State

Public Records Documents Only

Survey event #LYYB11

Facility: SANDSTONE OF TUCSON REHAB CENTRE

Revised 7-2020

QUALITY RATING CERTIFICATE

ARIZONA DEPARTMENT OF HEALTH SERVICES
NURSING CARE INSTITUTION

ADHS

Issued To:

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

The above named facility has met licensure requirements, has been licensed for one year or more and, therefore, has received the following quality rating as required by R9-10-427.

COMPONENTS	CRITERIA MET	
	Yes	No
I. Nursing Services	15	10
II. Resident Rights	25	0
III. Administration	25	0
IV. Environment and Infection Control	15	0
V. Food Services	10	0
TOTAL CRITERIA MET	90	10

QUALITY PERFORMANCE SCALE	
"A" Excellent	X
"B"	
"C"	
"D"	
"A" 90-100 Points "B" 89-80 Points "C" 70-79 Points "D" 69 or fewer Points	

License Effective

From: 09/15/2022

Issued: 11/02/2022

Number: NCI-2643

Recommended By: Megan Whitby

Megan Whitby, Interim Bureau Chief

Issued By: Tom

Thomas Salow, Assistant Director

TO BE FRAMED AND DISPLAYED IN A CONSPICUOUS PLACE

PIMA COUNTY
HEALTH DEPARTMENT

FOOD SAFETY INSPECTION REPORT

Page 1/4

As Governed by Pima County Code 8.08 3950 S. Country Club Rd, Ste 2301 Tucson AZ 85714 Phone 520-724-7908, Fax 520-724-9597	Number of Priority/Priority Foundation Violations	0	Date 06/15/2022 Time in 01:30 PM Time out 02:35 PM
	Number of Core Violations	0	

Establishment	Address	Rating	Educational
SAPPHIRE OF TUCSON NURSING & REHAB	2900 E MILBER ST TUCSON AZ 85714	**Purpose of Inspection** Standard Frequency Inspection - Routine	**Est. Type and Risk Category** Class 4 Institutional Food Operations Less than 2500sqft (4000C)
Permit# 3180926	**Permit Holder** SAPPHIRE OF TUCSON PROPERTIES LLC		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

IN = in compliance **OUT** = not in compliance **N/O** = not observed **N/A** = not applicable **COS** = corrected on-site during inspection **R** = repeat violation

Risk factors are food preparation practices and employees behaviors most commonly reported to the Centers for Disease Control and Prevention as contributing factors in foodborne illness outbreaks.

Public health interventions are control measures to prevent foodborne illness or injury

Compliance Status		COS	R
Supervision			
01. In	PIC present, demonstrates knowledge, and performs duties	☐	☐
02. In	Certified Food Protection Manager	☐	☐
Employee Health			
03. In	Management and food employee knowledge, and conditional employee; Knowledge, responsibility and reporting	☐	☐
04. In	Proper use of restrictions and exclusions	☐	☐
05. In	Clean-up of Vomiting and Diarrheal Events	☐	☐
Good Hygienic Practices			
06. In	Proper eating, tasting, drinking, or tobacco use	☐	☐
07. In	No discharge from eyes, nose, and mouth	☐	☐
Preventing Contamination by Hands			
08. In	Hands clean and properly washed	☐	☐
09. In	No bare hand contact with RTE foods or a pre-approved alternative procedure properly followed	☐	☐
10. In	Adequate handwashing sinks, properly supplied and accessible	☐	☐
Approved Source			
11. In	Food obtained from approved source	☐	☐
12. N/O	Food received at proper temperature	☐	☐
13. In	Food in good condition, safe, and unadulterated	☐	☐
14. N/A	Required records available: shellstock tags, parasite destruction	☐	☐
Protection from Contamination			
15. In	Food separated and protected	☐	☐
16. In	Food-contact surfaces: cleaned and sanitized	☐	☐
17. In	Proper disposition of returned, previously served, reconditioned, and unsafe food	☐	☐
Time Temperature Control for Safety Food (TCS Food)			
18. N/O	Proper cooking time and temperatures	☐	☐
19. N/O	Proper reheating procedures for hot holding	☐	☐
20. N/O	Proper cooling time and temperatures	☐	☐
21. In	Proper hot holding temperatures	☐	☐
22. In	Proper cold holding temperatures	☐	☐
23. In	Proper date marking and disposition	☐	☐
24. N/A	Time as a Public Health Control: procedures and records	☐	☐
Consumer Advisory			
25. N/A	Consumer advisory provided for raw or undercooked foods	☐	☐
Highly Susceptible Populations			
26. In	Pasteurized foods used; prohibited foods not offered	☐	☐
Food/Color Additives and Toxic Substances			
27. N/A	Food additives: approved and properly used	☐	☐
28. In	Toxic substances properly identified, stored, and used; held for retail sale, properly stored	☐	☐
Conformance with Approved Procedures			
29. N/A	Compliance with variance, specialized process, reduced oxygen packaging criteria or HACCP plan	☐	☐

