Medicare/Medicaid
Public Records Documents Only

Survey event #DOE0

Facility: SANDSTONE OF TUCSON REHAB

Revised 7-2020

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: DOE012

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: LTC0053

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **035099**

2.STATE VENDOR OR MEDICAID NO.
(L2) **835118**

3. NAME AND ADDRESS OF FACILITY
(L3) **SANDSTONE OF TUCSON REHAB CENTRE**
(L4) **2900 EAST MILBER STREET**
(L5) **TUCSON, AZ** (L6) **85714**

4. TYPE OF ACTION: **6** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds (L18)

13.Total Certified Beds (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
An offsite revisit survey event #DOE012 for complaint investigation was conducted on July 25, 2022. No deficiencies were cited.

17. SURVEYOR SIGNATURE
For Matthew Connolly, HCCM, by BKeilman
Bernadette Keilman
Date : 07/26/2022
(L19)

18. STATE SURVEY AGENCY APPROVAL
Bernadette Keilman
Date: Megan Whetley 07/26/2022
(L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
00000
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

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

Bernadette Keilman
LTC Customer Service Representative IV

\bk

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035099	A. BUILDING _____ B. WING _____	R-C 07/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDSTONE OF TUCSON REHAB CENTRE	**2900 EAST MILBER STREET TUCSON, AZ 85714**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An offsite follow-up survey was conducted on July 25, 2022. No deficiencies were cited.	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (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.

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
035099 Y1	A. Building B. Wing Y2	7/25/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDSTONE OF TUCSON REHAB CENTRE	2900 EAST MILBER STREET TUCSON, AZ 85714

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0677 Reg. # 483.24(a)(2) LSC	Correction Completed 07/29/2022	ID Prefix F0925 Reg. # 483.90(i)(4) LSC	Correction Completed 07/29/2022	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[X]	MC	7/25/2022	[signature]	7/25/2022
REVIEWED BY CMS RO [ ]	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
6/24/2022	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

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

UPOC F Tag

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

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 Whitby

Megan Whitby
Interim Long Term Care Bureau Chief

MW/MC:mm

Attachments

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035099	A. BUILDING _____ B. WING _____	C 06/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDSTONE OF TUCSON REHAB CENTRE	2900 EAST MILBER STREET TUCSON, AZ 85714

