State
Public Records Documents Only

Survey event #DOE0

Facility: SANDSTONE OF TUCSON REHAB

Revised 7-2020

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

July 26, 2022

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

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

Dear Mr. Valdez:

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

Enclosed is the **State Revisit Report form**, which indicates the licensee to be in substantial compliance based on your Plan of Correction. A copy of this form will become a part of the facility's public file. Please keep this current inspection report in the facility and available for review.

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

Sincerely,

Bernadette Keilman
LTC Customer Service Representative IV

\bk

Enclosure

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NCI-2643	A. BUILDING: _____ B. WING _____	R-C 07/25/2022

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

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

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

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
NCI-2643 (Y1)	A. Building B. Wing (Y2)	7/25/2022 (Y3)

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

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 Y1077 Reg. # R9-10-410.C.2. LSC	Correction Completed 07/29/2022	ID Prefix Y2505 Reg. # R9-10-425.A.2. LSC	Correction Completed 07/29/2022	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY	REVIEWED BY (INITIALS)	DATE		DATE
REVIEWED BY STATE AGENCY [X]	**REVIEWED BY (INITIALS)** MC	**DATE** 7/25/2022	**SIGNATURE OF SURVEYOR** [signature]	**DATE** 7/25/2022
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 6/24/2022	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?			[ ] YES [ ] NO

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

July 25, 2022

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

Dear Mr. Ryan Valdez,

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

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

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

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

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

Sincerely,

Tom Salow
Interim Assistant Director

CB/pdh

Enclosure

cc: CMS
Ombudsman

UPOC Y Tag

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

July 19, 2022

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

Dear Mr. Valdez:

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

The Plan of Correction is unacceptable for the following reasons:

Changes needed to the 2567:
-For all Ftags/Ytags indicate the frequency of the audits that will be conducted
-Indicate the completion date for the Plan of Correction (POC)

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

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

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

Sincerely,

Megan Whitby

Megan Whitby
Interim Long Term Care Bureau Chief

MW/MC:mm

Attachments

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NCI-2643	A. BUILDING: _____ B. WING _____	C 06/24/2022

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

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Y 000	Initial Comments The onsite investigation of complaints AZ00181682, AZ00179202, AZ00178375, AZ00183243, and AZ00178242 was conducted on June 17, 2022 and on June 20 through June 24, 2022. The following deficiencies were cited:	Y 000	**Y000** This Plan of Correction is submitted to meet the requirements established by 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.	
Y1077	R9-10-410.C.2. Resident Rights R9-10-410.C. A resident has the following rights: R9-10-410.C.2. To receive treatment that supports and respects the resident's individuality, choices, strengths, and abilities; This RULE is not met as evidenced by: Based on clinical record reviews, staff interviews, facility documentation, and policy, the facility failed to ensure three residents (#46, #136, and #140) received treatment that supported their individuality, choices, strengths, and abilities by failing to provide them with adequate showers. Findings include: Review of facility documentation revealed a shower schedule which included that residents are to receive two showers per week. -Resident #46 was admitted on November 6, 2021 with diagnoses that included difficulty in walking and vertigo of central origin. The resident's Activities of Daily Living (ADL) care plan revealed the resident had a self-care performance deficit related to weakness, unsteadiness on feet, difficulty walking, and	Y1077	***Y1077*** **A. Corrective actions:** 1. Residents #46, #136, and #140 were not found affected by this alleged deficient practice. 2. Residents #46 and #136 received showers and/or following facility survey, per facility shower schedule. Resident #140 discharged from the facility on August 6, 2021. 3. Documentation for showers and/or bed baths are available on electronic medical records and/or uploaded into resident charts. **B. Identify other residents** 1.No other residents were found to be affected by the alleged deficient practice noted. However, all residents have the potential to be affected by the alleged deficient practice.	