PIMA COUNTY
HEALTH DEPARTMENT

FOOD SAFETY INSPECTION REPORT

As Governed by Pima County Code 8.08 3950 S. Country Club Rd, Ste 2301 Tucson AZ 85714 Phone 520-724-7908, Fax 520-724-9597	Permit# 3180926	Date 06/15/2022

Establishment	Address
SAPPHIRE OF TUCSON NURSING & REHAB	2900 E MILBER STTUCSON AZ 85714

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the introduction of pathogens, chemicals, and physical objects into foods.

IN = in compliance **OUT** = not in compliance **N/O** = not observed **N/A** = not applicable **COS** = corrected on-site during inspection **R** = repeat violation

	Compliance Status	COS	R
Safe Food and Water			
30. In	Pasteurized eggs used where required	☐	☐
31. In	Water and ice from approved source	☐	☐
32. N/A	Variance obtained for specialized processing methods	☐	☐
Food Temperature Control			
33. In	Proper cooling methods used; adequate equipment for temperature control	☐	☐
34. N/O	Plant food properly cooked for hot holding	☐	☐
35. N/O	Approved thawing methods used	☐	☐
36. In	Thermometers provided and accurate	☐	☐
Food Identification			
37. In	Food properly labeled; original container	☐	☐
Prevention of Food Contamination			
38. In	Insects, rodents, and animals not present	☐	☐
39. In	Contamination prevented during food preparation, storage, and display	☐	☐
40. In	Personal cleanliness	☐	☐
41. In	Wiping cloths; properly used and stored	☐	☐
42. N/O	Washing fruits & vegetables	☐	☐
Proper Use of Utensils			
43. In	In-use utensils; properly stored	☐	☐
44. In	Utensils, equipment & linens; properly stored, dried, & handled	☐	☐
45. In	Single-use/single-service articles; properly stored, used	☐	☐
46. N/O	Gloves used properly	☐	☐
Utensils, Equipment and Vending			
47. In	Food and non-food-contact surfaces cleanable, properly designed, constructed and used	☐	☐
48. In	Warewashing facilities, installed, maintained, used, test strips	☐	☐
49. In	Non-food-contact surfaces clean	☐	☐
Physical Facilities			
50. In	Hot and cold water available; adequate pressure	☐	☐
51. In	Plumbing installed; proper backflow devices	☐	☐
52. In	Sewage and waste water properly disposed	☐	☐
53. In	Toilet facilities: properly constructed, supplied, clean	☐	☐
54. In	Garbage/refuse properly disposed; facilities maintained	☐	☐
55. In	Physical facilities installed, maintained, and clean	☐	☐
56. In	Adequate ventilation and lighting; designated areas used	☐	☐
Smoke Free			
57. In	Complies with Smoke Free Arizona 36-601.01	☐	☐
Pima County Code for Mobile Food Establishments ONLY			
58.	A1. Exterior	☐	☐
59.	A2. Interior	☐	☐
60.	B. Additional operating permit requirements	☐	☐
61.	C. Operations	☐	☐
62.	D. Commissary	☐	☐