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F 000	INITIAL COMMENTS The investigation of complaints AZ00181681, AZ00179201, AZ00178373, AZ00178379, and AZ00178241 was conducted on June 17, 2022 and from June 20 through 24, 2022. The following deficiencies were cited:	F 000	**F000** This Plan of Correction is submitted to meet the requirements established by Federal law. This Plan of Correction constitutes this facility's demonstration of compliance for the deficiencies cited. Submission of this Plan of Correction is not an admission that a deficiency existed or that one was correctly cited.	
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, staff interviews, facility documentation, and policy, the facility failed to provide adequate showers for three residents (#46, #136, and #140). The sample size was three residents. The deficient practice could result in residents with unmet hygiene needs. Findings include: Review of facility documentation revealed a shower schedule which included that residents are to receive two showers per week. -Resident #46 was admitted on November 6, 2021 with diagnoses that included difficulty in walking and vertigo of central origin. The resident's Activities of Daily Living (ADL) care 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	F 677	*F677* **A. Corrective actions:** 1. Residents #46, #136, and #140 were not found affected by this alleged deficient practice. 2. Residents #46 and #136 received showers and/or following facility survey, per facility shower schedule. Resident #140 discharged from the facility on August 6, 2021. 3. Documentation for showers and/or bed baths are available on electronic medical records and/or uploaded into resident charts. **B. Identify other residents** 1.No other residents were found to be affected by the alleged deficient practice noted. However, all residents have the potential to be affected by the alleged deficient practice.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (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 677	Continued From page 1 participate in the fullest extent possible with each interaction. A quarterly Minimum Data Set (MDS) assessment dated May 6, 2022 included that the resident required supervision with one-person physical assistance for personal hygiene and extensive assistance for bed mobility. This assessment included that bathing self-performance and bathing support provided did not occur during the 7-day look-back window of the assessment. The resident scored a 15 on the Brief Interview for Mental Status (BIMS) indicating he was cognitively intact. A review of the clinical record for April through June, 2022 included the following information regarding showers and/or bed baths: -0 showers/bed baths were completed for the weeks of: April 3 to 9, April 10 to 16, May 29 to June 4, and June 5 to 11. -1 shower/bed bath was completed for the weeks of: April 17 to 23 and May 1 to 7. -Resident #136 was admitted to the facility on November 19, 2019 with diagnoses of dementia and hemiplegia. The resident's ADL care plan revealed the resident had a self-care performance deficit related to decreased mobility, weakness, and hemiplegia of the right dominant side. An intervention included to provide supervision to extensive assistance from staff for ADLS as needed. A quarterly MDS assessment dated June 8, 2022 included that the resident required physical help in part of the bathing process and required setup	F 677	**C. Measures** 1. On July 15th, 2022, Nurse Unit Manager in-serviced and implement the staff on the following topics but not limited to: a. Facility policies and procedures for ADL care provided for dependent residents, including showers and bed baths b. Requirements for compliance regarding completion of shower sheets/bed baths and post shower documentation c. Administrator initiated a QA tool on July 12, 2022 regarding ADL Care and showers and bed baths to ensure: Resident are receiving showers and bed baths per the facility shower schedule Documentation following showers and/or bed bath is completed and uploaded into patient's chart. **D. Corrective Actions** 1. The administrator or designee will continue to conduct random twice a week audits for 6 weeks to ensure that residents are receiving 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 this POC will be submitted to the Quality Assurance and Performance Improvement committee for review and follow up.	7/29/22

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F 677	Continued From page 2 help with bathing. The resident scored a 0 on the BIMS indicating severe cognitive impairment. A review of the clinical record for April through June, 2022 included the following information regarding showers and/or bed baths: -0 showers/bed baths were completed for the weeks of: April 3 to 9, April 10 to 16, April 11 to 16, April 17 to 23, April 24 to 30, and May 15 to 21. -1 shower/bed bath was completed for the weeks of: May 1 to 7, May 9 to 14, and June 5 to 11. -Resident #140 was admitted to the facility on February 28, 2021 with diagnoses of dementia with behavioral disturbance and muscle weakness. This resident discharged on August 6, 2021. The resident's ADL care plan revealed the resident had a self-care performance deficit related to confusion and impaired cognition from dementia and Alzheimer's. An intervention included to monitor the resident for any changes in ability. A quarterly MDS assessment dated July 23, 2021 included that this resident required physical help in part of the bathing process and required 1 person physical assistance with bathing. The resident scored 0 on the BIMS indicating severe cognitive impairment. A review of the clinical record for June through July, 2021 included the following information regarding showers and/or bed baths: -0 showers/bed baths were completed for the weeks of: June 6 to 12, June 13 to 19, July 4 to 10, July 11 to 17, and July 18 to 24.	F 677		

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F 677	Continued From page 3 -1 shower/bed bath was completed for the weeks of: June 27 to July 3 and July 25 to 31. An interview was conducted on June 23, 2022 at 2.36 PM with a Certified Nursing Assistant (CNA/staff #96) who said that each day she is assigned to complete a certain amount of showers. She said that showers are posted on the bulletin board and broken down by shift. Bed one is done on the day shift and evening does bed two. She said that if she cannot complete a shower, then normally she will tell the nurse and hopefully the next shift will be able to complete the shower. She said that there are very few days she cannot get to a shower. She said that showers are documented on a specific paper and that gets turned into the nurse every day. She said that showers are also documented in the clinical record. She said that the CNA's would not know that residents had a shower without shower sheets or computer documentation unless they asked the person that worked that day. An interview was conducted on June 23, 2022 at 1:55 PM with a Licensed Practical Nurse (LPN/staff #72) who said that she signs shower sheets after the CNAs have bathed the resident or if they refuse. She said that the nurses can go to the clinical record and look up the resident and it shows when the resident has had a shower/bed bath. She said that if she did not know if a resident had a shower then she would ask the CNA and get confirmation. An interview was conducted on June 23, 2022 at 12:46 PM with the interim Director of Nursing (DON/staff #30) who said that residents are offered bathing twice a week and additional bathing upon the resident's request. She said it	F 677		

