes -October 14 - Invoice 2022 -April 12 - Rodent bait -April 14 - Inspection of activity -May 12 - Inspection of activity -June 2 - Installed 10 -June 9 - Inspection of activity Review of the facility's 2021 through June 16 2021 -November 20 - Night resident room 2022 -January 26 - Mice in -February 4 - Mice fee -March 1 - Mouse in ocaught in another resi -May 9 - Mice in one r -May 26 - Mice caugh -April 11 - Mice droppile -May 27 - Mouse caugh	ol inspections and services minator from October 13, 2022 included: s rodent station install for 7 week rodent trapping s stations some activity of rodent bait stations some of rodent rooms of resident room of the resident room of th	FS	925	weeks on door seals that lead to the out 3.The results of the audits completed or POC will be submitted to the Quality	ing of QA at ely ted logs e will side a this			
	-January 26 - Mice in -February 4 - Mice fed -March 1 - Mouse in o caught in another resi -May 9 - Mice in one r -May 26 - Mice caugh -April 11 - Mice droppi -May 27 - Mouse caugh	two resident rooms tes in a resident room the resident room, mouse dent room tesident room t in several resident rooms tings in one resident room	continue to conduct random audits for 6 weeks on door seals that lead to the outside 3. The results of the audits completed on this POC will be submitted to the Quality Assurance and Performance Improvement committee for review and follow up		side n this				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	D MANA						С	
		035099	B. WNG _	WING			/24/2022	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
				2900 EAST MILBER STREET				
SANDSTO	NE OF TUCSON REHAB	CENTRE		TUCSON, AZ 85714				
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION			N (X5)		
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	X (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)		COMPLETION DATE		
F 925	Continued From page	6	F 9	925				
	office and lobby							
	An interview was conducted on June 17, 2022 at 2:10 PM with a resident (#6) who said that he has seen mice in his room and that one was caught last night in a trap. He said that the mice are in the bathroom as well.							
	An observation was conducted of resident #6's bathroom immediately after the interview. Behind the toilet brush and trash can, there were small, dark brown objects that had the appearance of rodent droppings.							
	2:20 PM with a resider were running around a two days ago. This res	ducted on June 17, 2022 at ant (#72) who said little mice and that he had seen one sident's roommate (#34) ittle rat and a couple of little						
	at 2:24 PM in resident bed was moved out ar brown objects that had droppings against the	menducted on June 17, 2022 #98's room. The resident's and there were small, dark of the appearance of rodent wall where the head of the om also contained a metal						
	at 3:00 PM of a vacant 213)which had a hole 10 inches in the corne wall near the sink. This	approximately 5 inches by r of the bathroom in the sroom had multiple small, h the appearance of rodent						
		anducted on June 20, 2022 tween double doors to the						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035099 B. WING			С	
			D. WING _		06/24/2022
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	
CANDOTONE OF THOSON BELLAR CENTRE				2900 EAST MILBER STREET	
SANDSTONE OF TUCSON REHAB CENTRE				TUCSON, AZ 85714	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
	An observation was c at 7:23 AM of resident the floor there were significant that had the appearant corner of the dresser of t	and waste disposal area. conducted on June 21, 2022 t #98 and #62's room. On mall, dark brown objects are of rodent feces at the closest to the sink. ducted on June 21, 2022 at ector of maintenance (staff started in this position in id that he renewed the control company that was e used them because he ewith the rodents. He said butting traps in the building they keep using them. He ther stripping across the to have helped. He said why the facility is still ce. th a pest control staff June 21, 2022 at 12:30 company has had a y for the last 8 months to a y have traps in place and hat the rodents were gone ey have been back again He said that he works with ance who does follow the akes. He said that the side and that if they seal they get sealed inside. He side looking for water and comfortable.	F9	25	
		ucted at 8:08 AM on June ctor of Maintenance (Staff			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	TIPLE CONSTRUCTION NG	N (X3) DATE S COMPLE		
035099		B. WNG			С		
			00/24/2022				
NAME OF PROVIDER OR SUPPLIER			- 1	STREET ADDRESS, CITY, STATE, ZIP CODE			
SANDSTONE OF TUCSON REHAB CENTRE) I	2900 EASTMILBER STREET			
SANDSTONE OF TOCSON REHAB CENTRE				TUCSON, AZ 85714			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUNDERSON CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 925	#8) who acknowledged the outside trash area and inches at the base of were more gaps at was these were likely cause the door. He said that door. An interview was conducted that the facility has this problem and that said that they do have place. The facility's pest conducted that all tight fitting and free of shall be kept in such construction.	e gap in the door to the disaid it was about 0.5 the door. He said there aist and chest high and that sed by delivery people hitting e were bait stations outside he would fix the gaps in the diucted on June 24, 2022 at inistrator (staff #26) who as spent a lot of money on they are trying to fix it. She a pest control program in the arrows to prevent or control or spreading disease. This building openings shall be breaks, and that the facility condition and cleaning event the harborage or	FS	925			



July 26, 2022

Important Notice - Please Read Carefully

Ryan Valdez, Administrator Sandstone Of Tucson Rehab Centre 2900 East Milber Street Tucson, AZ 85714

Re:

Complaint Intake: #AZ00178241; #AZ00178242

#AZ00178373; #AZ00178375 #AZ00178379; #AZ00183243

Investigation: #DOE011

Dear Mr. Valdez:

Surveyors of the Arizona Department of Health Services (Department) have thoroughly investigated the above referenced complaint. Prior to being investigated, this complaint was broken down into allegations that correspond to the Department's rules for the facility.

The overall finding of this investigation is that at least one of the allegations was found to be substantiated.

You are in receipt of a Statement of Deficiencies that reflect the finding of this survey.

If we may be of further assistance, please contact the Bureau of Long Term Care at (602) 364-2690.

Sincerely,

Bernadette Keilman

Bureau of Long Term Care Licensing

Kilman

/bk



July 26, 2022

Important Notice - Please Read Carefully

Mr. Ryan Valdez, Administrator Sandstone Of Tucson Rehab Centre 2900 East Milber Street Tucson, AZ 85714

Re:

Complaint Intake: #AZ00179201; #AZ00179202

#AZ00181681; #AZ00181682

Investigation: #DOE011

Dear Mr. Valdez:

Surveyors of the Arizona Department of Health Services (Long Term Care) have thoroughly investigated the above referenced complaint. Prior to being investigated, this complaint was broken down into allegations that correspond to the Department's rules for the facility.

The overall finding of this investigation is that the allegations were unable to be substantiated.

You are in receipt of a Statement of Deficiencies for this survey that confirms the complaint was unsubstantiated.

If we may be of further assistance, please contact the Bureau of Long Term Care at (602) 364-2690.

Sincerely,

Bernadette Keilman

Bureau of Long Term Care Licensing

urnadette Keilman

/bk