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

ADHS LICENSING SERVICES

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Y1077	Continued From page 1 activity intolerance from respiratory failure. An intervention included to encourage the resident to participate in the fullest extent possible with each interaction. A quarterly Minimum Data Set (MDS) assessment dated May 6, 2022 included that the resident required supervision with one-person physical assistance for personal hygiene and extensive assistance for bed mobility. This assessment included that bathing self-performance and bathing support provided did not occur during the 7-day look-back window of the assessment. The resident scored a 15 on the Brief Interview for Mental Status (BIMS) indicating he was cognitively intact. A review of the clinical record for April through June, 2022 included the following information regarding showers and/or bed baths: -0 showers/bed baths were completed for the weeks of: April 3 to 9, April 10 to 16, May 29 to June 4, and June 5 to 11. -1 shower/bed bath was completed for the weeks of: April 17 to 23 and May 1 to 7. -Resident #136 was admitted to the facility on November 19, 2019 with diagnoses of dementia and hemiplegia. The resident's ADL care plan revealed the resident had a self-care performance deficit related to decreased mobility, weakness, and hemiplegia of the right dominant side. An intervention included to provide supervision to extensive assistance from staff for ADLS as needed. A quarterly MDS assessment dated June 8, 2022 included that the resident required physical help	Y1077	C. Measures 1.On July 15th, 2022, Nurse Unit Manager in-serviced and implement the staff on the following topics but not limited to: a. Facility policies and procedures for ADL care provided for dependent residents, including showers and bed baths b. Requirements for compliance regarding completion of shower sheets/bed baths and post shower documentation c. Administrator initiated a QA tool on July 12, 2022 regarding ADL Care and showers and bed baths to ensure: Resident are receiving showers and bed baths per the facility shower schedule Documentation following showers and/or bed bath is completed and uploaded into patient's chart. D. Corrective Actions 1 The administrator or designee will continue to conduct random audits, twice a week for 6 weeks to ensure that residents are receiving showers per facility schedule and that shower documentation is available on electronic medical records and/or uploaded into resident chart. 2.The results of the audits completed on this POC will be submitted to the Quality Assurance and Performance Improvement committee for review and follow up.	7/29/22

ADHS LICENSING SERVICES

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Y1077	Continued From page 2 in part of the bathing process and required setup help with bathing. The resident scored a 0 on the BIMS indicating severe cognitive impairment. A review of the clinical record for April through June, 2022 included the following information regarding showers and/or bed baths: -0 showers/bed baths were completed for the weeks of: April 3 to 9, April 10 to 16, April 11 to 16, April 17 to 23, April 24 to 30, and May 15 to 21. -1 shower/bed bath was completed for the weeks of: May 1 to 7, May 9 to 14, and June 5 to 11 -Resident #140 was admitted to the facility on February 28, 2021 with diagnoses of dementia with behavioral disturbance and muscle weakness. This resident discharged on August 6, 2021. The resident's ADL care plan revealed the resident had a self-care performance deficit related to confusion and impaired cognition from dementia and Alzheimer's. An intervention included to monitor the resident for any changes in ability. A quarterly MDS assessment dated July 23, 2021 included that this resident required physical help in part of the bathing process and required 1 person physical assistance with bathing The resident scored 0 on the BIMS indicating severe cognitive impairment. A review of the clinical record for June through July, 2021 included the following information regarding showers and/or bed baths: -0 showers/bed baths were completed for the weeks of: June 6 to 12, June 13 to 19, July 4 to 10, July 11 to 17, and July 18 to 24.	Y1077		

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Y1077	Continued From page 3 -1 shower/bed bath was completed for the weeks of June 27 to July 3 and July 25 to 31. An interview was conducted on June 23, 2022 at 2:36 PM with a Certified Nursing Assistant (CNA/staff #96) who said that each day she is assigned to complete a certain amount of showers. She said that showers are posted on the bulletin board and broken down by shift. Bed one is done on the day shift and evening does bed two. She said that if she cannot complete a shower, then normally she will tell the nurse and hopefully the next shift will be able to complete the shower. She said that there are very few days she cannot get to a shower. She said that showers are documented on a specific paper and that gets turned into the nurse every day. She said that showers are also documented in the clinical record. She said that the CNA's would not know that residents had a shower without shower sheets or computer documentation unless they asked the person that worked that day. An interview was conducted on June 23, 2022 at 1:55 PM with a Licensed Practical Nurse (LPN/staff #72) who said that she signs shower sheets after the CNAs have bathed the resident or if they refuse. She said that the nurses can go to the clinical record and look up the resident and it shows when the resident has had a shower/bed bath. She said that if she did not know if a resident had a shower then she would ask the CNA and get confirmation An interview was conducted on June 23, 2022 at 12:46 PM with the interim Director of Nursing (DON/staff #30) who said that residents are offered bathing twice a week and additional bathing upon the resident's request. She said it did not meet her expectations that the residents	Y1077		

