Medicare/Medicaid Public Records Documents Only

Survey event #LYYB11

Facility: SANDSTONE OF TUCSON REHAB CENTRE

Revised 7-2020

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

November 22, 2022

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

Re: Provider Number 035099

Dear Mr. Valdez:

Your facility has just undergone its Federal/State recertification survey, as required by the Federal Title XVIII (Medicare) program and Federal Title XIX (Medicaid/AHCCCS) program. As the result of this survey, the facility's Medicare Provider Agreement will be continuous, unless you are contacted by our Bureau or the Centers for Medicare/Medicaid Services to the contrary.

Please retain a copy of this notice with your signed provider agreement.

Sincerely,

Rosemary Gleason
Bureau Chief
Bureau of Long Term Care Licensing

RG/MC:mm

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: LYYB

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: **2** (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) **11/01/2021**

6. DATE OF SURVEY **09/15/2022** (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 **240** (L18)

13.Total Certified Beds **240** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements

Compliance Based On:

X 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: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	240			
(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):

Sandstone of Tucson Recertification survey #LYYB was conducted on 09/15/2022. There were deficiencies cited on the Life Safety Code and Health. Based on the allegation of compliance and acceptable plan of correction with evidence of compliance, the revisit survey completed on 11/18/22 (LSC and Health); State Agency recommended recertification.

17. SURVEYOR SIGNATURE
Matthew Connolly, HCM, by: Monica Miller
Date : 11/18/2022 (L19)

18. STATE SURVEY AGENCY APPROV/ :
Monica Miller 11/18/2022 (L20)

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

19. DETERMINATION OF ELIGIBILITY
X 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
02/05/1985
(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.
03101
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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
035292 Y1	A. Building B. Wing Y2	11/18/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDSTONE ESTATES REHAB CENTRE	2040 NORTH WILMOT ROAD TUCSON, AZ 85712

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 F0580 Reg. # 483.10(g)(14)(i)-(iv)(15) LSC	Correction Completed 11/18/2022	ID Prefix F0695 Reg. # 483.25(i) LSC	Correction Completed 11/18/2022	ID Prefix F0697 Reg. # 483.25(k) LSC	Correction Completed 11/18/2022
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

REVIEWED BY STATE AGENCY [X]	REVIEWED BY (INITIALS) MC	DATE 11/18/2022	SIGNATURE OF SURVEYOR Matt Cuy	DATE 11/18/2022
REVIEWED BY CMS RO [ ]	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
10/21/2022	[ ] 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

November 22, 2022

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

Dear Mr. Valdez:

On November 18, 2022, an offsite survey, #LYYB12, 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 for nursing homes participating in the Medicare and/or Medicaid programs.

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

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,

Monica Miller

Monica Miller
Program Project Specialist II
Bureau of Long Term Care Licensing

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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 11/18/2022

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 The offsite follow-up was conducted on November 18, 2022 for the recertification and complaint survey. Revised complaint list includes the following: AZ00186165, AZ00185498, AZ00183624, AZ00185483, AZ00184360, AZ00184923, AZ00183903, AZ00174055, AZ00175030, AZ00175164, AZ00175052, AZ00175354, AZ00174827, AZ00183513, AZ00178988, AZ00177915, AZ00177643, AZ00176703, AZ00176004, AZ00175666, AZ00175517, and AZ00174511. 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 01 - MAIN BUILDING 01 B. Wing Y2	11/18/2022 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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0223	11/18/2022	LSC K0293	11/18/2022	LSC K0342	11/18/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0355	11/18/2022	LSC K0363	11/18/2022	LSC K0511	11/18/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0920	11/18/2022	LSC K0923	11/18/2022	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
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	AV	11/18/2022	Anthony Valenti	11/18/2022
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
9/15/2022

☐ 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

November 22, 2022

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

Dear Mr. Valdez:

On November 18, 2022, an offsite **Life Safety Code** revisit survey, #LYYB22, was conducted at 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 for nursing homes participating in the Medicare and/or Medicaid programs.

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

Enclosed is the **Life Safety Code 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,

Monica Miller

Monica Miller
Program Project Specialist II
Bureau of Long Term Care Licensing

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Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035099	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	R **11/18/2022**

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
{K 000}	INITIAL COMMENTS Based on an acceptable plan of correction submitted to the Arizona Department of Health Services on November 18, 2022, for standard level deficiencies cited during the Medicare and Medicaid (CMS) Life Safety Code survey, no on-site follow up survey will be conducted for Event # LYYB22.	{K 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 (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
035099	A. Building B. Wing	11/18/2022

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 E0039 Reg. # 483.73(d)(2) LSC	Correction Completed 11/18/2022	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	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☒	REVIEWED BY (INITIALS) AV	DATE 11/18/2022	SIGNATURE OF SURVEYOR Anthony Valenti	DATE 11/18/2022
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
9/15/2022	☐ 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

November 22, 2022

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

Dear Mr. Valdez:

On November 18, 2022, an offsite **Emergency Preparedness** revisit survey, #LYYB22, was conducted at 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 for nursing homes participating in the Medicare and/or Medicaid programs.

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

Enclosed is the E**mergency Preparedness 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,

Monica Miller

Monica Miller
Program Project Specialist II

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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 11/18/2022

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
{E 000}	Initial Comments 42 CFR 483.73 Nursing Home The facility must meet the applicable provisions of Appendix Z- Emergency Preparedness All noted deficiencies on the survey dated September 13, 2022, have been corrected. This is a NO ON SITE follow-up based on an approved plan of correction with allegations of corrections and supporting documentation.	{E 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.

POC F TAG

ARIZONA DEPARTMENT
OF HEALTH SERVICES
LICENSING

November 2, 2022

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

Dear Mr. Valdez:

On **September 15, 2022**, a Medicare recertification survey #LYYB11 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 **November 12, 2022**. You must include all pages of the Statement of Deficiencies when submitting your PoC. Failure to submit an acceptable PoC by **November 12, 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 October 30, 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 September 15, 2022
Recommending to CMS Denial of Payment for New Admission

Mandatory Remedies

Your current period of noncompliance began on September 15, 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 **March 14, 2023**.

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 **December 14, 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 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 **November 12, 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,

Megan Whitby

Megan Whitby
Interim Long Term Care Bureau Chief

MW:bk

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 _____	09/15/2022

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 Recertification survey was conducted September 12, 2022 through September 15, 2022, in conjunction with the investigation of Complaints: AZ00186165, AZ00185694, AZ00185498, AZ00183624, AZ00185483, AZ00184360, AZ00184923, AZ00183903, AZ00174055, AZ00175030, AZ00175164, AZ00175052, AZ00175354, AZ00174827, AZ00183513, AZ00178988, AZ00177915, AZ00177643, AZ00176703, AZ00176004, AZ00175666, AZ00175517, and AZ00174511. The census was 156. 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 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609	***F609*** 1. Resident #19 had been discharged from the facility on 9/15/2022. A facility-reported incident (FRI) was submitted on 9/15/2022 during the survey period. 2. Administrator, DON and/or Social Services Director conducted facility wide in-services on abuse and neglect policy and reporting requirements. To be completed on 11/18/2022. 3. Administrator or designee will review and audit grievances and allegations of abuse weekly for 4 weeks, or until compliance is achieved, to ensure all reportable incidents are reported to the state agency in a timely manner. 4. The findings of these audits will be reported to the QAPI committee for review and recommendations.	11/18/22 12/9/22

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

administrator 11-11-22

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 609	Continued From page 1 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, and review of policy and procedures, the facility failed to ensure that an allegation of staff to resident abuse was reported to the State agency within the required 2-hour timeframe for one resident (#19). The deficient practice could result in allegations of abuse not being reported. Findings include: Resident #19 admitted to the facility on 05/25/22 with diagnoses that included pneumonia, type 2 diabetes mellitus with hyperglycemia, and unspecified protein-calorie malnutrition. Review of an admission 5-day Minimum Data Set assessment dated 06/10/22 revealed the resident scored 4 on the Brief Interview for Mental Status assessment, indicating severe cognitive impairment. The resident required supervision to extensive 1-person physical assistance for most activities of daily living. On 09/12/22 at 2:02 p.m., a phone interview was conducted with the resident's family member/representative. The representative stated that he had been talking to the resident on the phone and that he overheard someone mockingly calling the resident. He stated that he asked the resident who was saying that and the	F 609		

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F 609	Continued From page 2	F 609		

resident replied that it was one of the temporary nurses. The representative stated that he heard a smack sound and the phone dropped to the floor. He stated that he heard the resident begin to cry. He stated that after the resident was able to retrieve the phone the resident told him that the nurse had been abusive towards her. He stated that he called the facility and reported the incident to the charge nurse, but he could not remember her name. In addition, he stated that he could not recall the exact date of the alleged incident.

On 09/12/22 at 2:13 p.m., an interview was conducted with the facility administrator (staff #120) and the Interim Director of Nursing (DON/staff #141) and they were informed of the allegation of staff to resident abuse. Staff #120 and #141 were directed to follow their facility policy regarding reporting allegations of abuse.

However, per the State agency, the incident had not been reported.

Review of the resident's clinical record did not include documentation of the allegation.

An interview was conducted on 09/15/22 at 9:10 a.m. with the Interim DON (staff #141). She stated that she heard me report the allegation of abuse to the administrator (staff #120) and herself. She stated that she heard the direction that the administrator would have to follow the facility policy regarding reporting, and that the conversation had not met the requirement for reporting.

On 09/15/22 at 12:09 p.m., an interview was conducted with the administrator (staff #120). He stated that he had not misunderstood the

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F 609	Continued From page 3	F 609		

instructions regarding reporting the allegation of abuse. He stated that the resident's representative could not provide much detail regarding the incident. He stated that in speaking with the resident, the resident could not recall the incident. He stated that there was not enough information to go off of regarding the timeline, or articulation of the claim regarding what happened. He stated his policy stated that when abuse is reported they have 2 hours to report whenever there is any physical injury or if there is a resident to resident incident. He stated that pending their investigation, if there is insufficient evidence to support that the alleged incident took place, they do not report and that they make a soft file.

Review of the facility policy titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised April 2021, revealed all reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies, including: the state licensing/certification agency responsible for surveying/licensing the facility. "Immediately" is defined as within two hours of an allegation involving abuse or results in serious

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F 609	Continued From page 4 bodily injury.	F 609		
F 644 SS=E	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews, the facility failed to ensure three residents (#s 10, 42, and 44) with a diagnosis of a serious mental illness were referred to the appropriate state-designated mental health or intellectual disability authority for review. The sample size was 8. The deficient practice could result in necessary specialized services not being provided for residents who need it. Findings include: -Resident #10 was initially admitted on May 25,	F 644	***F644*** 1. Resident #10 had been discharged from the facility on 10/25/2022. Referral for PASARR level 2 for resident #44 had been submitted during the survey period. Resident #42 had been referred for level 2. 2. A full house audit will be completed on 11/11/2022 by social services director or designee to ensure compliance with PASRR. 3. Social services or designee will conduct in-services with facility staff on facility policies and procedures and state requirements for PASRR by 11/18/22. 4. Social Services Director/Designee will conduct audits on new admissions for four weeks or until compliance is achieved to ensure compliance with PASRR screening requirements. Findings will be reported to QAPI committee for review and recommendation.	11/18/22 12/9/22

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F 644	Continued From page 5 2022 with diagnoses that included quadriplegia, major depressive disorder, and dysphagia. Review of the clinical record revealed a Pre-Admission Screening and Resident Review (PASRR) Level 1 was completed on May 25, 2022 with a diagnosis of major depressive disorder, and a PASRR Level 2 completed. Further review of the medical record revealed no evidence that the facility received notification of a Level 2 review and recommendation. Review of the clinical record revealed no evidence of psychiatric evaluation /treatment from admission to current. Review of the care plan initiated on May 26, 2022 revealed the following: -Resident has a behavior problem "demanding" to go to the hospital for various reasons -Resident is/has potential to demonstrate verbally abusive behaviors related Ineffective coping skills, poor impulse control Further review of the clinical record revealed that the resident was hospitalized on July 7, 2022 and readmitted on July 21, 2022 with diagnoses that included left lower limb cellulitis, quadriplegia, pressure ulcer of sacral region, major depressive disorder, anxiety disorder, and post-traumatic stress disorder. Review of the clinical record revealed evidence of a new diagnosis of anxiety disorder on July 21, 2022. Review of the clinical record revealed no evidence that a PASRR Level 1 or 2 had been	F 644		

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F 644	Continued From page 6 completed related to the new diagnosis of anxiety or upon readmission from the hospital. Review of clinical notes dated May 29, 2022 through August 26, 2022, revealed evidence that the resident had episodes of yelling out, using inappropriate language and being verbally aggressive with staff. An interview was conducted on September 15, 2022 at 8:47 AM with the Director of Social Services (staff #61), who stated that the PASRR Level 1 screening comes from the referring facility on admission, if a level 2 is required it is emailed out. He stated that they then receive a report back saying if the resident qualifies for referral for appropriate specialized services. The Director of Social Services stated that he is not sure of the facility policy. He further stated that a PASRR evaluation would be completed upon admission, if the resident is hospitalized and returns, a change in mental status or behavioral status. He also stated that a new PASRR would need to be completed for a new mental disorder diagnosis. He reviewed the resident's clinical record and stated that there was no evidence that a new PASRR evaluation had been completed for the resident's new diagnosis of anxiety disorder on July 21, 2022. He stated that this does not meet the facility expectation, and the risk of not completing the evaluation could result in treatments not being completed, or the resident not being treated for a mental disorder. An interview was conducted on September 15, 2022 at 10:08 AM with the interim Director of Nursing (DON/staff #141), who stated that a PASRR evaluation should be complete prior to admission from the hospital, and also for a new	F 644		

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F 644	Continued From page 7	F 644		

diagnosis for a mental disorder. She reviewed the clinical record and stated that there was no evidence that a Level 1 and Level 2 PASRR had been completed with the diagnosis of anxiety disorder on July 21, 2022. She further stated that this did not follow the facility policy.

-Resident #42 was admitted to the facility on January 16, 2021 with diagnoses that included major depressive disorder, unspecified schizophrenia, adult failure to thrive, and other psychoactive substance abuse, uncomplicated.

Review of the care plan problem dated March 20, 2021 stated the resident had the potential for a behavior problem including but not limited to delusional thinking, rambling, false accusations, intrusive with other resident's care, hoarding food, verbally abusive, rejecting care, yelling, screaming, abusive language, related to diagnoses of major depressive disorder, psychoactive substance abuse, and hyperlipidemia. The interventions stated to explain all procedures to the resident before starting and allow the resident time to adjust to changes, administer medications as ordered, and anticipate and meet the resident's needs.

Review of the quarterly MDS (Minimum Data Set) assessment dated June 22, 2022 revealed a BIMS (Brief Interview Mental Status) score of 04, which indicated the resident had severe cognitive impairment. The MDS assessment included diagnoses of depression, and schizophrenia and that the resident received antipsychotic and antidepressant medications for 7 days of the 7-day lookback period.