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 677	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.	F 677		
F 925 SS=E	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 ongoing rodent problems.	F 925	*F925* **A. Corrective actions:** 1. No residents were found to be affected by 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 room was deep cleaned at time of survey.	

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F 925	Continued From page 5 Findings include: A review of pest control inspections and services from an outside exterminator from October 13, 2021 through June 16, 2022 included: 2021 -October 13 - Includes rodent station install -October 14 - Invoice for 7 week rodent trapping 2022 -April 12 - Rodent bait stations some activity -April 14 - Inspection of rodent bait stations some activity -May 12 - Inspection of rodent bait stations some activity -June 2 - Installed 10 traps units -June 9 - Inspection of rodent bait stations some activity Review of the facility's pest log from October 23, 2021 through June 16, 2022 included: 2021 -November 20 - Nightshift reported mouse in a resident room 2022 -January 20 - Droppings in three resident rooms -January 26 - Mice in two resident rooms -February 4 - Mice feces in a resident room -March 1 - Mouse in one resident room, mouse caught in another resident room -May 9 - Mice in one resident room -May 26 - Mice caught in several resident rooms -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	F 925	**B. Identify other residents** 1. No other residents were found to be affected by the alleged deficient practice noted. However, all residents have the potential to be affected by the alleged deficient practice. **C. Measures** 1. On June 23, 2022, Director of Maintenance in-serviced and implement the staff on the following topics but not limited to: a. Facility policies and procedures for cleaning resident rooms b. Requirements for compliance regarding completion of cleaning logs c. Importance of utilizing the pest control log d. Administrator or designee initiated a QA tool on June 23, 2022 regarding resident room cleanings to ensure: Resident rooms are cleaned appropriately per facility policy Cleaning logs are appropriately completed by housekeeping staff **D. Corrective Action** 1. The housekeeping director or designee will continue to conduct daily random audits for 6 weeks to ensure that resident rooms are appropriately cleaned and that cleaning logs are completed by facility staff 2. The maintenance director or designee will continue to conduct random twice a week 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	7/29/22

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 925	Continued From page 6 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 tiny 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	F 925		

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	035099	A. BUILDING _____ B. WING _____	C 06/24/2022

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F 925	Continued From page 7 outside loading dock and waste disposal area. An observation was conducted on June 21, 2022 at 7:23 AM of resident #98 and #62's room. On the floor there were small, dark brown objects that had the appearance of rodent feces at the corner of the dresser closest to the sink. An interview was conducted on June 21, 2022 at 10:55 AM with the director of maintenance (staff #8) who said that he started in this position in February 2022. He said that he renewed the contract with the pest control company that was being used. He said he used them because he wanted to fix the issue with the rodents. He said the company started putting traps in the building and if they see activity they keep using them. He said that they put weather stripping across the doors and that seems to have helped. He said that he does not know why the facility is still having trouble with mice. During an interview with a pest control staff (contract staff #34) on June 21, 2022 at 12:30 PM, he stated that the company has had a contract with the facility for the last 8 months to a year. He said that they have traps in place and bait stations. He said that the rodents were gone for months and that they have been back again for maybe 2-3 months. He said that he works with the director of maintenance who does follow the suggestions that he makes. He said that the rodents come from outside and that if they seal the areas, sometimes they get sealed inside. He said that they come inside looking for water and food and because it is comfortable. An interview was conducted at 8:08 AM on June 22, 2022 with the Director of Maintenance (Staff	F 925		