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Y1077	Continued From page 4 missed shower and/or bed baths. She said that the facility has a shower aid who was assigned to do showers, however, they do get pulled to help on the floor at times. An interview was conducted on June 24, 2022 at 1:30 PM with the administrator (staff #26) who said that she does not know if the facility has a bathing problem or a documentation problem, but that there is a problem. Review of the facility's bathing policy, revised February 2018, revealed a purpose to promote cleanliness, provide comfort to the residents, and to observe the condition of the residents' skin. The policy included to document the date and time a shower was performed as well as the title of the individual(s) who assisted the resident with the shower. The policy included that if the resident refused the shower, staff will document the reason(s) why and the intervention taken. The person recoding the data should sign the form and include their title.	Y1077		
Y2505	R9-10-425.A.2. Environmental Standards R9-10-425.A. An administrator shall ensure that: R9-10-425.A.2. A pest control program is implemented and documented; This RULE is not met as evidenced by: Based on observations, staff interviews, and review of facility documentation and policy, the facility failed to maintain an effective pest control program to ensure the facility was free from rodents.	Y2505	***Y2505*** **A. Corrective actions:** 1. No residents were found to be affected by the alleged deficient practice. 2. Residents #6, #72, #34, #98, #62 had rooms cleaned at the time of survey, and were all deep cleaned following survey 3. Gap underneath double doors to loading dock was fixed at time of survey. Vacant room 213 gap in wall was patched and room was deep cleaned at time of survey.	

ADHS LICENSING SERVICES

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Y2505	Continued From page 5 Findings include: A review of pest control inspections and services from an outside exterminator from October 13, 2021 through June 16, 2022 included: 2021 -October 13 - Includes rodent station install -October 14 - Invoice for 7 week rodent trapping 2022 -April 12 - Rodent bait stations some activity -April 14 - Inspection of rodent bait stations some activity -May 12 - Inspection of rodent bait stations some activity -June 2 - Installed 10 traps units -June 9 - Inspection of rodent bait stations some activity Review of the facility's pest log from October 23, 2021 through June 16, 2022 included: 2021 -November 20 - Nightshift reported mouse in a resident room 2022 -January 20 - Droppings in three resident rooms -January 26 - Mice in two resident rooms -February 4 - Mice feces in a resident room -March 1 - Mouse in one resident room, mouse caught in another resident room -May 9 - Mice in one resident room -May 26 - Mice caught in several resident rooms -April 11 - Mice droppings in one resident room -May 27 - Mouse caught in one resident room -June 14 - Rodents heard from up above in front office and lobby	Y2505	**B. Identify other residents** 1. No other residents were found to be affected by the alleged deficient practice noted. However, all residents have the potential to be affected by the alleged deficient practice. **C. Measures** 1. On June 23, 2022, Director of Maintenance in-serviced and implement the staff on the following topics but not limited to: a. Facility policies and procedures for cleaning resident rooms b. Requirements for compliance regarding completion of cleaning logs c. Importance of utilizing the pest control log d. Administrator or designee initiated a QA tool on June 23, 2022 regarding resident room cleanings to ensure: Resident rooms are cleaned appropriately per facility policy Cleaning logs are appropriately completed by housekeeping staff **D. Corrective Action** 1. The housekeeping director or designee will continue to conduct daily random audits for 6 weeks to ensure that resident rooms are appropriately cleaned and that cleaning logs are completed by facility staff 2. The maintenance director or designee will continue to conduct random audits twice a week for 6 weeks on door seals that lead to the outside 3. The results of the audits completed on this POC will be submitted to the Quality Assurance and Performance Improvement committee for review and follow up	7/29/22