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F 644	Continued From page 8	F 644		

Review of provider progress notes dated September 8, 2022 stated the resident was alert and oriented to name and place. The psychological examination stated the resident was positive for delusions, and resistant care. The diagnostic statement included bipolar disorder, depressive disorder and paranoid disorder.

On September 15, 2022, a document for level I and level II PASRR ((Medicaid Pre-Admission Screening and Resident Review), was requested. At 10:52 a.m. the facility provided a level I PASRR dated March 4, 2021.

However, the facility failed to provide evidence that a level II PASRR was completed.

An interview was conducted on September 13, 2022 at 1:47 p.m. with the social services director (staff #61) who stated the admission department would notify him if a resident needed a level II PASRR, then he would submit the referral.

-Resident #44 was admitted on June 21, 2022 with diagnosis of Schizoaffective Disorder.

The PASRR Level I Screening Tool dated June 16, 2022 revealed in section B, Serious Mental Illness was checked for Schizoaffective Disorder and that the resident did not have a primary diagnosis of dementia. Continued review of the tool revealed that section D - Referral Determination for Level II was marked as no referral necessary for any Level II.

The admission MDS assessment dated June 28, 2022 revealed a BIMS of 15 indicating the

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F 644	Continued From page 9	F 644		

resident was cognitively intact.

Review of the clinical record revealed a psychoactive medication consent dated July 18, 2022 for use of Geodon (antipsychotic medication) for Schizoaffective Disorder.

The care plan initiated on August 15, 2022 revealed the resident had the potential for auditory hallucinations related to Schizoaffective Disorder.

Review of the medication administration records for July 18, 2022 through September 13, 2022 revealed the resident was administered Geodon as ordered for Schizoaffective Disorder.

An interview was conducted with the Social Services Director (SSD/staff #61) on 09/13/22 at 1:47 PM. He stated the admissions/clinical liaison reviews information prior to admission. He stated admissions will let him know if there is an issue with the PASRR. The SSD stated if a resident needs a level II, he would submit the referral. He also stated the risk of not processing a level II would be the resident would not get the proper treatment. Regarding resident #44, the SSD stated it was something that admissions missed and he is working on a system to track these better. He stated resident #44 should have had a level II completed and it was missed.

An interview was conducted with the Administrator (staff #120) and Clinical Resource Nurse (staff #141) on 09/13/22 at 2:30 PM. The Administrator (staff #120) stated the admissions department oversees the PASRR process and if there are any issues or a resident needs a level II they will inform staff #61. Staff #141) stated the

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F 644	Continued From page 10 risk of not having a level II is that the resident would not be receiving the services needed. Review of the facility policy, Admission Criteria, stated the facility admits only residents whose medical and nursing needs can be met. The policy interpretation and implementation stated the facility conducts a level I PASRR (Medicaid Pre-Admission Screening and Resident Review), regardless of payer source, to determine if the individual meets the criteria for a mental disorder (MD) or intellectual disability (ID). It also included, if the level I screen indicated that the individual may meet the criteria for a MD or ID, he/she is referred to the state PASRR representative for the level II (evaluation and determination) screening process. The admitting nurse notifies the social service department when a resident is identified as having a possible (or evident) MD, ID, or RD. The social worker is responsible for making referrals to the appropriate state-designated authority. Upon completion of the level 2 evaluation, the state PASRR representative determines if the individual has a physical or mental illness condition, what specialized or rehabilitative services he or she needs, and whether placement in the facility is appropriate. The state PASRR representative provides a copy to the facility.	F 644		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:	F 645		

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(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 645	Continued From page 11 (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a	F 645	***F645*** 1. PASRR level 1 for resident #81 was obtained during the survey period. 2. A full house audit will be completed on 11/11/2022 by social services director or designee to ensure compliance with PASSARR. 3. Social services or designee will conduct in-services with facility staff on facility policies and procedures and state requirements for PASSARR by 11/18/22. 4. Social Services Director/Designee will conduct audits on new admissions for four weeks or until compliance is achieved to ensure compliance with PASARR screening requirements. Findings will be reported to QAPI committee for review and recommendation.	11/18/22 12/9/22

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F 645	Continued From page 12 hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, and the facility's policies and procedures, the facility failed to ensure one resident (#81) had a level I PASRR (Pre-Admission Screening and Resident Review), upon admission. The sample size was 8. The deficient practice could result in necessary specialized services not being provided for residents who need it. Findings include: Resident #81 was admitted to the facility April 6, 2022 with diagnoses that included bipolar disorder, current episode depression (mild to moderate severity), adjustment disorder with mixed anxiety and depressed mood, anxiety disorder, and recurrent major depressive	F 645		

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F 645	Continued From page 13 disorder. Review of the quarterly Minimum Data Set assessment dated July 14, 2022 revealed a Brief Interview of Mental Status score of 15, which indicated the resident's cognitive status was intact. The active diagnoses included anxiety disorder, depression (other than bipolar), and bipolar disorder. However, further clinical record review revealed no evidence of a PASRR (Medicaid Pre-Admission Screening and Resident Review) upon admission, and no evidence that a PASRR was completed after 30 days of convalescent stay. An interview was conducted on September 13, 2022 at 1:47 p.m. with the social services director (staff #61) who stated the admission/clinical liaison reviews information prior to admission. Staff #61 stated he was working on a system to track PASRR better. An interview was conducted on September 15, 2022 at 12:20 p.m. with the administrator (staff # 20). Staff #20 stated resident #81 did not have a PASRR when he was admitted to the facility. Review of the facility policy, Admission Criteria, stated the facility admits only residents whose medical and nursing needs can be met. The policy interpretation and implementation stated the facility conducts a level I PASRR, regardless of payer source, to determine if the individual meets the criteria for a mental disorder (MD) or intellectual disability (ID).	F 645		
F 655 SS=E	Baseline Care Plan	F 655		

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F 655	Continued From page 14 CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and	F 655	***F655*** 1. Resident #405 had been discharged from the facility on 9/28/2022. Resident #510 had been discharged from the facility on 9/21/2022. Resident #506 discharged from the facility on 7/14/2022. 2. An audit on current facility care plans was conducted on 11/4/2022 by unit manager to ensure compliance. 3. An in-service will by conducted with the interdisciplinary team to department heads and nurse leaders to ensure that baseline care plans are completed within 48 hours of admission and that family is notified. This will be completed by 11/18/2022. 4. Weekly audits for four weeks on new admissions will be conducted to ensure baseline care plans are completed within 48 hours and families are notified accordingly. Results of the audits will be presented to the QAPI committee for review and recommendation.	11/18/22 12/9/22

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F 655	Continued From page 15 dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, staff and family interviews, and policy review, the facility failed to initiate a baseline care plan within the required timeframe and provide a summary of that baseline care plan to residents (#s 405, 506, and 510) and their representatives. The sample size was 31. The deficient practice could result in residents not having a plan of care and not being aware of their plan of care. Findings include: -Resident #506 was admitted on July 1, 2022 with diagnoses of rectal abscess, type 2 Diabetes Mellitus, and acquired absence of left leg above knee. Review of the clinical record did not reveal a baseline care plan. Review of a care plan initiated on July 11, 2022 revealed that it consisted of 1 focus for nutrition/hydration. However, this care plan did not include infection, the resident's requirements for assistance, wound care, pain or any other required elements other than nutrition/hydration. A Social Services note dated July 11, 2022 revealed the writer called the resident's spouse about the upcoming Care Conference on July 13. This resident's wife stated she did not care about	F 655		

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F 655	Continued From page 16 any care conferences or plan of care and she would be taking this resident home on July 13. A discharge Minimum Data Set (MDS) assessment dated July 13, 2022 revealed this resident required extensive assistance with toileting, had a stage 2 pressure ulcer, and had received 7 days of antibiotics, anticoagulant and opioids medication. An interview conducted on September 13, 2022 at 2:45 PM with a family member indicated that this resident did not have a care plan for 11 days and that no attempt to have a care conference or copy of a care plan was provided to the resident or family member until July 11, 2022. -Resident #510 was admitted on September 2, 2022 with diagnoses of cerebral infarction due to embolism of right middle cerebral artery, multiple sclerosis, and dysphagia. A review of the clinical record revealed a care plan dated September 6, 2022. Review of the clinical record revealed no evidence the resident or the resident's representative were provided a summary of the care plan or that a care plan was initiated prior to September 6, 2022. An interview was conducted on September 15, 2022 at 12:15 PM with a Licensed Practical Nurse manager (LPN/staff #128) who said that a baseline care plan is initiated within 72 hours after admission. She reviewed resident #510's clinical record and said that this resident's care plan was initiated on September 6 and that it did not meet the 72-hour requirement. This nurse reviewed	F 655		

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F 655	Continued From page 17	F 655		

resident #506's clinical record and said that the resident was admitted on July 1, 2022 and that a care plan was initiated on July 11th. She said that was definitely not within the 48 hours. She reviewed resident #506's care plan and said that this resident does not have a care plan because the only thing on the care plan is nutritional.

An interview was conducted on September 15, 2022 at 1:58 PM with the acting Director of Nursing (DON/staff #141) who said that her expectation is that a baseline care plan should be created and available within 24 hours and communicated to the family or resident. She said that resident #510 was admitted on September 2 and that September 6 is when a care plan was initiated. She said that does not meet her expectations. She said that resident #506 was admitted on July 1 and that the care plan was initiated on July 11 and that it was communicated to the resident's family on July 13. She said that did not meet her expectations as it should be completed and communicated within 48 hours. She reviewed the care plan for resident #506 and said that the care plan does not meet her expectations.

-Resident #405 was admitted to the facility on 8/29/2022 with a diagnosis of cellulitis of the left lower limb.

Review of the admission Minimum Data Set assessment dated September 6, 2022 revealed a Brief Interview for Mental Status score of 15, which indicated the resident had intact cognition.

Review of the clinical record revealed no evidence that the resident was provided a written

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F 655	Continued From page 18 summary of the baseline care plan. An interview was conducted with the Director of Social Services (staff #61) on 09/15/22 at 1:17 PM, who stated the baseline care plan is to be completed by nursing and it is not being done. An interview was conducted with the Unit Nursing Manager (staff #128) on 09/15/22 at 1:19 PM, who stated the 48-hour baseline care plan is not being done. She also stated there is no process and no forms. An interview conducted on 09/15/22 at 1:36 PM with the Administrator (staff #120) on 09/15/22 at 1:36 PM, who stated he was unaware of the expectation of the 48-hour baseline care plan. An interview was conducted with the Clinical Resource Interim Director of Nursing (staff #141) on 09/15/22 at 1:52 PM. Staff #141 stated the baseline care plan should be completed within the first 48 hours of admission. Review of the facility's baseline care plan policy, revised March 2022, revealed that a baseline care plan to meet the resident's immediate health and safety needs is developed for each resident within 48 hours of admission. The policy included that the resident and their representative will be provided a summary of the baseline care plan.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the	F 656		

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F 656	Continued From page 19 resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews,	F 656	***F656*** 1. Resident #19 had been discharged from the facility on 9/15/2022. 2. MDS Director and/or designee will conduct full house audit on comprehensive care plans for residents with diagnosis of diabetes and to ensure that comprehensive care plan of current residents with diagnosis of diabetes mellitus addresses diabetes management and care. This will be completed by 11/11/2022. 3. Inservice to be completed by MDS nurses that regulation on comprehensive care plan was reviewed. 11/18/2022. 4. MDS Director/Coordinator/Designee will conduct weekly audits for four weeks on all new admissions whose comprehensive care plans are due to ensure that care plans address diabetes management and care of the resident who has diagnosis of diabetes mellitus. Results of the audits will be presented to the QAPI committee for review and recommendation.	11/18/22 12/9/22

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F 656	Continued From page 20 and review of policy and procedure, the facility failed to ensure one resident's (#19) comprehensive care plan included diabetes management and related insulin use. The sample size was 31. The deficient practice may result in an incomplete plan of care for residents. Findings include: Resident #19 admitted to the facility on 05/25/22 with diagnoses including pneumonia, type 2 diabetes mellitus (DM) with hyperglycemia, and unspecified protein calorie malnutrition. Review of physician orders included: -pioglitazone HCl (thiazolidinedione) 30 milligrams (mg); give 1 tablet one time a day for DM. Order dated 05/25/22. -Metformin (biguanide) HCl tablet 500 mg; give 500 mg two times a day for DM. Order dated 06/03/2022. The admission 5-day Minimum Data Set assessment dated 06/10/22 revealed the resident scored 4 on the Brief Interview for Mental Status, indicating severely impaired cognition. The resident required supervision to extensive assistance with most activities of daily living, and received insulin for 5 out of 7 days in the look-back period. However, review of the care plan did not include diabetes management. Additional physician orders revealed: -insulin isophane (intermediate-acting insulin) suspension 100 units/milliliter (mL); inject 12 units subcutaneously two times a day for DM. Order dated 07/10/22/	F 656		

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F 656	Continued From page 21 -insulin Lispro solution (antidiabetic) 100 units/mL; inject as per sliding scale: if 200 - 250 = 2 unit; 251 - 300 = 4 unit; 301 - 350 = 6 unit; 351 - 400 = 8 unit; 401 - 450 = 10 unit; 451 - 500 = 12 call physician, subcutaneously before meals and at bedtime for DM notify provider for BS above 450. Order dated 08/04/22. -Glucagon (glycogenolytic agent) 1 mg; inject 1 unit intramuscularly as needed for blood sugar less than 70 mg/mL and unable to take by mouth, per hypoglycemia protocol. May repeat in 20 minutes. Take a dose from the emergency kit. Order dated 08/31/22. However, review of the resident's comprehensive plan of care did not include insulin use, diabetes management, hyperglycemia or hypoglycemia protocols, and/or related interventions. An interview was conducted on 09/15/22 at 12:59 p.m. with the Interim Director of Nursing (DON/staff #141). She stated that the care plan should include high-risk medications and adverse effects monitoring. On 09/15/22 at 2:32 p.m., an interview was conducted with a Registered Nurse (RN/staff #130). She stated the comprehensive care plan should include the resident's diagnoses and any high-risk medications. She stated the care plan gets updated as needed and any area that has to be updated is the responsibility of that department. Review of the facility policy titled Care Plans, Comprehensive Person-Centered, revised March 2022, revealed a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the	F 656		