PIMA COUNTY
HEALTH DEPARTMENT

FOOD SAFETY INSPECTION REPORT

As Governed by Pima County Code 8.08 3950 S. Country Club Rd, Ste 2301 Tucson AZ 85714 Phone 520-724-7908, Fax 520-724-9597	Permit# 3180926	Date 06/15/2022

Establishment	Address
SAPPHIRE OF TUCSON NURSING & REHAB	2900 E MILBER STTUCSON AZ 85714

TEMPERATURE OBSERVATIONS

Item/Location	Temperature in Fahrenheit	Item/Location	Temperature in Fahrenheit
milk/TR-in	41	sliced cheese/TR-in	41
cottage cheese/TR-in	40	milk/TR-in	37
raw egg/WIR	35	milk/WIR	35
pork stock/WIR	41	baked potato/WIR	41

OBSERVATIONS AND CORRECTIVE ACTIONS

PIC = Person in charge RTE = Ready to eat TCS = Time/temperature control for safety

Item P /Pf/ C — Violations cited in this report must be corrected in the frames below as indicated. — Correction Date

PREVIOUS OBSERVATIONS

PIC = Person in charge RTE = Ready to eat TCS = Time/temperature control for safety

Item P /Pf/ C — Violations cited below were observed during a previous inspection. A pattern of non-compliance may result in Probationary status per PCC 8.08.060B

No previously cited observations

ACTIONS TAKEN

Notice of Violation Issued

First Routine Inspection packet provided

Incentive Program handout provided.

CLOSING COMMENTS

This inspection would have resulted in an EXCELLENT rating, however, at this time, all ROUTINE INSPECTIONS will be given an EDUCATIONAL rating.

This facility has been issued a Notice of Violation during this inspection for expired since 1/31/22.

Person in Charge (Print Name): Vibelle Martin

Person in Charge (Signature): [signature] **Date** 06/15/2022

Inspector (Print Name): Paul Bristol, Environmental Health Specialist I

Inspector (Signature): [signature] **Date** 06/15/2022

INSPECTION ADDITIONAL DETAILS

Notice of Inspection Rights Provided? Yes

PIMA COUNTY
HEALTH DEPARTMENT

FOOD SAFETY INSPECTION REPORT

As Governed by Pima County Code 8.08 3950 S. Country Club Rd, Ste 2301 Tucson AZ 85714 Phone 520-724-7908, Fax 520-724-9597	Permit# 3180926	Date 06/15/2022

Establishment	Address
SAPPHIRE OF TUCSON NURSING & REHAB	2900 E MILBER STTUCSON AZ 85714

Does this Inspection Require a Foodborne Illness Investigation Response? No

FIRE CODE PERMIT
CITY OF TUCSON

FIRE DEPARTMENT

Permit Activity Number: T21FO00832

Structure Address: 2900 E MILBER ST TUC

Project Description: COMPRESSED GASES

Permit Type: Compressed Gases

Occupancy Group:

Applicable Fire Code: 2018 IFC

Expiration Date: 12/08/2022
- or - Until Revoked: N

Permit Conditions:

Fire Code Official / Fire Inspector

12/08/2021
Issued Date

Fire is Everyone's Fight.