ADHS LICENSING SERVICES

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Y2505	Continued From page 6 An interview was conducted on June 17, 2022 at 2:10 PM with a resident (#6) who said that he has seen mice in his room and that one was caught last night in a trap. He said that the mice are in the bathroom as well. An observation was conducted of resident #6's bathroom immediately after the interview. Behind the toilet brush and trash can, there were small, dark brown objects that had the appearance of rodent droppings. An interview was conducted on June 17, 2022 at 2:20 PM with a resident (#72) who said little mice were running around and that he had seen one two days ago. This resident's roommate (#34) said that there was a little rat and a couple of little tiny ones An observation was conducted on June 17, 2022 at 2:24 PM in resident #98's room. The resident's bed was moved out and there were small, dark brown objects that had the appearance of rodent droppings against the wall where the head of the bed would be. The room also contained a metal rodent trap under the sink. An observation was conducted on June 17, 2022 at 3:00 PM of a vacant resident room (room 213)which had a hole approximately 5 inches by 10 inches in the corner of the bathroom in the wall near the sink. This room had multiple small, dark brown objects with the appearance of rodent feces behind the nightstand. An observation was conducted on June 20, 2022 of a gap under and between double doors to the outside loading dock and waste disposal area.	Y2505		

ADHS LICENSING SERVICES

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Y2505	Continued From page 7 An observation was conducted on June 21, 2022 at 7:23 AM of resident #98 and #62's room On the floor there were small, dark brown objects that had the appearance of rodent feces at the corner of the dresser closest to the sink. An interview was conducted on June 21, 2022 at 10:55 AM with the director of maintenance (staff #8) who said that he started in this position in February 2022. He said that he renewed the contract with the pest control company that was being used. He said he used them because he wanted to fix the issue with the rodents. He said the company started putting traps in the building and if they see activity they keep using them. He said that they put weather stripping across the doors and that seems to have helped. He said that he does not know why the facility is still having trouble with mice. During an interview with a pest control staff (contract staff #34) on June 21, 2022 at 12:30 PM, he stated that the company has had a contract with the facility for the last 8 months to a year. He said that they have traps in place and bait stations. He said that the rodents were gone for months and that they have been back again for maybe 2-3 months. He said that he works with the director of maintenance who does follow the suggestions that he makes. He said that the rodents come from outside and that if they seal the areas, sometimes they get sealed inside. He said that they come inside looking for water and food and because it is comfortable. An interview was conducted at 8:08 AM on June 22, 2022 with the Director of Maintenance (Staff #8) who acknowledged the gap in the door to the outside trash area and said it was about 0.5	Y2505		

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Y2505	Continued From page 8 inches at the base of the door. He said there were more gaps at waist and chest high and that these were likely caused by delivery people hitting the door. He said there were bait stations outside the door. He said that he would fix the gaps in the door. An interview was conducted on June 24, 2022 at 1:32 PM with the administrator (staff #26) who said that the facility has spent a lot of money on this problem and that they are trying to fix it. She said that they do have a pest control program in place. The facility's pest control policy, dated November 1, 2021, revealed a purpose to prevent or control insects and rodents from spreading disease. This policy included that all building openings shall be tight fitting and free of breaks, and that the facility shall be kept in such condition and cleaning procedures used to prevent the harborage or feeding of insects and rodents.	Y2505		

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

July 7, 2022

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

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

Dear Mr. Valdez:

Thank you for the courtesy and cooperation extended to our staff during the recent inspection of your facility.

Enclosed is a statement of **STATE** deficiencies noted during the inspection of your facility on June 24, 2022. A Plan of Correction (PoC) for the deficiencies must be submitted. This plan must be both specific to the problems noted and general to the overall process involved.

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 be advised that your plan of correction will be available as a public document for review by interested parties.**

Please place your plan of correction in the space provided in the right column of the statement of deficiencies and return the original to this office no later than **July 17, 2022**. You must include all pages of the Statement of Deficiencies when submitting your PoC. Please ensure to retain a copy for your files. If the plan of correction is not received by this Office on or before this date, state enforcement action may be taken.

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

Informal Dispute Resolution - You have an opportunity to dispute any deficiencies or language listed on the SOD through an Informal Dispute Resolution (IDR). To dispute a deficiency or language listed on the SOD, send a written request on a separate document **due 10 days from receipt of this letter**. The written request must include documentation that shows the licensee was in compliance at the time of the inspection. The Department will review the written request and documentation provided to the Department and notify you of the Department's decision. If you have any questions, please call: Diane Eckles, Bureau Chief, Bureau of Long Term Care, 150 North 18th Avenue, Suite 440, Phoenix, Arizona 85007 at (602) 364-2690.