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F 656	Continued From page 22 resident's physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan reflects currently recognized standards of practice for problem areas and conditions. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes and relevant clinical decision making.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, staff interviews, and facility policies, the facility failed to ensure services provided to one resident (#16) met professional standards of quality care. The deficient practice could result in residents receiving services that do not meet standards of quality. Findings include: Resident #16 was initially admitted on June 2, 2022 with diagnoses that included pneumonia, seizures, encephalitis and encephalomyelitis, cerebral cryptococcosis and disorder of the brain. Review of the physician order summary report (order date range: June 2, 2022 - September 30, 2022) revealed:	F 658	***F658*** 1. Resident #16 had been assessed during the survey period and no adverse effect noted. 2. Audit will be conducted by DON/designee on all residents who have orders for enteral feeding for timing of start/stop by 11/11/2022. Audit will be conducted by DON/designee on all IV antibiotic administration time by 11/11/2022. HR Director/Designee identified LPNs who requires advance/additional IV training required to handle IV procedures 11/11/2022. 3. Inservice nurses on compliance to feeding schedules, IV antibiotic administration, and proof of advanced training is required prior to handling IV lines. This will be completed by 11/30/2022. LPNs will be offered trainings for those who are unable to submit proof of advance training for IV effective 11/30/2022.	11/30/22

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F 658	Continued From page 23 -Enteral feed order two times a day Osmolite 1.5 at 60 ml (milliliter)/hour x 20 hours/day per peg via pump (off at 10:00 AM and on at 2:00 PM). -Turn off feeding at 10:00 AM, turn back on at 2:00 PM every day shift. -Enteral feed order every 4 hours, flush the peg tube with 100 ml of water. -Vancomycin HCL Solution 500 mg (milligram)/100 ml, use 500 mg intravenously every 12 hours for bacteremia for 28 days IV (intravenous) piggyback to normal saline bag. Review of the Medication Administration Record (MAR) dated September 1, 2022 through September 13, 2022 revealed that Licensed Practical Nurses (LPNs) provided: -flushed PICC (peripherally inserted central catheter) inserted line x 44 occasions. - mixed/administered Vancomycin x 18 occasions -administered enteral feeding via peg tube x 63 occasions -peg tube/care flush x 22 occasions An observation was conducted on September 14, 2022 at 11:19 AM of peg tube care/treatment. Upon entering the resident's room, it was observed that the enteral feeding was still being administered at 11:19 AM, the scheduled LPN (staff #142) was not in attendance on the unit. Further observation revealed an antibiotic bag hanging on the IV pole, undated. An immediate interview was conducted with the LPN (staff #103) who was at the nursing station at 11:24 AM. He immediately went to resident #16's room and stated the enteral feeding was still being administered, and that it should have been turned off at 10:00 AM, per the physician order. He also stated the risk of running the	F 658	4. Weekly random visual audits on feeding schedules will be conducted for four weeks, as well as weekly random visual audits on timeliness of administration of IV antibiotics will be conducted for four weeks. Results of the audits will be presented to the QAPI committee for review and recommendation.	12/9/22

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F 658	Continued From page 24	F 658		

enteral feed past the order time could result in aspiration, pneumonia and the stomach being too full. He further stated the IV medication bag was not timed or dated and he did not know when it had last been administered. He stated that he was certified to administer enteral feeding and medications via PICC line.

At 11:34 AM on September 14, 2022, a registry LPN (staff #142) returned to the unit. She stated that she did not stop the enteral feeding for resident #16 as ordered, and that it was her mistake. She further stated that she has not yet administered the Vancomycin as ordered, that it was ordered to be administered at 9:00 AM. At that time the LPN (staff #142) removed the Vancomycin from the medication cart and proceeded to reconstitute/mix the medication into the saline bag. The LPN also stated that she has completed specialized training to administer/care of PICC line IV medications and to mix IV medications.

An observation was conducted on September 14, 2022 at 11:45 AM of LPN #142 completing PICC Line care prior to administration of the Vancomycin. She cleaned the PICC hub with alcohol, flushed the line with 100 cc (cubic centimeter) saline, and then attached the IV antibiotic. The medication was ordered to be administered at 9:00 AM and was observed to be administered at 11:45 AM. The LPN proceeded to flush the peg tube, using gravity flow.

An interview was conducted on September 14, 2022 at 4:01 PM with the interim Director of Nursing (DON/staff #141), who stated that it is the facility policy to follow physician's orders as written. She further stated that it did not meet her

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expectations to have an enteral feed administration to continue an hour past the ordered stop time. She further stated that the risk could result in the resident receiving more calories than needed. She also stated antibiotics are expected to be administered at the ordered time frame.

Another interview was conducted on September 15, 2022 at 11:59 AM with the interim DON (staff #141), who stated the pharmacy policy provides the guidance and protocol for medication administration. She also stated that they provide competencies and observations to ensure that staff are qualified to administer medications. She further stated that LPNs would require specialized certification to administer medications via PICC line, enteral feed, PICC line/Peg tube care/treatment. She stated the specialized certification is checked upon hire by human resources. She also stated that she was not able to provide evidence of specialized training/certification for staff #142 and staff #103. The DON stated that this did not meet the facility policy, and that she has already reached out to the pharmacy to schedule training. She stated that she was aware in May 2022 that the LPNs did not have the specialized training, and was told the pharmacy had no one to do the training. She further stated the facility was allowing LPNs to administer medication via PICC lines, mix antibiotics, and administer enteral feeding via peg tube without the required certifications.

On September 15, 2022 at 8:00 AM a request was submitted for staff education, certification and training for LPN/registry (staff #141) and LPN (staff #103) regarding IV medication administration, PICC medication

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F 658	Continued From page 26 administration/care, care and central line flushing. The administrator (staff #120) stated that the facility did not have any documentation of the LPNs' certification/training regarding PICC/IV medication administration, or care. On September 15, 2022 at 8:20 AM a policy was requested regarding contract/registry staff education/training and special certifications and was not provided by the facility. Review of the facility policy titled, Enteral Feedings Safety Precautions, revealed that all personnel responsible for preparing, storing and administering enteral nutrition formulas will be trained, qualified and competent in his or her responsibilities. Review of the facility policy titled, Infusion Therapy Products Provider, revealed that the professional nurse with documented IV education may set up a primary infusion. Review of the facility policy titled, Administering Medications, revealed that medications are administered in accordance with prescriber orders, including any required time frame. Only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so. Review of the pharmacy policy titled, Scope of Practice and Competency Assessment, revealed that nurses administering infusion therapy and performing vascular access insertion and management must be qualified and competent based on their licensure and perform only duties within their scope of practice. Documentation of completed continuing education and competency	F 658		

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F 658	Continued From page 27 assessments should be available in facility or employee files. No nurse, LPN or RN (registered nurse), should perform any procedure that he or she has not been specifically trained to do.	F 658		
F 676 SS=E	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks,	F 676	***F676*** 1. Resident #132 had been discharged from the facility on 10/5/2022. Showers had been provided prior to discharge. Resident #38 was discharged from the facility on 10/12/2022. Showers had been provided prior to discharge. Resident #510 had been discharged from the facility on 9/21/2022. Showers had been provided prior to discharge. 2. ADON/Unit Managers/Designee conducted an audit on shower compliance. 3. Inservice to nursing staff on compliance of showers and protocol will be completed by 11/18/2022. 4. Random daily audits to be completed by DON/designee for four weeks. Results of the audits will be presented to the QAPI committee for review and recommendation.	11/18/22 12/9/22

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F 676	Continued From page 28 §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on the clinical record review, facility documents, staff interviews and facility policy, the facility failed to ensure that bathing assistance was provided for three residents (#s 38, 510, and 132). The sample size was 9. The deficient practice could result in residents' hygiene needs not being met. Findings include: -Resident #38 was admitted on March 16, 2022 with diagnoses of dementia, type 2 diabetes mellitus and anxiety disorder. This resident was out of the facility from May 19, 2022 to May 26, 2022. Review of the Activities of Daily Living (ADL) Lookback Reports for May 2022 revealed this resident received bathing assistance on May 4, 2022. However, no other showers were recorded for May 2022. Review of the shower sheets for May 2022 indicated this resident had 1 shower on May 4, 2022. No other showers were recorded for May, 2022. A quarterly Minimum Data Set (MDS) assessment dated June 21, 2022 included a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. This assessment revealed the	F 676		

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resident required extensive 2+ person assistance for bed mobility and extensive 1-person assistance for locomotion on and off the unit.

-Resident #510 was admitted on September 2, 2022 with diagnoses of cerebral infarction due to embolism of right middle cerebral artery, multiple sclerosis, and dysphagia.

A review of the shower sheets for September 2022 revealed this resident had been offered bathing on September 5, 8, and 12.

A review of the bathing/shower/sponge bath electronic documentation revealed the resident was offered bathing on September 3 and 12. This resident received an offer of bathing once the week of September 11-17, 2022.

An interview was conducted on September 15, 2022 at 1:40 PM with a Licensed Practical Nurse Manager (LPN/staff #128) who said that residents should get bathing twice a week and as requested. She said that if we do not offer showers twice a week it is not what is expected.

An interview was conducted on September 15, 2022 at 1:58 PM with the acting Director of Nursing (DON/staff #141) who said that showers should be provided twice a week.

-Resident #132 was admitted to the facility on August 20, 2022 with diagnoses that included type 2 diabetes mellitus with foot ulcer, osteomyelitis of left ankle and foot, unsteadiness on feet, need for assistance with personal care and absence of right leg below knee.

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F 676	Continued From page 30 Review of the admission Minimum Data Set assessment dated August 24 2022, revealed a Brief Interview for Mental Status score of 14, which indicated the resident had intact cognition. Further review revealed that supervision and support were required for bathing, and there was no rejection of care. Review of the clinical record shower tasks dated August 2022 through September 13, 2022, revealed showers were provided three times between August 20, 2022 and September 13, 2022: -August 20, 2022 -August 23, 2022 -September 6, 2022, thirteen days between showers August 24 and September 5, 2022. -No evidence of showers provided or refused between September 6 and September 13, 2022, seven days. Review of the shower sheets dated August 20, 2022 through September 13, 2022, revealed evidence of: -one shower form dated August 22, 2022 -one shower form with no date, indicated refusal - incomplete documentation -one shower form dated September 6, 2022 Continued review of the shower sheet revealed areas to document: -resident name/date/time and room number -visual skin assessment (bruising, skin tears, rashes, swelling, dryness, heels, lesions, decubitus, blisters, scratches, abnormal skin/color/temp, hardened skin) -finger/toe nail care -skin care -oral care	F 676		

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F 676	Continued From page 31 -refusal/reason, number of attempts -nurse notification -staff name, agency, staff signature, nurse signature Review of progress notes dated August 1, 2022 through September 13, 2022, revealed no evidence of showers being provided. An interview was conducted on September 15, 2022 at 9:00 AM with a Certified Nursing Assistant (CNA/staff #102), who stated that the resident received showers on Monday and Thursday nights. She also stated that she was not aware of the resident ever refusing showers. An interview was conducted on September 15, 2022 at 9:03 AM with a Licensed Practical Nurse (LPN/staff #128), who stated that shower sheets are completed for all residents, and that the residents are offered showers twice a week following a shower schedule. She stated the facility policy is to shower residents twice a week. The LPN also stated that if the shower is given or refused, that CNAs are expected to document in the clinical record or on the shower sheets. She reviewed the shower sheets for August through September 2022 and stated that one shower form was completed in August 2022, and two shower sheets were completed in September 2022. She stated that there is one shower sheet that is undated, and she does know if it was offered between September 1 and 4, 2022, because of where it was in her shower file. She further stated that she reviewed the medical record, shower task forms dated August 2022 through September 2022, and stated that there were 11 days between showers from August 22, 2022 through September 5, 2022 with no evidence that	F 676		

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F 676	Continued From page 32	F 676		

showers were provided or refused. She stated that this did not meet the facility policy for showers and the risk of not being showered regularly could result in skin breakdown, and affect dignity.

An interview was conducted on September 15, 2022 at 10:02 AM with the interim Director of Nursing (DON/staff #141), who stated they have shower schedules, and CNAs are to offer showers to all residents twice a week. She stated that CNAs complete documentation of showers that are provided or refused on the tasks form in the clinical record or on the shower sheets. She reviewed the clinical record and stated the documentation in the clinical record tasks revealed showers were provided on August 23, 2022 and the next was documented on September 6, 2022. She stated that there were 11 days between showers with no other documentation of showers being provided or refused. She stated this did not meet the facility expectation, and the risk could result in possible skin breakdown, and the resident's wellbeing.

A review of the facility policy titled, Bath, Shower/Tub, revealed the purpose of this procedure is to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. Document the date and time the shower/tub, bath was performed, if the resident refused, and all assessment data obtained during the procedure.

Review of the facility policy titled, Supporting Activities of Daily Living (ADLs), revealed that residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming

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F 676	Continued From page 33 and personal hygiene. This includes bathing, dressing and grooming.	F 676		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on the clinical record review and staff interviews, the facility failed to ensure that one sampled resident (#38) was provided care in accordance with professional standards of care regarding an ultrasound. The deficient practice could result in delayed treatment for residents. Findings include: Resident #38 was admitted on March 16, 2022 with diagnoses of dementia, type 2 diabetes mellitus and anxiety disorder. This resident was out of the facility from May 19, 2022 to May 26, 2022. A nurse's note dated May 14, 2022 included the resident had a swollen right foot and the writer assessed it. The note also included the resident's feet were elevated and the provider would be notified. A physician's order dated May 14, 2022 included	F 684	*F684 –* 1. Resident #38 had been discharged from the facility on 10/5/2022. 2. DON/Designee conducted an audit on STAT laboratory and radiology orders as of 11/7/2022 and no other residents had been affected. 3. Inservice retraining was provided to nurses on policy and protocols for carrying out STAT orders. This will be completed on 11/18/2022. 4. Random weekly audits will be conducted by DON/designee for four weeks to ensure that STAT laboratory and radiology orders are carried out as STAT. Results of the audits will be presented to the QAPI committee for review and recommendation x 3 months.	11/18/22 12/9/22

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F 684	Continued From page 34 venous ultrasound of the right foot STAT for edema. A nurse's note dated May 19, 2022 revealed the writer called the mobile diagnostic company on May 14, 2022 to order the STAT venous ultrasound order and the company said the soonest the ultrasound would be done was Monday, May 16, 2022. The writer gave the face sheet and the ultrasound order to the next nurse and informed the nurse about the STAT order on Monday. The writer worked in the unit on May 19, 2022 and found out the resident did not have a venous ultrasound. The writer called the mobile diagnostic company to question them and they said they came to the facility and did not find the order. The nurse checked the orders and found one of the staff members had accidentally marked it off and that is why the mobile diagnostic company could not find the order on Monday, May 16, 2022. A quarterly Minimum Data Set assessment dated June 21, 2022 included a Brief Interview for Mental Status score of 3, which indicated the resident had severe cognitive impairment. This assessment included extensive 2+ person assistance was required for bed mobility and extensive 1-person assistance was needed for locomotion on and off the unit and that this resident utilized dressings to the feet and had 1 venous or arterial ulcer present. An interview was conducted on September 15, 2022 at 1:40 PM with a Licensed Practical Nurse Manager (LPN/staff #128) who said that a STAT order should be carried out as soon as possible with medication and that they have to outsource laboratory orders. She said that a STAT order at	F 684		