FIRE CODE PERMIT
CITY OF TUCSON

FIRE DEPARTMENT

Permit Activity Number: T21FO00687

Structure Address: 2900 E MILBER ST TUC

Project Description: 240 BEDS

Permit Type: State Llc Facls Annual Inspectio

Occupancy Group: I-1

Applicable Fire Code: 2018 IFC

Expiration Date: ~~10/14/2022~~ 10/7/2022 TSP
- or - Until Revoked: N

Permit Conditions:

Fire Code Official / Fire Inspector

10/14/2021
Issued Date

Fire is Everyone's Fight

FRMS# 035893

October 07th 2021

CITY OF TUCSON

FIRE DEPARTMENT

CHUCK RYAN
FIRE CHIEF

FIRE PREVENTION DIVISION

Sapphire Estates Rehab Center
2900 E Milber St.
Occupancy I-2 (240 beds)
775-771-5076
Starskycortez@sapphireestatesrc.com / epetkovic@sepphireoftucson.com

Attn: Starsky Cortez / Elma Petkovic

Re: Fire inspection

On October 07th 2021 a fire safety inspection was conducted at the above location. The following violations were discovered and shall be corrected to gain compliance with the 2018 International Fire Code is below.

1. **105.1.1 IFC Permit Required:** A property owner or owner's authorized agent who intends to conduct an operation or business, or install or modify systems and equipment that are regulated by this code, or to cause any such work to be performed, shall first make application to the fire code official and obtain the required permit.

- Obtain appropriate permit - obtained

2. **907.8.5 IFC Inspection, testing and maintenance** The building owner shall be responsible to maintain the fire and life safety systems in an operable condition at all times.

- Provide fire sprinkler report showing no deficiencies.
- Provide kitchen hood extinguishing system report showing no deficiencies.
- Provide proof that fire alarm system is capable of monitoring Carbone Monoxide levels.
- Provide documentation stating that all fire doors will activate during fire alarm activation

300 S. FIRE CENTRAL PL.▪ TUCSON, AZ 85701-1640
(520) 791-4502 ▪ FAX (520) 791-5346 TTY (520) 791-2639
www.tucsonaz.gov

CITY OF TUCSON

FIRE DEPARTMENT

CHUCK RYAN
FIRE CHIEF

FIRE PREVENTION DIVISION

9. **703.1 IFC Maintaining protection.** Materials and fire-stop systems used to protect membrane and through penetrations in fire-resistive-rated-construction and construction installed to resist the passage of smoke shell be maintained.
   - Remove holes in walls and ceiling – laundry room, nursing station (A1), by barber shop and throughout.

10. **906.2 IFC General requirements (extinguishers)** Portable fire extinguishers shall be selected installed and maintained in accordance with this section and NFPA 10.
    - Replace missing 2A10BC fire extinguisher – lobby and elevator room.

11. **315.3.1 IFC Ceiling clearance.** Storage shall be maintained 2 feet or more below the ceiling in non-sprinklered area of building or not less than 18 inches below sprinkler head deflector in sprinklered area of building.
    - Remove items from top shelf – IT office

12. **506.1 IFC Where required (Key Box)** Where access to or within a structure or an area is restricted because of secured opening or where immediate access is necessary for life-safety or fire-fighting purposes, the fire code official is authorized to require a key box to be installed in an approved location.
    - Replace missing Knox Box – front entrance.

13. **505.3 IFC Markings** Where required be the fire code official, approved signs or other approved notices or markings that include the words NO PARKING – FIRA LINE shall be provided for fire apparatus access roads to identify such roads or prohibit the obstruction thereof.
    - Replace missing fire line signs – throughout front access.

14. **102.9 IFC Matters not provided for.** Requirements that are essential for the public safety of an existing or proposed activity, building or structure, or for the safety of the occupants thereof, that are not specifically provided for by this code, shall be determined by the fire code official.
    - Replace missing NOT AN EXIT sign – office A1 and B1 area.