Sincerely,

Diane Eckles

Diane Eckles
Bureau Chief

DE:bk

Attachments

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NCI-2643	A. BUILDING: _____ B. WING _____	C 06/24/2022

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

(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) COMPLETE DATE
Y 000	Initial Comments The onsite investigation of complaints AZ00181682, AZ00179202, AZ00178375, AZ00183243, and AZ00178242 was conducted on June 17, 2022 and on June 20 through June 24, 2022. The following deficiencies were cited:	Y 000	**Y000** This Plan of Correction is submitted to meet the requirements established by 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.	
Y1077	R9-10-410.C.2. Resident Rights R9-10-410.C. A resident has the following rights: R9-10-410.C.2. To receive treatment that supports and respects the resident's individuality, choices, strengths, and abilities; This RULE is not met as evidenced by: Based on clinical record reviews, staff interviews, facility documentation, and policy, the facility failed to ensure three residents (#46, #136, and #140) received treatment that supported their individuality, choices, strengths, and abilities by failing to provide them with adequate showers. Findings include: Review of facility documentation revealed a shower schedule which included that residents are to receive two showers per week. -Resident #46 was admitted on November 6, 2021 with diagnoses that included difficulty in walking and vertigo of central origin. The resident's Activities of Daily Living (ADL) care plan revealed the resident had a self-care performance deficit related to weakness, unsteadiness on feet, difficulty walking, and	Y1077	***Y1077*** **A. Corrective actions:** 1. Residents #46, #136, and #140 were not found affected by this alleged deficient practice. 2. Residents #46 and #136 received showers and/or following facility survey, per facility shower schedule. Resident #140 discharged from the facility on August 6, 2021. 3. Documentation for showers and/or bed baths are available on electronic medical records and/or uploaded into resident charts. **B. Identify other residents** 1.No other residents were found to be affected by the alleged deficient practice noted. However, all residents have the potential to be affected by the alleged deficient practice.	

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

ADHS LICENSING SERVICES

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Y1077	Continued From page 1 activity intolerance from respiratory failure. An intervention included to encourage the resident to participate in the fullest extent possible with each interaction. A quarterly Minimum Data Set (MDS) assessment dated May 6, 2022 included that the resident required supervision with one-person physical assistance for personal hygiene and extensive assistance for bed mobility. This assessment included that bathing self-performance and bathing support provided did not occur during the 7-day look-back window of the assessment. The resident scored a 15 on the Brief Interview for Mental Status (BIMS) indicating he was cognitively intact. A review of the clinical record for April through June, 2022 included the following information regarding showers and/or bed baths: -0 showers/bed baths were completed for the weeks of: April 3 to 9, April 10 to 16, May 29 to June 4, and June 5 to 11. -1 shower/bed bath was completed for the weeks of: April 17 to 23 and May 1 to 7. -Resident #136 was admitted to the facility on November 19, 2019 with diagnoses of dementia and hemiplegia. The resident's ADL care plan revealed the resident had a self-care performance deficit related to decreased mobility, weakness, and hemiplegia of the right dominant side. An intervention included to provide supervision to extensive assistance from staff for ADLS as needed. A quarterly MDS assessment dated June 8, 2022 included that the resident required physical help	Y1077	**C. Measures** 1.On July 15th, 2022, Nurse Unit Manager in-serviced and implement the staff on the following topics but not limited to: a. Facility policies and procedures for ADL care provided for dependent residents, including showers and bed baths b. Requirements for compliance regarding completion of shower sheets/bed baths and post shower documentation c. Administrator initiated a QA tool on July 12, 2022 regarding ADL Care and showers and bed baths to ensure: Resident are receiving showers and bed baths per the facility shower schedule Documentation following showers and/or bed bath is completed and uploaded into patient's chart. **D. Corrective Actions** 1.The administrator or designee will continue to conduct audits for 6 weeks to ensure that residents are receiving showers per facility schedule and that shower documentation is available on electronic medical records and/or uploaded into resident chart. 2.The results of the audits completed on this POC will be submitted to the Quality Assurance and Performance Improvement committee for review and follow up.	