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F 684	Continued From page 35 the lab takes 4 hours and that STAT X-rays are about 4 hours as well. She said that ultrasounds take a bit longer. She reviewed this resident's clinical record and said the ultrasound was ordered May 15, 2022 and that according to the electronic record the resident did not get the ultrasound. The LPN said the physician was informed about the ultrasound on May 19, 2022 and then the resident was sent to the hospital. This nurse said that the staff definitely should have notified the physician prior to that. An interview was conducted on September 15, 2022 at 1:58 PM with the acting Director of Nursing (DON/staff #141) who said that STAT orders from their venders should be within 4 hours or notify the physician within 4 hours. She reviewed the resident record and said that a STAT order should be provided before that but the facility did not have STAT services for ultrasounds. She said that it should be communicated to the physician. She said that the physician was notified on May 19, 2022.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to	F 686	***F686*** 1. Orders for low air loss mattress (LALM) for resident #16 was obtained and transcribed during the survey period 9/15/2022. 2. Treatment nurse conducted a baseline audit of residents with LALM to ensure that orders are present. This was completed on 10/7/2022. 3. Inservice started on 9/29/2022 with treatment nurse to take the lead in ensuring orders for specialized mattress are in place, as well as training on documentation with CNAs on how to document turning and repositioning.	11/18/22

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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 686	Continued From page 36 promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interviews, and policy review, the facility failed to ensure one resident (#16) received care and treatments consistent with professional standards of practice to promote healing and prevention of pressure ulcers. The sample size was 4. The deficient practice could result in delayed healing of pressure ulcers. Findings include: Resident #16 was initially admitted on June 2, 2022 with diagnoses that included pneumonia, seizures, encephalitis and encephalomyelitis, cerebral cryptococcosis and disorder of the brain. Review of the admission Minimum Data Set (MDS) dated June 9, 2022, revealed a Brief Interview of Mental Status (BIMS) score of 13 which indicated the resident had intact cognition. The assessment also revealed the resident required extensive assistance of two-person physical assistance for bed mobility, and was admitted with three deep tissue injuries. Review of the census report revealed the resident had been discharged on July 28, 2022 and re-admitted on August 12, 2022. Review of the Skin Observation Task forms, question 3 turning/repositioning dated August 2022, revealed no evidence of turning/repositioning being provided each shift on 12 days/shifts: August 13, 14, 16, 17, 18, 20, 21, 23, 24, 25, 27, 28.	F 686	4. Weekly audits for four weeks will be conducted by treatment nurse for residents who are identified as high risk for skin breakdown. Results of the audits will be presented to the QAPI committee for review and recommendation x 3 months.	12/9/22

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F 686	Continued From page 37 A physician order dated September 9, 2022 included sacral wound: cleanse with normal saline or wound cleanser, apply 1/4 Dakin's solution moistened 4x4, cover with foam dressing every day shift for wound and as needed for wound, replace dressing if soiled or displaced. Review of the Skin Observation Task forms, question 3 turning/repositioning dated September 2022, revealed no evidence that the resident had been turned/repositioned prior to September 13, 2022. Further review of the task from dated September 13, 2022 revealed evidence that the task had occurred on one shift that day. Review of the physician orders revealed no order for a low air loss mattress (LALM). An observation conducted on September 14, 2022, revealed a LALM present on the resident's bed. Review of the clinical record revealed no evidence that the mattress had been observed for proper functioning since readmission on August 12, 2022. Review of wound care observation form revealed that a new right hip deep tissue injury was identified on September 14, 2022, during wound care treatment. A wound care observation was conducted on September 14, 2022 at 8:00 AM with a Registered Nurse (RN) wound care nurse (staff #70) and a Certified Nursing Assistant (CNA/staff #110). The resident was observed lying on a LALM. The RN stated that they have been using	F 686		

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F 686	Continued From page 38	F 686		

a LALM, and turning/repositioning every 2 hours for pressure relief. During the wound care, the RN stated that she just identified a new area on the right ischium, that had a bluish hue, and that she would call the provider. Staff #110 stated that they do not document turning/repositioning in the clinical record, but they round every 2 hours.

An interview was conducted on September 14, 2022 at 9:32 AM with the RN/wound care nurse (staff #70), who stated that the facility policy for pressure relief interventions included LALM, pillows, turn/repositioning every 2 hours. The RN stated the CNAs perform turning/repositioning every 2 hours. She stated that it is in the CNAs document turning/repositioning in the clinical record. The RN further stated that it is standard of care that a resident with a pressure ulcer would be turned/repositioned every 2 hours, even if they are using a LALM. The wound care nurse then stated that the new open area on the right hip, was a possible deep tissue injury (DTI). She also stated that pressure could cause a deep tissue injury. She further stated that there was no evidence in the clinical record that indicates the resident was turned/repositioned every 2 hours in September 2022 per the facility policy. The RN stated there should also be orders in the medical record for use of a LALM, and to check the LALM for inflation, every shift. She reviewed the clinical record and stated that she did not see an order for use of the LALM or to check the LALM for proper functioning every shift. She stated that there was no evidence in the clinical record that the LALM had been checked for proper functioning, or an order for use of the LALM. The RN stated that this did not follow facility policy regarding physician orders, and that the facility had been providing treatment without a physician

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F 686	Continued From page 39 order. She further stated that this did not follow the facility policy. She stated the risk of not turning/repositioning the resident could result in a new pressure ulcer development. She further stated that the new deep tissue injury could have been avoided. She reviewed the clinical record, CNA Skin Observation Task form, question 3 turning/repositioning, and stated that there was no evidence the resident was turned and repositioned every shift on from August 16, 2022 through September 14, 2022. An interview was conducted on September 14, 2022 at 10:24 AM with a CNA (staff #143), who stated the facility policy is to turn/reposition bed bound residents every 2 hours, and document the tasks in the clinical record every shift. An interview was conducted on September 14, 2022 at 3:44 PM with the interim Director of Nursing (DON/staff #141), who stated that she had been updated on the new pressure area that was identified today. She also stated the facility policy is to turn/reposition any bed bound residents every 2 hours. The DON stated turning/repositioning is documented in the CNA tasks skin observation form. She stated she had reviewed the clinical record earlier and there was no evidence the resident had been turned/repositioned on multiple days, especially on the night shift, during September 2022. She stated this did not follow the facility process, and the risk could result in skin break down. The DON further stated there was no evidence in the clinical record that the resident had been turned/repositioned on September 13, 2022, prior to the new deep tissue injury being observed on September 14, 2022.	F 686		

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F 686	Continued From page 40 Review of the facility policy titled, Repositioning," revealed that repositioning is a common, effective intervention for preventing skin breakdown, promoting circulation, and providing pressure relief. Repositioning is critical for a resident who is immobile or dependent upon staff for repositioning. Turning/repositioning program includes a continuous consistent program for changing the resident position and realigning the body. A program is defined as a specific approach that is organized, planned, documented, monitored and evaluated. Residents who are in bed should be on at least every two-hour repositioning schedule. For residents with a Stage 1 or above pressure ulcer, every two-hour repositioning schedule is inadequate. Review of the facility policy titled, Pressure Ulcers/Skin Breakdown, revealed that the physician will order wound treatments, including pressure reduction surfaces.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, and review of policy and procedure, the facility failed to ensure one resident (#205) with extensive behavioral health needs was	F 689	***F689*** 1. Resident #205 had been discharged from the facility since 12/20/2021. 2. IDT meeting with Behavioral Health Services are being held every Tuesday and no current residents had been identified that require being transferred or discharged due to their welfare and/or needs that could not be met in the facility. 3. Continue with the weekly IDT meeting with Behavioral Health Services, and once a month pharmacy meeting for gradual dose reduction of psychotropic medications.	11/18/22

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F 689	Continued From page 41 transferred or discharged due to her welfare, and/or her needs could not be met in the facility, and/or the safety of individuals in the facility were being endangered due to the clinical/behavioral needs of the resident. Findings include: Resident #205 was admitted to the facility on 01/30/17 and readmitted on 06/21/17 with diagnoses that included paranoid schizophrenia, obsessive-compulsive disorder, and anxiety disorder. A Level II Pre-admission Screening and Resident Review (PASRR) dated 02/16/17 was identified in the clinical record. A behavioral care plan revised on 04/02/21 related to a history of refusing care, being combative with care, making false accusations, non-compliance in care and treatments, obsession and delusions regarding time and tasks, and verbal aggression. A nursing note dated 04/20/21 at 3:04 p.m. included that the resident was continuing to refuse hygiene care, causing odor on the unit, despite the plan of staff setting times and re-approaching with an egg-timer so the resident could prepare for the task. The annual Minimum Data Set (MDS) assessment dated 05/04/21 revealed the resident scored 15 on the Brief Interview for Mental Status (BIMS) assessment, displayed verbal behaviors directed towards others for 1-3 out of 7 days in the look-back period, and required supervision to extensive assistance with most activities of daily	F 689	4. Continue with weekly IDT meeting with Behavioral Health Services to identify residents who will be required to be transferred or discharged due to their welfare and/or needs that could not be met at the facility. Results of the audits will be presented to the QAPI committee for review and recommendation x 3 months.	12/9/22

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F 689	Continued From page 42	F 689		

living. The goal was for the resident to not express negative statements and verbalization of sadness. Interventions included to meet the resident in her reality, explaining the risks and benefits, and to perform the cares of the resident in accordance with her preferences.

A nursing note dated Monday, 06/06/21 at 5:36 p.m. included that based upon the report, the resident was last changed on Friday. The note stated that a very strong odor was coming from her room and that halos were seen on the bed linen from head to toe.

A nursing note dated 06/20/21 at 4:37 p.m. included that the resident had refused care and medications, and that she had been hoarding old food brought in by her family days ago. The note included that the resident had been redirected with no changes noted and that due to the resident refusing care multiple days at a time the stench of urine was unbearable and lingered into the corridor area.

A nursing note dated 07/03/21 at 11:36 a.m. included that the resident was seen laying on soiled bed linen, and that she had requested to be changed at 3:34 p.m., reasoning that "I behind on my stuffs."

A social service note dated 08/24/21 at 12:35 p.m. included that the writer had filed an adult protective services report related to the resident's self-neglect and refusal of basic care, including bathing, peri-care, removal of trash from room, and that she had also refused to allow the exterminator to perform general maintenance in room for insect removal.

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F 689	Continued From page 43 A nursing note dated 08/27/21 at 6:28 p.m. included that the resident got combative and had hit the staff in the chest. Review of a behavior note dated 09/21/21 at 12:42 p.m. revealed the resident refused all medications that day due to the wound nurse performing a dressing change at the time the resident preferred medications. The quarterly MDS assessment dated 10/21/21 revealed that the resident displayed verbal behavioral symptoms directed towards others 4 to 6 days, but less than daily. However, the section for overall presence of behavioral symptoms, the section related to the impact of behavioral symptoms on the resident, the section related to the impact of behavioral symptoms on others, including whether or not they significantly disrupted care or the living environment, and the section which included whether or not there had been a change in the resident's behaviors had all been left blank. A nursing note dated 11/08/21 at 5:12 a.m. included that the resident had declined all incontinence care that shift, despite multiple redirections. A nursing note dated 12/18/21 at 5:35 p.m. included that the resident had been verbally and physically aggressive towards staff during an attempt to change the resident's linens and incontinence brief. The note included that the resident was soaked with bowel movement and urine, and that room odor was observed. Per the note, the resident sustained a skin tear from the bedside closet while trying to push staff.	F 689		

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F 689	Continued From page 44 A nursing note dated 12/20/21 at 5:00 p.m. revealed the resident and a family member requested to speak with the administrator and social services and that they met with the resident and family member along with UM (utilization management). The resident complained of left arm pain and stated she did not feel safe. The note stated an order was obtained to send the resident to the emergency room for further evaluation. The note also revealed the family member with the resident gathered the resident's belongings per the resident request. Review of the discharge MDS assessment dated 12/20/2021 revealed the resident was discharged, return not anticipated, to the hospital. Per the physician note dated 12/21/21 at 4:27 p.m. safety had been assessed and the resident had been deemed to be low risk today, and remained appropriate for continued skilled nursing facility inpatient placement. On 09/15/22 at 3:05 p.m., an interview was conducted with a Licensed Practical Nurse (LPN/staff #80). She stated that she did not think a resident who refused incontinence care on a regular basis or who refused to have soiled bedding changed would be contributing to a safe environment for themselves or others, She stated that if psychiatric services, providing activities or talking to the resident did not de-escalate the resident, then she would say that the resident would not be safe from themselves. She stated that residents like that affect everyone on the unit, residents and staff. An interview was conducted on 09/15/22 at 3:44 p.m. with the Interim Director of Nursing	F 689		

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F 689	Continued From page 45 (DON/staff #141). She stated that residents who are PASRR Level II reside in the facility. She stated that staff have been trained to work with residents who have behaviors and dementia. She stated that the facility has housed residents with hoarding behaviors, as well as assaultive, angry ones. She stated that she would have the behavioral health physicians review the resident, review/change their medications, and perhaps send the resident out for acute care/management of care, and perhaps stabilize the resident enough to come back. She stated that if the facility were not able to provide the care at the facility, the resident would not be safe and the psychosocial well-being of other residents would be affected as well. She stated that it is very difficult to send a resident out, that the hospital will usually medicate them and send them back. She stated that in terms of resources, they do not know what more they can do. The facility policy titled Behavioral Health Services, revised February 2019, revealed the facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care. Residents who exhibit signs of emotional/psychosocial distress receive services and support that address their individual needs and goals for care.	F 689		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a	F 756		

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F 756	Continued From page 46 licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and policy review, the facility failed to act upon the pharmacy Medication Regimen Review for	F 756	***F756*** 1. Orders for resident #81 had already been carried out prior to the date of survey. 2. Review reports of consultant pharmacist to identify still require to be carried out. All pharmacist recommendations had been reviewed by physician and carried out as of 10/20/2022. 3. Nursing leadership team will include status of pharmacist recommendation in risk management meeting, conducted 11/11/2022 and ongoing. 4. Weekly audits for four weeks will be conducted by DON/designee to ensure pharmacy recommendations had been reviewed and carried out. Results of the audits will be presented to the QAPI committee for review and recommendation.	11/11/22 12/9/22