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F 925	Continued From page 8 #8) who acknowledged the gap in the door to the outside trash area and said it was about 0.5 inches at the base of the door. He said there were more gaps at waist and chest high and that these were likely caused by delivery people hitting the door. He said there were bait stations outside the door. He said that he would fix the gaps in the door. An interview was conducted on June 24, 2022 at 1:32 PM with the administrator (staff #26) who said that the facility has spent a lot of money on this problem and that they are trying to fix it. She said that they do have a pest control program in place. The facility's pest control policy, dated November 1, 2021, revealed a purpose to prevent or control insects and rodents from spreading disease. This policy included that all building openings shall be tight fitting and free of breaks, and that the facility shall be kept in such condition and cleaning procedures used to prevent the harborage or feeding of insects and rodents.	F 925		

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

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.

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 aduits 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.

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

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

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

Diane Eckles
Bureau Chief

DE:bk

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F 000	INITIAL COMMENTS The investigation of complaints AZ00181681, AZ00179201, AZ00178373, AZ00178379, and AZ00178241 was conducted on June 17, 2022 and from June 20 through 24, 2022. The following deficiencies were cited:	F 000	**F000** This Plan of Correction is submitted to meet the requirements established by Federal law. This Plan of Correction constitutes this facility's demonstration of compliance for the deficiencies cited. Submission of this Plan of Correction is not an admission that a deficiency existed or that one was correctly cited.	
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, staff interviews, facility documentation, and policy, the facility failed to provide adequate showers for three residents (#46, #136, and #140). The sample size was three residents. The deficient practice could result in residents with unmet hygiene needs. Findings include: Review of facility documentation revealed a shower schedule which included that residents are to receive two showers per week. -Resident #46 was admitted on November 6, 2021 with diagnoses that included difficulty in walking and vertigo of central origin. The resident's Activities of Daily Living (ADL) care 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	F 677	***F677*** **A. Corrective actions:** 1. Residents #46, #136, and #140 were not found affected by this alleged deficient practice. 2. Residents #46 and #136 received showers and/or following facility survey, per facility shower schedule. Resident #140 discharged from the facility on August 6, 2021. 3. Documentation for showers and/or bed baths are available on electronic medical records and/or uploaded into resident charts. **B. Identify other residents** 1.No other residents were found to be affected by the alleged deficient practice noted. However, all residents have the potential to be affected by the alleged deficient practice.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (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.

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F 677	Continued From page 1 participate in the fullest extent possible with each interaction. A quarterly Minimum Data Set (MDS) assessment dated May 6, 2022 included that the resident required supervision with one-person physical assistance for personal hygiene and extensive assistance for bed mobility. This assessment included that bathing self-performance and bathing support provided did not occur during the 7-day look-back window of the assessment. The resident scored a 15 on the Brief Interview for Mental Status (BIMS) indicating he was cognitively intact. A review of the clinical record for April through June, 2022 included the following information regarding showers and/or bed baths: -0 showers/bed baths were completed for the weeks of: April 3 to 9, April 10 to 16, May 29 to June 4, and June 5 to 11. -1 shower/bed bath was completed for the weeks of: April 17 to 23 and May 1 to 7. -Resident #136 was admitted to the facility on November 19, 2019 with diagnoses of dementia and hemiplegia. The resident's ADL care plan revealed the resident had a self-care performance deficit related to decreased mobility, weakness, and hemiplegia of the right dominant side. An intervention included to provide supervision to extensive assistance from staff for ADLS as needed. A quarterly MDS assessment dated June 8, 2022 included that the resident required physical help in part of the bathing process and required setup	F 677	**C. Measures** 1.On July 15th, 2022, Nurse Unit Manager in-serviced and implement the staff on the following topics but not limited to: a. Facility policies and procedures for ADL care provided for dependent residents, including showers and bed baths b. Requirements for compliance regarding completion of shower sheets/bed baths and post shower documentation c. Administrator initiated a QA tool on July 12, 2022 regarding ADL Care and showers and bed baths to ensure: Resident are receiving showers and bed baths per the facility shower schedule Documentation following showers and/or bed bath is completed and 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 receiving 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 this POC will be submitted to the Quality Assurance and Performance Improvement committee for review and follow up.	