ADHS LICENSING SERVICES

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Y1077	Continued From page 2 in part of the bathing process and required setup help with bathing. The resident scored a 0 on the BIMS indicating severe cognitive impairment. A review of the clinical record for April through June, 2022 included the following information regarding showers and/or bed baths: -0 showers/bed baths were completed for the weeks of: April 3 to 9, April 10 to 16, April 11 to 16, April 17 to 23, April 24 to 30, and May 15 to 21. -1 shower/bed bath was completed for the weeks of: May 1 to 7, May 9 to 14, and June 5 to 11. -Resident #140 was admitted to the facility on February 28, 2021 with diagnoses of dementia with behavioral disturbance and muscle weakness. This resident discharged on August 6, 2021. The resident's ADL care plan revealed the resident had a self-care performance deficit related to confusion and impaired cognition from dementia and Alzheimer's. An intervention included to monitor the resident for any changes in ability. A quarterly MDS assessment dated July 23, 2021 included that this resident required physical help in part of the bathing process and required 1 person physical assistance with bathing. The resident scored 0 on the BIMS indicating severe cognitive impairment. A review of the clinical record for June through July, 2021 included the following information regarding showers and/or bed baths: -0 showers/bed baths were completed for the weeks of: June 6 to 12, June 13 to 19, July 4 to 10, July 11 to 17, and July 18 to 24.	Y1077		

ADHS LICENSING SERVICES

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Y1077	Continued From page 3 -1 shower/bed bath was completed for the weeks of: June 27 to July 3 and July 25 to 31. An interview was conducted on June 23, 2022 at 2:36 PM with a Certified Nursing Assistant (CNA/staff #96) who said that each day she is assigned to complete a certain amount of showers. She said that showers are posted on the bulletin board and broken down by shift. Bed one is done on the day shift and evening does bed two. She said that if she cannot complete a shower, then normally she will tell the nurse and hopefully the next shift will be able to complete the shower. She said that there are very few days she cannot get to a shower. She said that showers are documented on a specific paper and that gets turned into the nurse every day. She said that showers are also documented in the clinical record. She said that the CNA's would not know that residents had a shower without shower sheets or computer documentation unless they asked the person that worked that day. An interview was conducted on June 23, 2022 at 1:55 PM with a Licensed Practical Nurse (LPN/staff #72) who said that she signs shower sheets after the CNAs have bathed the resident or if they refuse. She said that the nurses can go to the clinical record and look up the resident and it shows when the resident has had a shower/bed bath. She said that if she did not know if a resident had a shower then she would ask the CNA and get confirmation. An interview was conducted on June 23, 2022 at 12:46 PM with the interim Director of Nursing (DON/staff #30) who said that residents are offered bathing twice a week and additional bathing upon the resident's request. She said it did not meet her expectations that the residents	Y1077		

ADHS LICENSING SERVICES

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Y1077	Continued From page 4 missed shower and/or bed baths. She said that the facility has a shower aid who was assigned to do showers, however, they do get pulled to help on the floor at times. An interview was conducted on June 24, 2022 at 1:30 PM with the administrator (staff #26) who said that she does not know if the facility has a bathing problem or a documentation problem, but that there is a problem. Review of the facility's bathing policy, revised February 2018, revealed a purpose to promote cleanliness, provide comfort to the residents, and to observe the condition of the residents' skin. The policy included to document the date and time a shower was performed as well as the title of the individual(s) who assisted the resident with the shower. The policy included that if the resident refused the shower, staff will document the reason(s) why and the intervention taken. The person recoding the data should sign the form and include their title.	Y1077		
Y2505	R9-10-425.A.2. Environmental Standards R9-10-425.A. An administrator shall ensure that: R9-10-425.A.2. A pest control program is implemented and documented; This RULE is not met as evidenced by: Based on observations, staff interviews, and review of facility documentation and policy, the facility failed to maintain an effective pest control program to ensure the facility was free from rodents.	Y2505	***Y2505*** **A. Corrective actions:** 1. No residents were found to be affected by the alleged deficient practice. 2. Residents #6, #72, #34, #98, #62 had rooms cleaned at the time of survey, and were all deep cleaned following survey 3. Gap underneath double doors to loading dock was fixed at time of survey. Vacant room 213 gap in wall was patched and room was deep cleaned at time of survey.	