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F 756	Continued From page 47 one resident (#81). The sample size was 5. The deficient practice could result in MRRs not being followed through. Findings include: Resident #81 was admitted to the facility April 6, 2022 with diagnoses that included diabetes type 2, essential (primary) hypertension, and heart failure. Regarding heparin Review of the physician orders dated April 6, 2022, revealed an order for Heparin Sodium Solution 5000 unit/milliliter, inject 5000 units subcutaneously every 12 hours for clotting prevention. Review of a quarterly MDS (Minimum Data Set) assessment dated July 14, 2022 revealed a BIMS (Brief Interview of Mental Status) score of 15, which indicated the resident's cognitive status was intact. The active diagnoses included heart failure, hypertension, and diabetes mellitus. The MDS assessment revealed the resident received 7 days of injections and anticoagulant medication during the 7-day lookback period. Review of a consultant pharmacy's medication regimen review (MRR) dated August 24, 2022 stated to clarify the duration of heparin injections and/or stop date for resident #81. A provider responded to "discontinue (dc) now" and signed the MRR without a date. The consultant pharmacist's signature dated August 27, 2022 was affixed on the bottom of the MRR. However, review of Medication Administration	F 756		

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F 756	Continued From page 48 Records (MARs) dated August 2022 and September 2022 revealed that Heparin was not discontinued, and was administered to resident #81 from August 28 through September 14, 2022. An interview was conducted on September 15, 2022 at 12:59 p.m. with the director of nurses (DON/staff #141). Staff #141 stated Heparin orders must include a stop date because of a high risk for bleeding. The DON stated her expectation was for the nursing staff to follow the pharmacist's consultant recommendation and the physician orders. Regarding Furosemide Review of the physician orders dated April 7, 2022, revealed an order for Furosemide 40 milligrams by mouth one time a day for edema. The order stated to hold Furosemide for blood pressure less than 100 and heart rate less than 60. Review of the monthly MRR (Medication Regimen Review) dated August 24, 2022 stated resident #81 has active orders for Furosemide 40 milligrams, Losartan 25 milligrams, and Carvedilol 25 milligrams. Further, the MRR stated all orders indicated to hold if the systolic blood pressure is less than 110, however the resident was receiving Furosemide for edema treatment, not hypertension. The MRR stated to consider removing the hold parameters for systolic blood pressure and low pulse rate for Furosemide. A physician/prescriber response dated August 29, 2022, located directly below the MRR record, stated "agree", and a physician/prescriber's signature was included.	F 756		

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F 756	Continued From page 49 However, review of the MAR (Medication Administration Record) dated September 2022, revealed the heart rate and blood pressure hold parameters were not discontinued on the Furosemide order. Further review of the MAR for September 2022, revealed the medication Furosemide was signed by staff with code 14 (vitals out of parameter) on September 1, 5, 8, and 14. An interview was conducted on September 15, 2022 at 12:59 p.m. with a director of nurses (DON/staff #141) who stated code 14 is a code for vital signs outside of parameter, therefore the medication was held (not administered). Staff #141 stated her expectation regarding pharmacy recommendation if signed by the physician included following the physician orders. Review of the policy, Administering Medications, stated medications are administered in a safe and timely manner, and as prescribed. The policy interpretation and implementation included medication are administered in accordance with prescriber orders, including any required time frame.	F 756		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar	F 806		

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F 806	Continued From page 50 nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, resident and staff interviews, and review of facility policy, the facility failed to ensure one resident (#125) was consistently served food that accommodated the resident's food allergies. The sample size was 9. The deficient practice increases the risk for food-related allergic reactions. Findings include: Resident #125 was admitted to the facility on 08/27/20 with diagnoses that included morbid obesity due to excess calories, necrotizing fasciitis, and type 2 diabetes mellitus with hyperglycemia. Review of the resident Medical Diagnosis profile indicated the resident food allergies included fish, peaches, and seafood. A nutrition/hydration care plan revised on 09/14/22 related to morbid obesity had a goal for the resident to maintain adequate nutritional status. Interventions included providing and serving diet as ordered. On 09/15/22 at 12:24 p.m., an observation of the resident was conducted. The resident was in the process of sending the meal tray back to the kitchen because. The resident stated to the dietary aide, he had ordered a taco salad but was being served a tuna sandwich.	F 806	***F806*** 1. Meal tray for resident #125 was immediately replaced on the day it was identified on 9/15/2022. 2. Spot check was conducted on 9/15/2022 and reminder provided to staff to verify allergies, not only for meal trays, but also for request for substitutions, and snack trays. 3. Inservice was provided to kitchen staff on checking allergies on food trays on the food line. This will be completed by 11/18/2022. 4. Weekly audits for four weeks will be conducted by unit clerks for residents' trays to ensure no food identified as allergies are served to the residents. Results of the audits will be presented to the QAPI committee for review and recommendation x 3 months.	11/18/22 12/9/22

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F 806	Continued From page 51	F 806		

At 12:26 p.m. on 09/15/22, an interview was conducted with the resident. The resident stated that he has been served fish multiple times and that he was allergic to fish.

An interview was conducted on 09/15/22 at 1:36 p.m. with the Dietary Manager (staff #3). He stated that on the admissions form, there is a section which states whether or not the resident has food allergies. He stated that the allergies will be entered on the meal tickets that are placed on the residents' meal trays. He stated that he will spot-check when he can to ensure residents do not receive foods to which they are allergic. He stated that there is also a member of the dietary staff who is assigned to review the trays before they are placed on the cart for delivery. He stated that if the resident was to eat the item(s) to which they were allergic, they may have an allergic reaction such as anaphylactic shock. He stated that he was made aware of the situation that had occurred with resident #125 that day. He stated that the resident's roommate had ordered tuna sandwiches, and that the tray was given to the wrong resident.

On 09/15/22 at 1:45 p.m., an interview was conducted with the interim Director of Nursing (DON/staff #141). She stated that the facility becomes aware of residents' food allergies through hospital records, family interviews, or through interviews with the residents themselves. She stated that the dietary department has access to the residents' electronic records and is responsible for inputting relative information into their software. She stated that she was not sure, but that she thought that information was also printed on the residents' meal ticket. The DON stated that it would not meet her expectations for

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F 806	Continued From page 52 residents to be served foods that they are allergic to. She stated that the risks would include anaphylactic/allergic reactions. The facility policy titled Food Allergies and Intolerances, revised August 2017, revealed residents with food allergies and/or intolerances are identified upon admission and offered food substitutions of similar appeal and nutritional value. Steps are taken to prevent resident exposure to the allergen.	F 806		
F 882 SS=D	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4)(c) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. §483.80 (c) IP participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality	F 882	***F882*** 1. No resident was found to be affected by this alleged deficient practice. 2. No other resident had been affected. An infection preventionist was already in place during the period of survey. 3. An infection preventionist was already in place during the period of survey. 4. No further action required as the facility is currently compliant with an infection preventionist in the facility.	

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F 882	Continued From page 53 assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility policy, and review of the Center for Disease Control (CDC) recommendations, the facility failed to designate a qualified individual as the Infection Preventionist (IP) on an ongoing basis. The deficient practice could result in improper infection prevention practices within the facility. Findings include: During an interview conducted on September 14, 2022 at 2:30 PM with the interim Director of Nursing (DON/staff #141), the DON stated the previous DON last day of employment at the facility was on June 10, 2022. The DON further stated that the facility did not have Infection Preventionist (IP) coverage until August 25, 2022. She also stated that there was no one else in the facility that had been trained as an IP. She stated that she knew that this did not meet the requirements. The DON stated that she has been covering as IP since August 25, 2022. Review of the facility policy titled, Infection Prevention, revealed the infection prevention and control (IPC) program is coordinated and overseen by an infection prevention specialist (Infection Preventionist). The CDC Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes updated September 23, 2022 stated to assign one or more individuals with training in infection control to provide on-site management of the IPC program. CDC has	F 882		

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F 882	Continued From page 54 created an online training course that can orient individuals to this role in nursing homes.	F 882		
F 885 SS=D	Reporting-Residents,Representatives&Families CFR(s): 483.80(g)(3)(i)-(iii) §483.80(g) COVID-19 reporting. The facility must— §483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must— (i) Not include personally identifiable information; (ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and (iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, and review of policy and procedures, the facility failed to ensure that residents, their representatives and families were notified of positive COVID-19 cases occurring in the facility, within the required timeframe. The deficient	F 885	***F885*** 1. No residents are affected by the alleged deficient practice. 2. Website was updated during the period of survey. 3. Inservice/reminder the IDT team involved in the reporting of COVID-19 cases (administrator, nursing leadership, regulatory guideline to notify residents and families of COVID-19 positive cases by 5 PM the next calendar day as required. The announcement should include the cumulative number of cases at the facility. This will be completed by 11/18/2022. 4. DON/Designee will audit website and announcement at front desk per one incident of COVID-19 positive case (staff or resident) or presentation of three residents and/or staff with respiratory symptoms. Results of the audits will be presented to the QAPI committee for review and recommendation.	11/18/22 12/9/22

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F 885	Continued From page 55 practice could result in residents and their representatives/families not being aware of new COVID-19 cases in the facility and the actions implemented to reduce the risk of transmission. Findings include: Review of the facility Line Listing revealed evidence of two staff members (#61 and #51) that had positive COVID-19 tests: -Staff #61 had a positive COVID test result on August 26, 2022 with signs/symptoms that included congestion, runny nose. -Staff #51 had a positive COVID test result on August 28, 2022 with symptoms that included fever, cough, headache, congestion, and runny nose. Further review of the facility website for COVID-19 Reporting revealed evidence that the website had been updated on September 1, 2022, and prior to that, notification was on August 25, 2022. Further review of the website revealed no evidence that residents/representatives and families had been notified of the two staff members that had tested positive on August 26 and 28, 2022. An interview was conducted on September 14, 2022 at 2:33 PM with the interim Director of Nursing (DON/staff #141), who stated the facility notifies residents/family and representatives on a website. She stated that the expectation is to update the website every week, even if there are positives during the week. She further stated that she understands that the regulation is to update by 5 PM the next calendar day when a positive COVID-19 test occurs. She also stated that the updates did not include a cumulative number of	F 885		

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F 885	Continued From page 56 staff/residents that have tested positive. The DON stated that the facility had two confirmed staff that tested positive for COVID-19, and there were no updates by 5 PM the next day. Review of the facility policy titled, Coronavirus Disease (COVID-19) Reporting Facility Data to Residents and Families, revealed residents and families are kept informed of the current COVID-19 situation in the facility. Residents and their representatives and families are notified when there is a single confirmed case of COVID-19. Notices are provided to residents, representatives and families no later than 5 PM of the calendar day following the occurrences. Cumulative information on the number of cases of confirmed COVID-19. Cumulative updates are reported at least weekly.	F 885		
F 888 SS=D	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for	F 888	***F888*** 1. F888 Staff Matrix had been updated to include contracted staff starting 10/10/2022. 2. No residents are affected by the alleged deficient practice. 3. Meeting with IDT committee on F888 (HR director, infection preventionist, staffing coordinator, nursing leadership, administrator) was conducted to ensure that the committee understands respective responsibilities. This will be completed by 11/18/2022. 4. Weekly audits for four weeks will be conducted by DON/designee to ensure contracted agencies (therapy, nursing agencies, providers) have submitted documentation on COVID-19 vaccination. Results of the audits will be presented to the QAPI committee for review and recommendation x 3 months.	11/18/22 12/9/22

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F 888	Continued From page 57 the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of	F 888		

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F 888	Continued From page 58 additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19	F 888		

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F 888	Continued From page 59 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on staff interview and facility policy, the facility failed to develop and implement their policy to ensure that contracted staff were vaccinated for COVID-19. The deficient practice may result in other staff not being vaccinated for COVID-19. Findings include: A request was made on September 13, 2022 upon entrance to the facility, for the COVID-19 vaccination status records for contract staff that	F 888		

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F 888	Continued From page 60 enter the facility. Further request for the list of vaccination status records for contract staff on September 14, 2022 at 2:33 PM was not provided. An interview was conducted with the interim Director of Nursing (DON/staff #141) on September 14, 2022 at 2:30 PM, who stated that they do not have a list of the vaccination status of contract staff that enter the facility. She also stated that they do not have a way to track or ensure vaccination status for contracted staff. The DON stated that she was aware this requirement was issued at the beginning of 2022. Review of the facility policy titled, Coronavirus Disease (COVID-19) Vaccination of Staff, revealed that all staff are required to be fully vaccinated for COVID-19. Staff means individuals who provide any care, treatment or other services for the facility and/or its residents. This included individuals under contract or other arrangement. The Infection Preventionist maintains a tracking worksheet of staff members and their vaccination status. The tracking worksheet provides the most current vaccination status of all staff who provide any care, treatment or other services for the facility and/or its residents. The facility maintains documentation related to staff COVID-19 vaccination that includes verification of vaccination or documentation of exemption.	F 888		
F 943 SS=D	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12,	F 943		

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	035099	A. BUILDING _____ B. WING _____	09/15/2022

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 943	Continued From page 61 facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on personnel file review, staff interviews, and policy reviews, the facility failed to provide evidence that 1 out of 10 sampled staff (#143) received training regarding abuse, neglect, exploitation, misappropriation of resident property, and dementia management. The deficient practice could result in staff not being educated regarding abuse, neglect, exploitation, misappropriation of resident property, and dementia management. Findings include: Staff #143 was hired on 02/2022 as a Registered Nurse (RN) through a contracted agency. Review of staff #143's personnel file revealed no evidence that she had completed training during orientation, which included training on abuse, neglect, exploitation, misappropriation of resident property, or dementia management. On 09/15/22 at 11:23 a.m., an interview was conducted with the Director of Human Resources (staff #82). She stated the competencies that are	F 943	***F943*** 1. Contracted agency staff #143 had no longer been picking up shifts at the facility since date of survey. 2. No residents are affected by the alleged deficient practice. 3. Staffing coordinator continues to ensure incoming contracted agency staff to complete training requirement for abuse, neglect and exploitation policy and protocol of the facility. This will be completed by 11/30/2022. 4. Weekly audits for four weeks will be conducted by DON/designee for agency and other contracted staff to ensure that they attended training for abuse, neglect, and exploitation and have documentation to support such training. Results of the audits will be presented to the QAPI committee for review and recommendation x 3 months.	11/30/22 12/9/22

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 943	Continued From page 62	F 943		

required on a yearly basis included skills, abuse, resident rights, and dementia care for staff that work in direct care positions such as Certified Nursing Assistants, nurses, and therapy staff. She stated that she did not remember staff #143's start date, but that they had a skills fair in July 2022 and completed training with the staff. She stated she has been way too trusting with staffing agencies and trusting them to ensure that the agency staff are up to date with screening and training.

An interview was conducted on 09/15/22 at 11:46 a.m. with the Interim Director of Nursing (DON staff #141). She stated that there is an orientation packet which new employees must complete prior to the start of shift on the first day. She stated if there was no date of completion or staff name on the page, it could have very well been for anyone. She stated that it did not meet her expectations.

A review of the facility Abuse Prevention Program policy revealed during orientation of new employees that abuse, neglect, misappropriation of resident property, and dementia management are topics that will be covered.