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F 677	Continued From page 2	F 677		

help with bathing. The resident scored a 0 on the BIMS indicating severe cognitive impairment.

A review of the clinical record for April through June, 2022 included the following information regarding showers and/or bed baths:
-0 showers/bed baths were completed for the weeks of: April 3 to 9, April 10 to 16, April 11 to 16, April 17 to 23, April 24 to 30, and May 15 to 21.
-1 shower/bed bath was completed for the weeks of: May 1 to 7, May 9 to 14, and June 5 to 11.

-Resident #140 was admitted to the facility on February 28, 2021 with diagnoses of dementia with behavioral disturbance and muscle weakness. This resident discharged on August 6, 2021.

The resident's ADL care plan revealed the resident had a self-care performance deficit related to confusion and impaired cognition from dementia and Alzheimer's. An intervention included to monitor the resident for any changes in ability.

A quarterly MDS assessment dated July 23, 2021 included that this resident required physical help in part of the bathing process and required 1 person physical assistance with bathing. The resident scored 0 on the BIMS indicating severe cognitive impairment.

A review of the clinical record for June through July, 2021 included the following information regarding showers and/or bed baths:
-0 showers/bed baths were completed for the weeks of: June 6 to 12, June 13 to 19, July 4 to 10, July 11 to 17, and July 18 to 24.

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F 677	Continued From page 3 -1 shower/bed bath was completed for the weeks of: June 27 to July 3 and July 25 to 31. An interview was conducted on June 23, 2022 at 2:36 PM with a Certified Nursing Assistant (CNA/staff #96) who said that each day she is assigned to complete a certain amount of showers. She said that showers are posted on the bulletin board and broken down by shift. Bed one is done on the day shift and evening does bed two. She said that if she cannot complete a shower, then normally she will tell the nurse and hopefully the next shift will be able to complete the shower. She said that there are very few days she cannot get to a shower. She said that showers are documented on a specific paper and that gets turned into the nurse every day. She said that showers are also documented in the clinical record. She said that the CNA's would not know that residents had a shower without shower sheets or computer documentation unless they asked the person that worked that day. An interview was conducted on June 23, 2022 at 1:55 PM with a Licensed Practical Nurse (LPN/staff #72) who said that she signs shower sheets after the CNAs have bathed the resident or if they refuse. She said that the nurses can go to the clinical record and look up the resident and it shows when the resident has had a shower/bed bath. She said that if she did not know if a resident had a shower then she would ask the CNA and get confirmation. An interview was conducted on June 23, 2022 at 12:46 PM with the interim Director of Nursing (DON/staff #30) who said that residents are offered bathing twice a week and additional bathing upon the resident's request. She said it	F 677		

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F 677	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.	F 677		
F 925 SS=E	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 ongoing rodent problems.	F 925	***F925*** **A. Corrective actions:** 1. No residents were found to be affected by 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 room was deep cleaned at time of survey.	