ADHS LICENSING SERVICES

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Y2505	Continued From page 5 Findings include: A review of pest control inspections and services from an outside exterminator from October 13, 2021 through June 16, 2022 included: 2021 -October 13 - Includes rodent station install -October 14 - Invoice for 7 week rodent trapping 2022 -April 12 - Rodent bait stations some activity -April 14 - Inspection of rodent bait stations some activity -May 12 - Inspection of rodent bait stations some activity -June 2 - Installed 10 traps units -June 9 - Inspection of rodent bait stations some activity Review of the facility's pest log from October 23, 2021 through June 16, 2022 included: 2021 -November 20 - Nightshift reported mouse in a resident room 2022 -January 20 - Droppings in three resident rooms -January 26 - Mice in two resident rooms -February 4 - Mice feces in a resident room -March 1 - Mouse in one resident room, mouse caught in another resident room -May 9 - Mice in one resident room -May 26 - Mice caught in several resident rooms -April 11 - Mice droppings in one resident room -May 27 - Mouse caught in one resident room -June 14 - Rodents heard from up above in front office and lobby	Y2505	**B. Identify other residents** 1. No other residents were found to be affected by the alleged deficient practice noted. However, all residents have the potential to be affected by the alleged deficient practice. **C. Measures** 1. On June 23, 2022, Director of Maintenance in-serviced and implement the staff on the following topics but not limited to: a. Facility policies and procedures for cleaning resident rooms b. Requirements for compliance regarding completion of cleaning logs c. Importance of utilizing the pest control log d. Administrator or designee initiated a QA tool on June 23, 2022 regarding resident room cleanings to ensure: Resident rooms are cleaned appropriately per facility policy Cleaning logs are appropriately completed by housekeeping staff **D. Corrective Action** 1. The housekeeping director or designee will continue to conduct random audits for 6 weeks to ensure that resident rooms are appropriately cleaned and that cleaning logs are completed by facility staff 2. The maintenance director or designee will continue to conduct random audits for 6 weeks on door seals that lead to the outside 3.The results of the audits completed on this POC will be submitted to the Quality Assurance and Performance Improvement committee for review and follow up	

ADHS LICENSING SERVICES

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Y2505	Continued From page 6 An interview was conducted on June 17, 2022 at 2:10 PM with a resident (#6) who said that he has seen mice in his room and that one was caught last night in a trap. He said that the mice are in the bathroom as well. An observation was conducted of resident #6's bathroom immediately after the interview. Behind the toilet brush and trash can, there were small, dark brown objects that had the appearance of rodent droppings. An interview was conducted on June 17, 2022 at 2:20 PM with a resident (#72) who said little mice were running around and that he had seen one two days ago. This resident's roommate (#34) said that there was a little rat and a couple of little tiny ones. An observation was conducted on June 17, 2022 at 2:24 PM in resident #98's room. The resident's bed was moved out and there were small, dark brown objects that had the appearance of rodent droppings against the wall where the head of the bed would be. The room also contained a metal rodent trap under the sink. An observation was conducted on June 17, 2022 at 3:00 PM of a vacant resident room (room 213)which had a hole approximately 5 inches by 10 inches in the corner of the bathroom in the wall near the sink. This room had multiple small, dark brown objects with the appearance of rodent feces behind the nightstand. An observation was conducted on June 20, 2022 of a gap under and between double doors to the outside loading dock and waste disposal area.	Y2505		

ADHS LICENSING SERVICES

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Y2505	Continued From page 7 An observation was conducted on June 21, 2022 at 7:23 AM of resident #98 and #62's room. On the floor there were small, dark brown objects that had the appearance of rodent feces at the corner of the dresser closest to the sink. An interview was conducted on June 21, 2022 at 10:55 AM with the director of maintenance (staff #8) who said that he started in this position in February 2022. He said that he renewed the contract with the pest control company that was being used. He said he used them because he wanted to fix the issue with the rodents. He said the company started putting traps in the building and if they see activity they keep using them. He said that they put weather stripping across the doors and that seems to have helped. He said that he does not know why the facility is still having trouble with mice. During an interview with a pest control staff (contract staff #34) on June 21, 2022 at 12:30 PM, he stated that the company has had a contract with the facility for the last 8 months to a year. He said that they have traps in place and bait stations. He said that the rodents were gone for months and that they have been back again for maybe 2-3 months. He said that he works with the director of maintenance who does follow the suggestions that he makes. He said that the rodents come from outside and that if they seal the areas, sometimes they get sealed inside. He said that they come inside looking for water and food and because it is comfortable. An interview was conducted at 8:08 AM on June 22, 2022 with the Director of Maintenance (Staff #8) who acknowledged the gap in the door to the outside trash area and said it was about 0.5	Y2505		