Review of the Orientation Program for Newly Hired Employees, Transfers, Volunteers policy, revised May 2019, included that all newly hired personnel/volunteers/transfers/contractors must attend a 10-hour orientation within their first 5 days of hire. The orientation program is separate from the required state-approved nurse aide orientation, and the role-specific training and/or in-service training of new and existing staff.

POC K TAG

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

November 2, 2022

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

Dear Mr. Valdez:

On September 15, 2022, a **Life Safety Code** survey #LYYB21 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.

[X] 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).

[] 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).

[] This survey found the most serious deficiency(ies) in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy as evidenced by the attached form 2567 whereby significant corrections are required (G).

[] This survey found the most serious deficiency(ies) in your facility to be a pattern of deficiencies that constitute actual harm that is not immediate jeopardy as evidenced by the attached form 2567 whereby significant corrections are required (H).

[] This survey found the most serious deficiency(ies) in your facility to be widespread deficiencies that constitute actual harm that is not immediate jeopardy, as evidenced by the attached form 2567 whereby significant corrections are required (I).

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 **November 12, 2022**. You must include all pages of the Statement of Deficiencies when submitting your PoC. Failure to submit an acceptable PoC by **November 12, 2022**, may result in the imposition of remedies.

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.

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

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 **10/30/2022.**

If, upon the 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 continuing 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, per day, per tag, effective September 15, 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.

Mandatory Remedies

Your current period of noncompliance began on September 15, 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 03/14/2022.

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 Bureau of Long Term Care, 150 North 18th Avenue, Suite 440, Phoenix, Arizona 85007. **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.**

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.

Retain a copy of the PoC for your files. If the PoC is not received by this Office by **November 12, 2022,** 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,

Megan Whitby

Megan Whitby
Interim Long Term Care Bureau Chief

MW\bk

Attachments

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035099	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/15/2022

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
K 000	INITIAL COMMENTS 42 CFR 482.41 Nursing Home The facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code of the National Fire Protection Association This is a recertification survey for Medicare under LSC 2012, Chapter 19, Existing. The entire facility, was surveyed on September 13, 2022. The facility meets the standards, based on acceptance of a plan of correction.	K 000	**K000** This Plan of Correction is submitted to meet the requirements established by Federal and State 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.	
K 223 SS=D	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to ensure doors were not being propped open. Failing to keep self-closing or automatic closing doors closed will allow smoke and heat, during a fire, to spread throughout the facility, which could cause	K 223	***K223*** 1. Maintenance Director/Designee fixed issue immediately during survey and during tour on 9/13/22. A facility-wide audit was conducted an no other rated doors were propped open. 2. Maintenance Director/Designee provided in-service to our dietary staff about propping open doors to be completed on 11/18/22. 3. Maintenance Director/Designee will perform random weekly audits for 4 weeks to ensure no doors are being propped open. This will be completed by 12/9/22. 4. Results of the audit will be presented at the monthly QAPI meeting for review and suggestions for 3 months.	11/18/22 12/9/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 11-11-2022

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035099	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/15/2022**

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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K 223	Continued From page 1 harm to the patients. NFPA 101 Life Safety Code, 2012, Chapter 19 Existing, Section 19.3.6.3.10 Doors shall not be held open by devices other than those that release when the door is pushed or pulled. Findings include: Observations made while on tour on September 13, 2022, revealed the rated door between the kitchen and main dining room was being held open with an U.S. flag and base. During the exit conference on September 13, 2022, the above findings were again acknowledged by the management team.	K 223		
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to ensure one illuminated exit sign was at an exit. Failing to install and maintain the illuminated exit sign could cause harm to patients and/or staff in time of a fire or emergency. NFPA 101 Life Safety Code, 2012, Chapter 19,	K 293	***K293*** *1.* Exit sign in the C-wing hall is now illuminated on 11/9/22. A facility-wide walkthrough was conducted to ensure that all exit signs are illuminated per life safety code. *2.* Maintenance Director & assistant will be re-inserviced on importance of having all exit signs illuminated by 11/18/22. *3.* Maintenance Director/Designee will perform random weekly audits of exit signs for 4 weeks of exit signage to ensure all exit signs are illuminated. This will be completed by 12/9/22. 4. Results of the audit will be presented at the monthly QAPI meeting for review and suggestions for 3 months.	11/18/22 12/9/22

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K 293	Continued From page 2 Section 19.2.10.1, Means of egress shall have signs in accordance with Section 7.10 unless otherwise permitted by 19.2.10.2, 19.2.10.3, or 19.2.10.4. Chapter 7, Section 7.10.1.2.1, "Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access." Section 7.10.1.5.1, "Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants." Findings include: Observations made while on tour on September 13, 2022, revealed in the C wing hall exit did not have an illuminated exit sign. During the exit conference on September 24, 2019, the above finding was again acknowledged by the management team.	K 293		
K 342 SS=D	Fire Alarm System - Initiation CFR(s): NFPA 101 Fire Alarm System - Initiation Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations or other continuously attended staff location, provided alarm boxes are visible, continuously accessible, and 200' travel distance is not exceeded. 18.3.4.2.1, 18.3.4.2.2, 19.3.4.2.1, 19.3.4.2.2,	K 342	***K342*** *1.* Maintenance Director fixed issue immediately during survey and during tour 9/13/22. Table with plants removed immediately. Wheelchairs moved immediately to storage area. *2.* Inservice for staff on not blocking manual fire alarm pull station will be completed by 11/18/22. *3.* Maintenance Director/Designee will perform random weekly audits for 4 weeks to ensure that all manual fire alarm pull stations are readily accessible. This will be completed by 12/9/22. 4. Results of the audit will be presented at the monthly QAPI meeting for review and suggestions for 3 months.	11/18/22 12/9/22

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K 342	Continued From page 3 9.6.2.5 This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to prevent the fire alarm pull station to be accessible and unobstructed. Obscuring the fire alarm pull stations from view may prevent or delay the initiating of the fire alarm system in an emergency and this has potential harm to the patients during a fire. NFPA 101 Life Safety Code, 2012, Chapter 19, Section 19.3.4.2.1 "Initiation of the required fire alarm systems shall be by manual means in accordance with 9.6.2 and by means of any required sprinkler system waterflow alarms, detection devices, or detection systems, unless otherwise permitted by 19.3.3.2.2 through 19.3.4.2.4." Chapter 9, Section 9.6.2.7, "Each manual fire alarm box on a system shall be accessible, unobstructed, and visible." Findings include: Observation made while tour on September 13, 2022, revealed the following; 1) a table with plants on it was obstructing access to the manual fire alarm pull station near the main door 2) two (2) wheel chairs were obstructing access to the manual fire alarm pull station in the second floor B wing hall During the exit conference on September 13, 2022, the above finding was again acknowledged by management staff.	K 342		
K 355 SS=D	Portable Fire Extinguishers	K 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 355	Continued From page 4 CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: 1) Based on observation the facility failed to prevent fire extinguishers from being blocked and readily accessible in the facility. Failing to have clear access to a fire extinguisher during an emergency could result in harm to the patients and/or staff. NFPA 101 Life Safety Code, 2012, Chapter 19, Section 19.3.5.12 "Portable fire extinguishers shall be provided in all health care occupancies in accordance with 9.7.4.1" Section 9.7.4.1 "Where required by the provisions of another section of this Code, portable fire extinguishers shall be installed, inspected, and maintained in accordance with NFPA 10, Standard for portable Fire Extinguishers." NFPA 10, Chapter 7, Section 7.2.2 Periodic inspections or electronic monitoring of fire extinguishers shall include a check of at least the following items: No obstruction to access or visibility. Findings include: During a facility tour conducted on September 13, 2022, revealed the following; 1) a plastic table was blocking access to an ABC portable fire extinguisher in the regional area office	K 355	***K355*** ***1.*** Maintenance Director fixed issue immediately during survey and during tour 9/13/22. Plastic table and wheelchairs blocking access to ABC portable fire extinguisher immediately removed. Also, maintenance Director replaced mounting bracket and wet chemical fire extinguisher is now properly stored. ***2.*** Inservice for staff on not blocking ABC portable fire extinguisher will be completed by 11/18/22. ***3.*** Maintenance Director or designee will perform random weekly audits for 4 weeks to ensure that all fire extinguishers are properly stored. This will be completed by 12/9/22. 4. Results of the audit will be presented at the monthly QAPI meeting for review and suggestions for 3 months.	11/18/22 12/9/22

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K 355	Continued From page 5 2) two (2) wheelchairs were blocking access to an ABC portable fire extinguisher in the 2nd floor B wing hall During the exit conference on September 13, 2022, the above findings were again acknowledged by the management team. 2) Based on observation and staff interview, the facility failed to ensure that fire extinguishers are protected and properly installed. Failing to protect and have proper installation of fire extinguishers has potential to cause harm to staff and patients. NFPA 101 Life Safety Code, 2012, Chapter 19, Section 19.3.5.12 "Portable fire extinguishers shall be provided in all health care occupancies in accordance with 9.7.4.1" Section 9.7.4.1 "Where required by the provisions of another section of this Code, portable fire extinguishers shall be installed, inspected, and maintained in accordance with NFPA 10, Standard for portable Fire Extinguishers." NFPA 10, Section 6.1.3.7 "Fire extinguishers installed under conditions where they are subject to physical damage (e.g., from impact, vibration, the environment) shall be protected against damage." Section 6.1.3.8.1 "Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. Section 6.1.3.8.2 "Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be installed so that the top of the fire extinguisher is not more than 3 1/2 ft (1.07 m) above the floor." Findings include:	K 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 355	Continued From page 6 Observation made while on tour on September 13, 2022, revealed a wet chemical fire extinguisher in the kitchen was found on the floor. The mount bracket had been damaged the there was not way to hang the fire extinguisher. The fire extinguisher was missing the plastic protective boot and the metal base was dented. During the exit conference on September 13, 2022, the above finding was acknowledged by the management team.	K 355		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames	K 363	***K363*** *1.* Maintenance Director has identified doors to verify the issue with latching. Hinge of central supply door had been repaired and is latching according to regulation. The Cholla dining room doors swing arm has been adjusted and is now meeting regulatory standards. Upon receipt of parts, door in the Cholla dining room will be repaired to meet regulation. A facility-wide walkthrough was conducted and no other rated doors had been identified to require repairs. *2.* Maintenance Director & assistant will be re-inserviced on importance of having all exit signs illuminated by 11/18/22. *3.* Maintenance Director or designee will perform random weekly audits on rated door for 4 weeks to ensure that rated doors are properly maintained and are latching. This will be completed by 12/9/22. 4. Results of the audit will be presented at the monthly QAPI meeting for review and suggestions for 3 months.	11/18/22 12/9/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035099	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/15/2022**

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
K 363	Continued From page 7 shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to ensure rated doors had been properly maintained. Failing to ensure rated doors are properly maintained could cause harm to patients and/or staff in the event of a fire. NFPA 101, Life Safety Code, 2012 edition, Chapter 19, Section 19.3.6.3.5. "Doors shall be provided with a means for keeping the door closed that is acceptable to the authority having jurisdiction." Findings include: Observations made while on tour on September 13, 2022, revealed the following; 1) the rated door for central supply and environmental services failed to close and latch secure when tested three of three times 2) the rated doors at the Cholla dining room failed to close and latch secure when tested three of three times	K 363		

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K 363	Continued From page 8 During the exit conference on September 13, 2022, the above findings were again acknowledged by the management team.	K 363		
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to ensure several electrical panels could be secured along with other electrical issues. Failure to cover open junction boxes could cause harm to patients and/or staff. NFPA 101 Life Safety Code, 2012 Edition, Chapter 19, Section 19.5.1.1 "Utilities shall comply with the provisions of Section 9.1." Section 9.1.2, "Electrical wiring and equipment installed shall be in accordance with NFPA 70 'National Electrical Code" NEC, 2011. NFPA 70, Article 314, Section 314.28 "Boxes and conduit bodies used as pull or junction boxes shall comply with 314.28(A) through (E). Subsection (C) Covers. "All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body	K 511	***K511*** 1. Maintenance Director has replaced 4-gang electrical outlet on 11/9/22. 2 new electrical panel covers had been ordered for the kitchen and will be installed as soon as they are received. A facility-wide audit was conducted to locate outlets and panels that need to be replaced. No further areas of concern identified. 2. Inservice will be provided to staff to ensure to report any issue with electrical outlets and electrical panel to our repairing portal – TELS. This will be completed by 11/18/22. 3. Maintenance Director will perform random weekly audits for 4 weeks to ensure that no electrical outlets are covered, electric panels are attached appropriate, and electrical panel is blocked not blocked. This will be completed by 12/9/22. 4. Log will serve as a tool for compliance. Maintenance Director/Designee will bring results of the audit to the Quality Assurance committee for review and recommendation for 3 months.	11/18/22 12/9/22

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	035099	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/15/2022**

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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K 511	Continued From page 9 construction and suitable for the conditions of use. Where used, metal covers shall comply with the grounding requirements of 250. 110. Findings include: Observations made while on tour on September 13, 2022, revealed the following; 1) a four (4) gang electrical outlet was missing a cover in the laundry room 2) two (2) electrical panels in the kitchen, one the door was attached by only 1 hinge and the second was missing a screw allowing a gap between the panel and wall 3) electrical panel access was blocked in a closet in the 2nd floor dining room by a scale and wheelchair During the exit interview on September 13, 2022, the above finding was acknowledged by the management team.	K 511		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms	K 920		

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K 920	Continued From page 10 (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure that staff did not use daisy chain power strips (power strip plugged into power strip), multi plug adapters, extension cords from being properly used in the facility. The use of daisy chained power strips could create an overload of the electrical system and could cause a fire or an electrical hazard. A fire could cause harm to the patients. NFPA 101 2012 Edition. 9.1 Utilities. 9.1.2 Electrical Systems. Electrical wiring and equipment shall be in accordance with NFPA 70 National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service. NEC 70 2011 Edition. 400.8 Uses Not Permitted. Unless specifically permitted in 400.7 flexible cords and cables shall not be used for the following: 1. As a substitute for the fixed wiring of a structure 2. Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors 3. Where run through doorways, windows, or similar openings 4. Where attached to building surfaces. Exception to (4): Flexible cord and cable shall be	K 920	***K920*** 1. Maintenance Director/Designee has corrected the identified issues – extension cord in conference room; multiplug adapter in laundry room, refrigerators into power strips in A unit nurse station, and wound care office. A facility-wide audit was completed to locate improper use of outlet adapters, extension cords, and daisy chained power strips. No further areas of concern identified. 2. Inservice will be provided to staff that use of extension cords/power strip is not an accepted standard due to fire hazard. This will be completed by 11/18/22. 3. Maintenance Director or designee will perform random weekly audits for 4 weeks to ensure no unapproved power strips or use. This will completed by 12/9/22. 4. Maintenance Director or designee will bring results of the weekly audit and present to the QAPI committee for review and recommendation	11/18/22 12/9/22