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F 925	Continued From page 5 Findings include: A review of pest control inspections and services from an outside exterminator from October 13, 2021 through June 16, 2022 included: 2021 -October 13 - Includes rodent station install -October 14 - Invoice for 7 week rodent trapping 2022 -April 12 - Rodent bait stations some activity -April 14 - Inspection of rodent bait stations some activity -May 12 - Inspection of rodent bait stations some activity -June 2 - Installed 10 traps units -June 9 - Inspection of rodent bait stations some activity Review of the facility's pest log from October 23, 2021 through June 16, 2022 included: 2021 -November 20 - Nightshift reported mouse in a resident room 2022 -January 20 - Droppings in three resident rooms -January 26 - Mice in two resident rooms -February 4 - Mice feces in a resident room -March 1 - Mouse in one resident room, mouse caught in another resident room -May 9 - Mice in one resident room -May 26 - Mice caught in several resident rooms -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	F 925	**B. Identify other residents** 1. No other residents were found to be affected by the alleged deficient practice noted. However, all residents have the potential to be affected by the alleged deficient practice. **C. Measures** 1. On June 23, 2022, Director of Maintenance in-serviced and implement the staff on the following topics but not limited to: a. Facility policies and procedures for cleaning resident rooms b. Requirements for compliance regarding completion of cleaning logs c. Importance of utilizing the pest control log d. Administrator or designee initiated a QA tool on June 23, 2022 regarding resident room cleanings to ensure: Resident rooms are cleaned appropriately per facility policy Cleaning logs are appropriately completed by housekeeping staff **D. Corrective Action** 1. The housekeeping director or designee will continue to conduct random audits for 6 weeks to ensure that resident rooms are appropriately cleaned and that cleaning logs are completed by facility staff 2. The maintenance director or designee will 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035099	A. BUILDING _____ B. WING _____	C 06/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDSTONE OF TUCSON REHAB CENTRE	2900 EAST MILBER STREET TUCSON, AZ 85714

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F 925	Continued From page 6 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 tiny 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	F 925		

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 925	Continued From page 7 outside loading dock and waste disposal area. An observation was conducted on June 21, 2022 at 7:23 AM of resident #98 and #62's room. On the floor there were small, dark brown objects that had the appearance of rodent feces at the corner of the dresser closest to the sink. An interview was conducted on June 21, 2022 at 10:55 AM with the director of maintenance (staff #8) who said that he started in this position in February 2022. He said that he renewed the contract with the pest control company that was being used. He said he used them because he wanted to fix the issue with the rodents. He said the company started putting traps in the building and if they see activity they keep using them. He said that they put weather stripping across the doors and that seems to have helped. He said that he does not know why the facility is still having trouble with mice. During an interview with a pest control staff (contract staff #34) on June 21, 2022 at 12:30 PM, he stated that the company has had a contract with the facility for the last 8 months to a year. He said that they have traps in place and bait stations. He said that the rodents were gone for months and that they have been back again for maybe 2-3 months. He said that he works with the director of maintenance who does follow the suggestions that he makes. He said that the rodents come from outside and that if they seal the areas, sometimes they get sealed inside. He said that they come inside looking for water and food and because it is comfortable. An interview was conducted at 8:08 AM on June 22, 2022 with the Director of Maintenance (Staff	F 925		

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F 925	Continued From page 8 #8) who acknowledged the gap in the door to the outside trash area and said it was about 0.5 inches at the base of the door. He said there were more gaps at waist and chest high and that these were likely caused by delivery people hitting the door. He said there were bait stations outside the door. He said that he would fix the gaps in the door. An interview was conducted on June 24, 2022 at 1:32 PM with the administrator (staff #26) who said that the facility has spent a lot of money on this problem and that they are trying to fix it. She said that they do have a pest control program in place. The facility's pest control policy, dated November 1, 2021, revealed a purpose to prevent or control insects and rodents from spreading disease. This policy included that all building openings shall be tight fitting and free of breaks, and that the facility shall be kept in such condition and cleaning procedures used to prevent the harborage or feeding of insects and rodents.	F 925		

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

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

Bernadette Keilman
Bureau of Long Term Care Licensing

/bk

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

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

Bernadette Keilman
Bureau of Long Term Care Licensing

/bk