ADHS LICENSING SERVICES

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Y2505	Continued From page 8 inches at the base of the door. He said there were more gaps at waist and chest high and that these were likely caused by delivery people hitting the door. He said there were bait stations outside the door. He said that he would fix the gaps in the door. An interview was conducted on June 24, 2022 at 1:32 PM with the administrator (staff #26) who said that the facility has spent a lot of money on this problem and that they are trying to fix it. She said that they do have a pest control program in place. The facility's pest control policy, dated November 1, 2021, revealed a purpose to prevent or control insects and rodents from spreading disease. This policy included that all building openings shall be tight fitting and free of breaks, and that the facility shall be kept in such condition and cleaning procedures used to prevent the harborage or feeding of insects and rodents.	Y2505		

ADHS
LICENSING

Notice of Inspection Rights

Facility/Agency Name: Sandstone Of Tucson Rehab Centre

Address: 2900 East Milber Street		City: Tucson	Zip: 85714
Facility I.D.#: LTC0053	License #: NCI-2643	Medicare #: 035099	Date of Inspection: June 17, 2022

Survey Event ID: DOE011

Inspector/Team Coordinator: Carey Sexton

Accompanied By:

BUREAU OF LONG TERM CARE LICENSING

This inspection is conducted under the authority of:

1. Arizona Revised Statutes (A.R.S.) Title 36, Chapters 1 and 4, and Arizona Administrative Code (A.A.C.), Title 9, Chapter 10. Some of the activities during the inspection may include, but are not limited to, a facility premise inspection, review and/or copying of records, including personnel records, interviews with residents/patients/clients, family and staff, and review of services offered.
2. The purpose of this inspection is to:
   - ☐ Determine compliance with health care institution requirements pursuant to the above A.R.S. and A.A.C.
   - ☐ Conduct a complaint investigation.
3. No fees are charged for this inspection.
4. An authorized representative of this facility may accompany the inspector(s) during the inspection conducted on these premises, except during any confidential interview.
5. You have the right to receive copies of any original documents taken by the inspector(s) during the inspection in those cases where the agency has authority to take original documents.
6. You and your staff have the opportunity to provide any information that would clarify an issue. Additionally, interviews with staff, family or residents/patients/clients may be conducted privately. Each person interviewed will be informed that statements made by the person may be included in the inspection report and each person whose conversations are tape or video recorded will be informed that the conversation is being tape or video recorded.
7. Upon completion of the inspection the inspector(s) will conduct an exit interview and informally disclose their findings. A Statement of Deficiencies (SOD) formally notifying you of the findings will be provided within 30 working days. You will be afforded an opportunity to submit a Plan of Correction (POC) unless the Department is considering enforcement against the license.
8. You have an opportunity to dispute any findings of non-compliance through an Informal Dispute Resolution (IDR). Details of the IDR process will be provided when the SOD is mailed to you.
9. If you have questions regarding this inspection, you may contact: Diane Eckles, Bureau Chief, at 150 N. 18th Ave., Suite 440, Phoenix, Arizona 85007-3242, Phone: (602) 364-2675, FAX: (602) 324-0993, E-Mail: Diane.Eckles@azdhs.gov. If you have an issue that you cannot resolve with the Bureau or the Division, you may contact the Office of Ombudsman-Citizens' Aide, 7878 N. 16th St., Suite 235 Phoenix AZ 85020 (602) 277-7292.
10. Your administrative hearing rights are found at A.R.S. § 41-1092 et seq., and rights relating to appeal of a final agency decision can be found in A.R.S. §12-901 et seq.

Upon entry to the premises for this inspection, the inspector(s) presented photo identification indicating that they are Arizona Department of Health Services (ADHS) employees and reviewed with me the above Notice of Inspection Rights. I have read the disclosures and am notified of my inspection and due process rights as listed. I understand that while I have the right to decline to sign this form, the ADHS representative(s) may proceed with the inspection.

Administrator/Director/Agency Representative Signature — Date: 6-17-2022

☐ Administrator/Director/Agency Representative refused to sign this form.
☐ Administrator/Director/Agency Representative or authorized on-site representative is not present.

Inspector/Team Coordinator Signature: — Date: 6/17/2022

☒ Copy left with Administrator/Director/Agency Representative