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K 920	Continued From page 11 permitted to be attached to building surfaces in accordance with the provisions of 368.56(B) 5. Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings 6. Where installed in raceways, except as otherwise permitted in this Code 7. Where subject to physical damage Findings include: Observations made while on tour on September 13, 2022, revealed the following; 1) a circular fan was found in the ceiling (above the ceiling tiles) near the conference room. The fan was plugged into an extension cord which was plugged into a power strip. The fan was on at the time it was observed. 2) a multi plug adapter was found in the laundry room behind the washing machines 3) two (2) refridgerators were observed plugged into a power strip in the A unit nurses station 4) a power strip was observed plugged into a second power strip in the B wing 2 wound care office During the exit conference conducted on September 13, 2022, the above findings were again acknowledged by the management team.	K 920		
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet	K 923		

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K 923	Continued From page 12 Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to secure their oxygen cylinders in a containment made of noncombustible materials. Failing to store compressed medical gas cylinders in a combustible storage area could cause harm to the patients and/or staff during a fire.	K 923	*K923* 1. Maintenance Director/Designee performed visual inspection of oxygen storage area. A new area has been designated for storage of facility oxygen tanks. Boxes were removed from the oxygen storage area. 2. Inservice will be provided to staff to not put anything combustible in or near new storage area per life safety code. This will be completed by 11/18/22. 3. New storage area identified, and oxygen tanks will be moved to new location. New storage area meets all requirements required by the life safety code. This will be completed on 11/18/22. 4. Date of completion will be noted in the next QAPI meeting.	11/18/22 11/18/22

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K 923	Continued From page 13 NFPA 101 Life Safety Code, 2012, Chapter 19, Section 19.3.2.4 "Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities." NFPA 99 2012 Edition Chapter 11 Section 11.3 Cylinder and Container Storage Requirements. 11.3.2 Storage for nonflammable gases greater than 8.5 m3 (300 ft3), but less than 85 m3 (3000 ft3), at STP shall comply with the requirements in 11.3.2.1 through 11.3.2.3.11.3.2.1 Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry.11.3.2.2 Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor.11.3.2.3 Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) Minimum distance of 6.1 m (20 ft) (2) Minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) Enclosed cabinet of noncombustible construction having a minimum fire protection rating of 1/ 2 hour Findings include: Observations made while on tour on September 13, 2022, revealed the facility stored compressed oxygen cylinders in a containment made with plywood walls. There was boxes being stored within 5 feet of the containment. During the exit conference on September 13, 2022, the above findings were again acknowledged by the management staff.	K 923		

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POC E TAG

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

November 2, 2022

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

Dear Mr Valdez:

On September 15, 2022, a Emergency Preparedness survey #LYYB21 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. Although the survey found that your facility was in substantial compliance with the participation requirements, some deficiencies exist.

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 **November 12, 2022.** You must include all pages of the Statement of Deficiencies when submitting your PoC. Failure to submit an acceptable PoC by **November 12, 2022** may result in the imposition of remedies.

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.

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

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.

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 Bureau of Long Term Care, 150 North 18th Avenue, #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 **November 12, 2022**, 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,

Megan Whitby

Megan Whitby
Interim Long Term Care Bureau Chief

MW\bk

Attachments

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 000	Initial Comments 42 CFR 483.73 Long Term Care Facilities. The facility must meet all applicable Federal, State and local emergency preparedness requirements as outlined in the Medicare and Medicaid Programs: Emergency Preparedness Requirements of Medicare and Medicaid Participating Providers and Suppliers Final Rule (81 FR 63860) September 16, 2016. The facility meets the standards, based upon acceptance of a plan of corrections.	E 000	**E000** This Plan of Correction is submitted to meet the requirements established by Federal and State 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. **E039** 1. Maintenance Director/Designee had performed a Full-scale facility-based exercise on 9/9/2022 which was a man-made disaster; Facility wide power outage for 3-4 hours. Our Emergency Plan was activated on 9/9/2022 due to facility wide power outage for 3-4 hours. For our 2nd full scale exercise, we have a mock drill scheduled for 11/16/2022 which will be an active shooter drill. 2. Maintenance Director/Designee provided in-service to our staff during facility wide power outage completed on 9/9/2022. Maintenance Director/Designee will provide in-service for all staff on 11/16/2022 for facility wide Active Shooter drill. 3. Maintenance Director/Designee will identify an exercise of choice by 12/5/2022 and prepare for 2023 exercise of choice to comply with emergency preparedness regulations. 4. Results will be presented at the monthly QAPI meeting for documentation.	
E 039 SS=D	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires	E 039		12/5/2022

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

Administrator 11-11-2022

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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SANDSTONE OF TUCSON REHAB CENTRE	2900 EAST MILBER STREET TUCSON, AZ 85714

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E 039	Continued From page 1 activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from	E 039		

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 _____	09/15/2022

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
E 039	Continued From page 2 engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is	E 039		

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 _____	09/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 039	Continued From page 3 community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based	E 039		

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	035099	A. BUILDING _____ B. WING _____	09/15/2022

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
E 039	Continued From page 4 functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based	E 039		

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	035099	A. BUILDING _____ B. WING _____	09/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 039	Continued From page 5 functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by	E 039		

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	035099	A. BUILDING _____ B. WING _____	09/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 039	Continued From page 6 a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.	E 039		

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 _____	09/15/2022

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SANDSTONE OF TUCSON REHAB CENTRE	2900 EAST MILBER STREET TUCSON, AZ 85714

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E 039	Continued From page 7 (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.	E 039		

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E 039	Continued From page 8 (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and	E 039		

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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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E 039	Continued From page 9 maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to participate in a community based exercise in 2021/2022. Failure to provide policy and procedures for the training and testing program may lead to untrained staff in an emergency situation and may result in harm to the residents during an emergency. Findings include: Based on record review and staff interview on September 13, 2022, revealed the facility was unable to provide documentation of the following: 1. Participate in a full-scale exercise (FSE) that is community-based. 2. Conduct an additional exercise that may include, but is not limited to the following: (A) A second FSE that is individual, facility-based. (B) A tabletop exercise. During the exit conference on September 13, 2022, the above finding was again acknowledge by the management team.	E 039		

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

Date Printed: 9/12/2022
Unit: All
Floor: All

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

Provider No.	Medicare F75	Medicaid F76	Other F77	Total Residents F78
	7	127	20	154

ADL	Independent	Assist of One or Two Staff	Dependent
Bathing	F79 11	F80 91	F81 52
Dressing	F82 6	F83 142	F84 6
Transferring	F85 16	F86 128	F87 10
Toilet Use	F88 7	F89 133	F90 14
Eating	F91 43	F92 108	F93 3

A. Bowel/Bladder Status

F94 17 With indwelling or external catheter

F95 Of the total number of residents with catheters, how many were present on admission 17?

F96 111 Occasionally or frequently incontinent of bladder

F97 80 Occasionally or frequently incontinent of bowel

F98 111 On urinary toileting program

F99 82 On bowel toileting program

B. Mobility

F100 26 Bedfast all or most of time

F101 75 In a chair all or most of time

F102 25 Independently ambulatory

F103 28 Ambulation with assistance or assistive device

F104 0 Physically restrained

F105 Of the total number of residents with restraints, how many were admitted or readmitted with orders for restraints 0?

F106 38 With contractures

F107 Of the total number of residents with contractures, how many had a contracture(s) on admission 38?

C. Mental Status

F108-114 - indicate the number of residents with:

F108 2 Intellectual and/or developmental disability

F109 36 Documented signs and symptoms of depression

F110 71 Documented psychiatric diagnosis (exclude dementias and depression)

F111 53 Dementia: (e.g., Lewy-Body, vascular or Multi-infarct, mixed, frontotemporal such as Pick's disease; and dementia related to Parkinson's or Creutzfeldt-Jakob diseases), or Alzheimer's Disease

F112 46 Behavioral healthcare needs

F113 Of the total number of residents with behavioral healthcare needs, how many have an individualized care plan to support them 28?

F114 0 Receiving health rehabilitative services for MI and/or ID/DD

D. Skin Integrity

F115-118 - indicate the number of residents with:

F115 8 Pressure ulcers (exclude Stage 1)

F116 Of the total number of residents with pressure ulcers excluding Stage 1, how many residents had pressure ulcers on admission 6?

F117 118 Receiving preventive skin care

F118 0 Rashes

Date Printed: 9/12/2022
Unit: All
Floor: All

E. Special Care

F119-132 - indicate the number of residents receiving:

F119	6	Hospice care
F120	0	Radiation therapy
F121	1	Chemotherapy
F122	4	Dialysis
F123	6	Intravenous therapy, IV nutrition, and/or blood transfusion
F124	13	Respiratory treatment
F125	0	Tracheostomy care
F126	4	Ostomy care
F127	0	Suctioning
F128	44	Injections (exclude vitamin B12 injections)
F129	6	Tube feedings
F130	43	Mechanically altered diets including pureed and all chopped food (not only meat)
F131	44	Rehabilitative services (Physical therapy, speech-language therapy, occupational therapy, etc.) Exclude health rehabilitation for MI and/or ID/DD
F132	3	Assistive devices while eating

F. Medications

F133-139 - indicate the number of residents receiving:

F133	101	Any psychoactive medication
F134	46	Antipsychotic medications
F135	20	Antianxiety medications
F136	94	Antidepressant medications
F137	1	Hypnotic medications
F138	6	Antibiotics
F139	84	On pain management program

G. Other

F140	3	With unplanned significant weight loss/gain
F141	3	Who do not communicate in the dominant language of the facility (include those who use American sign language)
F142	1	Who use non-oral communication devices
F143	154	With advance directives
F144	95	Received influenza immunization
F145	40	Received pneumococcal vaccine

I certify that this information is accurate to the best of my knowledge.

Signature of Person Completing the Form	Title	Date
[signature]	MDS Director	9/12/22

TO BE COMPLETED BY SURVEY TEAM

F146 Was ombudsman notified prior to survey? ✓ Yes __ No

F147 Was ombudsman present during any portion of the survey? ✓ Yes __ No

F148 Medication error rate 0 %

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

OMB Exempt

LONG-TERM CARE FACILITY APPLICATION FOR MEDICARE AND MEDICAID

Standard Survey:		**Extended Survey:**	
From: F1 *(mm/dd/yyyy)*	To: F2 *(mm/dd/yyyy)*	From: F3 *(mm/dd/yyyy)*	To: F4 *(mm/dd/yyyy)*
09/12/2022	09/16/2022		

Name of Facility	Provider Number	Fiscal Year Ending: F5 *(mm/dd/yyyy)*
Sandstone of Tucson	520-294-0005	

Street Address
2900 E Milber St

City	County	State	Zip Code
Tucson	Pima	AZ	85714

Telephone Number: F6	State/County Code: F7	State/Region Code: F8
(520) 294-0005		

F9 [0 1]
01 Skilled Nursing Facility (SNF) - Medicare Participation
02 Nursing Facility (NF) - Medicaid Participation
03 SNF/NF - Medicare/Medicaid

Is this facility hospital based? F10 ..... ○ Yes ◉ No
If yes, indicate Hospital Provider Number: F11 [ ][ ][ ][ ][ ][ ]

Ownership: F12 [1 3]

For-Profit	Non-Profit	Government	
01 Individual	04 Church Related	07 State	10 City/County
02 Partnership	05 Nonprofit Corporation	08 County	11 Hospital District
03 Corporation	06 Other Nonprofit	09 City	12 Federal
13 Limited Liability Corporation			

Owned or leased by Multi-Facility Organization: F13 ..... ◉ Yes ○ No

Name of Multi-Facility Organization: F14
Sandstone Healthcare

Dedicated Special Care Units: *(show number of beds for all that apply)*

F15 AIDS	F16 Alzheimer's Disease	F17 Dialysis
[0][ ][ ]	[0 4 0]	[0][ ][ ]
F18 Disabled Children/Young Adults	**F19 Head Trauma**	**F20 Hospice**
[0][ ][ ]	[0][ ][ ]	[0][ ][ ]
F21 Huntington's Disease	**F22 Ventilator/Respiratory Care**	**F23 Other Specialized Rehabilitation**
[0][ ][ ]	[0][ ][ ]	[0 4 0]

Does the facility currently have an organized residents' group? F24 ..... ◉ Yes ○ No

Does the facility currently have an organized group of family members of residents? ..... ○ Yes ◉ No

Does the facility conduct experimental research? F26 ..... ○ Yes ◉ No

Is the facility part of a continuing care retirement community (CCRC)? F27 ..... ○ Yes ◉ No

If the facility currently has a staffing waiver, indicate the type(s) of waiver(s) by writing in the date(s) of last approval. Indicate the number of hours waived for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks.

Waiver of seven day RN requirement:		**Waiver of 24 hr licensed nursing requirement:**	
Date: F28 *(mm/dd/yyyy)*	Hours waived per week: F29	Date: F30 *(mm/dd/yyyy)*	Hours waived per week: F31

Does the facility currently have an approved Nurse Aide Training and Competency Evaluation Program? F32 ..... ○ Yes ◉ No

Name of Person Completing Form	Time
Ryan Valdez	11:11 am
Signature	**Date**
	9-12-2022

SANDSTONE OF TUCSON REHAB CENTRE
2900 EAST MILBER STREET
TUCSON, AZ 85714
State's Region Code: TUC
Compliance Status: Provider meets requirements

CCN: 035099
Phone Number: (520)294-0005
Participation Date: 02/05/1985

Provider Beds
Total: 240
Certified: 240

Provider Category: SNF/NF (DUAL)

Type Action: RECERTIFICATION
Type Ownership: FOR PROFIT - CORPORATION

Program Requirements

Current Survey/Revisit Dates - 04/28/2021

Prior 3 Survey 09/2016	S/S Code	Prior 2 Survey 10/2017	S/S Code	Prior 1 Survey 01/2019	S/S Code	Current Survey 03/11/2021	S/S Code	Plan/Date of Correction		Requirement
-	-	X	D	-	-	- -	-	-	REQ	F0154-INFORMED OF HEALTH STATUS, CARE, & TREATMENTS
-	-	-	-	-	-	- -	-	-	REQ	F0156-NOTICE OF RIGHTS, RULES, SERVICES, CHARGES
-	-	-	-	-	-	- -	-	-	REQ	F0157-NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)
-	-	-	-	-	-	- -	-	-	REQ	F0159-FACILITY MANAGEMENT OF PERSONAL FUNDS
-	-	-	-	-	-	- -	-	-	REQ	F0164-PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS
-	-	-	-	-	-	- -	-	-	REQ	F0166-RIGHT TO PROMPT EFFORTS TO RESOLVE
-	-	-	-	-	-	- -	-	-	REQ	F0167-RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE
-	-	-	-	-	-	- -	-	-	REQ	F0174-RIGHT TO TELEPHONE ACCESS WITH PRIVACY
-	-	-	-	-	-	- -	-	-	REQ	F0204-PREPARATION FOR SAFE/ORDERLY
-	-	-	-	-	-	- -	-	-	REQ	F0221-RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS
-	-	-	-	-	-	- -	-	-	REQ	F0223-FREE FROM ABUSE/INVOLUNTARY SECLUSION
-	-	-	-	-	-	- -	-	-	REQ	F0225-INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS
-	-	-	-	-	-	- -	-	-	REQ	F0226-DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES
-	-	-	-	-	-	- -	-	-	REQ	F0241-DIGNITY AND RESPECT OF INDIVIDUALITY
-	-	X	D	-	-	- -	-	-	REQ	F0242-SELF-DETERMINATION - RIGHT TO MAKE CHOICES
-	-	-	-	-	-	- -	-	-	REQ	F0246-REASONABLE ACCOMMODATION OF
-	-	-	-	-	-	- -	-	-	REQ	F0247-RIGHT TO NOTICE BEFORE ROOM/ROOMMATE
-	-	-	-	-	-	- -	-	-	REQ	F0250-PROVISION OF MEDICALLY RELATED SOCIAL SERVICE
-	-	X	D	-	-	- -	-	-	REQ	F0253-HOUSEKEEPING & MAINTENANCE SERVICES
-	-	-	-	-	-	- -	-	-	REQ	F0258-MAINTENANCE OF COMFORTABLE SOUND LEVELS
-	-	-	-	-	-	- -	-	-	REQ	F0272-COMPREHENSIVE ASSESSMENTS
-	-	-	-	-	-	- -	-	-	REQ	F0278-ASSESSMENT ACCURACY/COORDINATION/CERTIFIED
-	-	-	-	-	-	- -	-	-	REQ	F0279-DEVELOP COMPREHENSIVE CARE PLANS
-	-	X	D	-	-	- -	-	-	REQ	F0280-RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP
-	-	-	-	-	-	- -	-	-	REQ	F0281-SERVICES PROVIDED MEET PROFESSIONAL
-	-	X	E	-	-	- -	-	-	REQ	F0309-PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

! = Past Non-compliance C = Date of Correction N = No Date Given P = Plan of Correction R = Refused to Correct W = Waived F = FSES X = Deficient
* = Regional Office Flag (Includes COPs) ELE = Element STD = Standard COP = Condition REQ = Requirement - = No Data Entered

SANDSTONE OF TUCSON REHAB CENTRE **CCN:** 035099

Prior 3 Survey 09/2016	S/S Code	Prior 2 Survey 10/2017	S/S Code	Prior 1 Survey 01/2019	S/S Code	Current Survey 03/11/2021	S/S Code	Plan/Date of Correction		Requirement
-	-	-	-	-	-	- -	-	-	REQ	F0312-ADL CARE PROVIDED FOR DEPENDENT RESIDENTS
-	-	-	-	-	-	- -	-	-	REQ	F0313-TREATMENT/DEVICES TO MAINTAIN HEARING/VISION
-	-	-	-	-	-	- -	-	-	REQ	F0314-TREATMENT/SVCS TO PREVENT/HEAL PRESSURE
-	-	-	-	-	-	- -	-	-	REQ	F0315-NO CATHETER, PREVENT UTI, RESTORE BLADDER
-	-	X	G	-	-	- -	-	-	REQ	F0318-INCREASE/PREVENT DECREASE IN RANGE OF MOTION
-	-	X	E	-	-	- -	-	-	REQ	F0323-FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES
-	-	-	-	-	-	- -	-	-	REQ	F0328-TREATMENT/CARE FOR SPECIAL NEEDS
-	-	X	E	-	-	- -	-	-	REQ	F0329-DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS
-	-	-	-	-	-	- -	-	-	REQ	F0332-FREE OF MEDICATION ERROR RATES OF 5% OR MORE
-	-	-	-	-	-	- -	-	-	REQ	F0333-RESIDENTS FREE OF SIGNIFICANT MED ERRORS
-	-	-	-	-	-	- -	-	-	REQ	F0356-POSTED NURSE STAFFING INFORMATION
X	D	-	-	-	-	- -	-	-	REQ	F0364-NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP
X	D	-	-	-	-	- -	-	-	REQ	F0371-FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY
-	-	-	-	-	-	- -	-	-	REQ	F0425-PHARMACEUTICAL SVC - ACCURATE PROCEDURES,
X	E	-	-	-	-	- -	-	-	REQ	F0431-DRUG RECORDS, LABEL/STORE DRUGS &
-	-	-	-	-	-	- -	-	-	REQ	F0441-INFECTION CONTROL, PREVENT SPREAD, LINENS
-	-	-	-	-	-	- -	-	-	REQ	F0463-RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH
-	-	-	-	-	-	- -	-	-	REQ	F0490-EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING
-	-	-	-	-	-	- -	-	-	REQ	F0508-PROVIDE/OBTAIN RADIOLOGY/DIAGNOSTIC SVCS
-	-	-	-	-	-	- -	-	-	REQ	F0513-X-RAY/DIAGNOSTIC REPORT IN RECORD-SIGN/DATED
-	-	-	-	-	-	- -	-	-	REQ	F0514-RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE
-	-	X	E	-	-	- -	-	-	REQ	F0520-QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS
-	-	-	-	X	D	X C	E	04/20/2021	REQ	F0552-Right to be Informed/Make Treatment Decisions
-	-	-	-	X	E	- -	-	-	REQ	F0578-Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir
-	-	-	-	X	E	- -	-	-	REQ	F0584-Safe/Clean/Comfortable/Homelike Environment
-	-	-	-	X	E	- -	-	-	REQ	F0600-Free from Abuse and Neglect
-	-	-	-	X	E	- -	-	-	REQ	F0607-Develop/Implement Abuse/Neglect Policies
-	-	-	-	X	D	X C	D	04/20/2021	REQ	F0609-Reporting of Alleged Violations
-	-	-	-	-	-	X C	D	04/20/2021	REQ	F0610-Investigate/Prevent/Correct Alleged Violation
-	-	-	-	X	D	- -	-	-	REQ	F0623-Notice Requirements Before Transfer/Discharge
-	-	-	-	X	D	- -	-	-	REQ	F0641-Accuracy of Assessments
-	-	-	-	X	E	X C	E	04/20/2021	REQ	F0645-PASARR Screening for MD & ID

SANDSTONE OF TUCSON REHAB CENTRE **CCN:** 035099

Prior 3 Survey	S/S Code	Prior 2 Survey	S/S Code	Prior 1 Survey	S/S Code	Current Survey	S/S Code	Plan/Date of Correction		Requirement
09/2016		10/2017		01/2019		03/11/2021				
-	-	-	-	-	-	X C	E	04/20/2021	REQ	F0656-Develop/Implement Comprehensive Care Plan
-	-	-	-	X	E	- -	-	-	REQ	F0657-Care Plan Timing and Revision
-	-	-	-	-	-	X C	D	04/20/2021	REQ	F0684-Quality of Care
-	-	-	-	X	D	X C	D	04/20/2021	REQ	F0689-Free of Accident Hazards/Supervision/Devices
-	-	-	-	X	D	X C	D	04/20/2021	REQ	F0695-Respiratory/Tracheostomy Care and Suctioning
-	-	-	-	X	E	- -	-	-	REQ	F0698-Dialysis
-	-	-	-	X	E	- -	-	-	REQ	F0725-Sufficient Nursing Staff
-	-	-	-	-	-	X C	B	04/20/2021	REQ	F0732-Posted Nurse Staffing Information
-	-	-	-	-	-	X C	D	04/20/2021	REQ	F0756-Drug Regimen Review, Report Irregular, Act On
-	-	-	-	X	D	X C	E	04/20/2021	REQ	F0758-Free from Unnec Psychotropic Meds/PRN Use
-	-	-	-	-	-	X C	E	04/20/2021	REQ	F0761-Label/Store Drugs and Biologicals
-	-	-	-	-	-	X C	D	04/20/2021	REQ	F0806-Resident Allergies, Preferences, Substitutes
-	-	-	-	-	-	X C	D	04/20/2021	REQ	F0812-Food Procurement, Store/Prepare/Serve Sanitary
-	-	-	-	X	D	- -	-	-	REQ	F0842-Resident Records - Identifiable Information
-	-	-	-	X	E	- -	-	-	REQ	F0867-QAPI/QAA Improvement Activities
-	-	-	-	-	-	X C	E	04/20/2021	REQ	F0880-Infection Prevention & Control
-	-	-	-	-	-	X C	D	04/20/2021	REQ	F0886-COVID-19 Testing-Residents & Staff
-	-	-	-	X	D	- -	-	-	REQ	F0919-Resident Call System

LSC Deficiencies

Edition of LSC Applied

2012 HC Prior 3 Survey	S/S Code	2012 HC Prior 2 Survey	S/S Code	2012 HC Prior 1 Survey	S/S Code	2012 HC Current Survey	S/S Code	Plan/Date of Correction		LSC Deficiencies - Bldg # 01
09/2016		10/2017		01/2019		03/11/2021				
-	-	-	-	X	C	- -	-	-	REQ	E0009-Local, State, Tribal Collaboration Process
-	-	-	-	X	C	- -	-	-	REQ	E0015-Subsistence Needs for Staff and Patients
-	-	-	-	X	C	- -	-	-	REQ	E0023-Policies/Procedures for Medical Documentation
-	-	-	-	X	C	- -	-	-	REQ	E0024-Policies/Procedures-Volunteers and Staffing
-	-	-	-	X	C	- -	-	-	REQ	E0025-Arrangement with Other Facilities
-	-	-	-	X	C	- -	-	-	REQ	E0026-Roles Under a Waiver Declared by Secretary

SANDSTONE OF TUCSON REHAB CENTRE **CCN:** 035099

Edition of LSC Applied

2012 HC Prior 3 Survey 09/2016	S/S Code	2012 HC Prior 2 Survey 10/2017	S/S Code	2012 HC Prior 1 Survey 01/2019	S/S Code	2012 HC Current Survey 03/11/2021	S/S Code	Plan/Date of Correction		LSC Deficiencies - Bldg # 01
-	-	-	-	X	F	- -	-	-	REQ	E0036-EP Training and Testing
-	-	-	-	-	-	X C	C	04/23/2021	REQ	E0037-EP Training Program
-	-	-	-	-	-	- -	-	-	STD	K0161-Building Construction Type and Height
-	-	-	-	-	-	- -	-	-	STD	K0232-Aisle, Corridor, or Ramp Width
-	-	-	-	-	-	- -	-	-	STD	K0281-Illumination of Means of Egress
-	-	-	-	X	E	X C	C	04/19/2021	STD	K0291-Emergency Lighting
-	-	X	D	-	-	X C	E	04/19/2021	STD	K0321-Hazardous Areas - Enclosure
-	-	X	D	-	-	- -	-	-	STD	K0324-Cooking Facilities
-	-	-	-	X	E	- -	-	-	STD	K0325-Alcohol Based Hand Rub Dispenser (ABHR)
-	-	-	-	-	-	- -	-	-	STD	K0331-Interior Wall and Ceiling Finish
X	E	-	-	X	E	- -	-	-	STD	K0353-Sprinkler System - Maintenance and Testing
X	E	-	-	-	-	X C	E	04/19/2021	STD	K0363-Corridor - Doors
-	-	-	-	-	-	X C	E	04/19/2021	STD	K0372-Subdivision of Building Spaces - Smoke Barrie
-	-	-	-	-	-	- -	-	-	STD	K0374-Subdivision of Building Spaces - Smoke Barrie
-	-	-	-	-	-	- -	-	-	STD	K0379-Smoke Barrier Door Glazing
X	F	X	D	X	D	X C	E	04/19/2021	STD	K0511-Utilities - Gas and Electric
-	-	-	-	-	-	X C	F	04/19/2021	STD	K0711-Evacuation and Relocation Plan
-	-	-	-	-	-	X C	F	04/19/2021	STD	K0712-Fire Drills
-	-	-	-	-	-	- -	-	-	STD	K0741-Smoking Regulations
-	-	-	-	-	-	- -	-	-	STD	K0753-Combustible Decorations
-	-	-	-	X	F	- -	-	-	STD	K0761-Maintenance, Inspection and Testing - Doors
-	-	-	-	-	-	- -	-	-	STD	K0781-Portable Space Heaters
-	-	-	-	X	F	- -	-	-	STD	K0914-Electrical Systems - Maintenance and Testing
-	-	-	-	X	E	- -	-	-	STD	K0918-Electrical Systems - Essential Electric Syste
-	-	-	-	X	D	X C	E	04/19/2021	STD	K0920-Electrical Equipment - Power Cords and Extens
-	-	-	-	-	-	X C	E	04/19/2021	STD	K0921-Electrical Equipment - Testing and Maintenanc
-	-	-	-	-	-	- -	-	-	STD	K0923-Gas Equipment - Cylinder and Container Storag
-	-	-	-	-	-	X C	E	04/19/2021	STD	K0926-Gas Equipment - Qualifications and Training

SANDSTONE OF TUCSON REHAB CENTRE **CCN:** 035099

Deficiency Summary

Type of Deficiency	Current Survey	Prior 1 Survey	Prior 2 Survey	Prior 3 Survey
Requirement	17	25	9	3
Health Total	16	18	9	3
Life Safety Code	11	15	3	3
Life Safety Code + Health	27	33	12	6

Complaint Survey Information

Survey Date	Status
07/19/2022	Unsubstantiated
06/24/2022	Substantiated
01/20/2022	Unsubstantiated
09/13/2019	Substantiated

SANDSTONE OF TUCSON REHAB CENTRE **CCN:** 035099

LTC Resident Census

Resident Census on 03/11/2021
Total: 164
Medicare: 20
Medicaid: 118
Other: 26

Total Certified Beds: 240

SNF	SNF/NF	NF	ICF/IID
0	240	0	0

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

November 28, 2022

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

Re: Complaint Intakes: #AZ00176004, #AZ00176005, #AZ00175184, AZ00175185
Investigation # LYYB11

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,

Monica Miller

Monica Miller
Program Project Specialist II
Bureau of Long Term Care Licensing

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

November 28, 2022

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

Re: **Complaint Intakes:**
#AZ00184923, #AZ00184924, #AZ00174055, #AZ00174056,#AZ00183903, #AZ00183904, #AZ00175354, #AZ00175355,#AZ00185501, #AZ00185498, #AZ00183513, #AZ00183514, #AZ00185483, #AZ00185486,#AZ00175666, #AZ00175670, #AZ00176703, #AZ00176706, #AZ00177643, #AZ00177644, #AZ00177915, #AZ00177917, #AZ00178988, #AZ00178990, #AZ00174511, #AZ00174512, #AZ00174827, #AZ00174830, #AZ00175030, #AZ00175032, #AZ00175052, #AZ00175053, #AZ00175517, #AZ00175521
Investigation # LYYB11

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,

Monica Miller

Monica Miller
Program Project Specialist II
Bureau of Long Term Care Licensing