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CITY OF TUCSON

FIRE
DEPARTMENT

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PIMA COUNTY
HEALTH DEPARTMENT

Paul Bristol, REHS/RS
Environmental Health Specialist I

3950 S. Country Club Road, Suite 100 • Tucson, AZ 85714
Phone: 520-724-7908, Cell: 520-306-7593
paul.bristol@pima.gov • www.pima.gov

PIMA COUNTY
HEALTH DEPARTMENT

FOOD SAFETY INSPECTION REPORT

As Governed by Pima County Code 8.08 3950 S. Country Club Rd, Ste 2301 Tucson AZ 85714 Phone 520-724-7908, Fax 520-724-9597	Number of Priority/Priority Foundation Violations	0	Date 06/15/2022 Time in 01:30 PM Time out 02:35 PM
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Establishment	Address	Rating	
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Permit# 3180926	**Permit Holder** SAPPHIRE OF TUCSON PROPERTIES LLC	**Purpose of Inspection** Standard Frequency Inspection - Routine	**Est. Type and Risk Category** Class 4 Institutional Food Operations Less than 2500sqft (4000C)

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02. In	Certified Food Protection Manager	☐	☐
Employee Health			
03. In	Management and food employee knowledge, and conditional employee; Knowledge, responsibility and reporting	☐	☐
04. In	Proper use of restrictions and exclusions	☐	☐
05. In	Clean-up of Vomiting and Diarrheal Events	☐	☐
Good Hygienic Practices			
06. In	Proper eating, tasting, drinking, or tobacco use	☐	☐
07. In	No discharge from eyes, nose, and mouth	☐	☐
Preventing Contamination by Hands			
08. In	Hands clean and properly washed	☐	☐
09. In	No bare hand contact with RTE foods or a pre-approved alternative procedure properly followed	☐	☐
10. In	Adequate handwashing sinks, properly supplied and accessible	☐	☐
Approved Source			
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14. N/A	Required records available: shellstock tags, parasite destruction	☐	☐
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21. In	Proper hot holding temperatures	☐	☐
22. In	Proper cold holding temperatures	☐	☐
23. In	Proper date marking and disposition	☐	☐
24. N/A	Time as a Public Health Control: procedures and records	☐	☐
Consumer Advisory			
25. N/A	Consumer advisory provided for raw or undercooked foods	☐	☐
Highly Susceptible Populations			
26. In	Pasteurized foods used; prohibited foods not offered	☐	☐
Food/Color Additives and Toxic Substances			
27. N/A	Food additives: approved and properly used	☐	☐
28. In	Toxic substances properly identified, stored, and used; held for retail sale, properly stored	☐	☐
Conformance with Approved Procedures			
29. N/A	Compliance with variance, specialized process, reduced oxygen packaging criteria or HACCP plan	☐	☐

PIMA COUNTY
HEALTH DEPARTMENT

FOOD SAFETY INSPECTION REPORT

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Establishment	Address
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34. N/O	Plant food properly cooked for hot holding	☐	☐
35. N/O	Approved thawing methods used	☐	☐
36. In	Thermometers provided and accurate	☐	☐
Food Identification			
37. In	Food properly labeled; original container	☐	☐
Prevention of Food Contamination			
38. In	Insects, rodents, and animals not present	☐	☐
39. In	Contamination prevented during food preparation, storage, and display	☐	☐
40. In	Personal cleanliness	☐	☐
41. In	Wiping cloths; properly used and stored	☐	☐
42. N/O	Washing fruits & vegetables	☐	☐
Proper Use of Utensils			
43. In	In-use utensils; properly stored	☐	☐
44. In	Utensils, equipment & linens; properly stored, dried, & handled	☐	☐
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46. N/O	Gloves used properly	☐	☐
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48. In	Warewashing facilities, installed, maintained, used, test strips	☐	☐
49. In	Non-food-contact surfaces clean	☐	☐
Physical Facilities			
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51. In	Plumbing installed; proper backflow devices	☐	☐
52. In	Sewage and waste water properly disposed	☐	☐
53. In	Toilet facilities: properly constructed, supplied, clean	☐	☐
54. In	Garbage/refuse properly disposed; facilities maintained	☐	☐
55. In	Physical facilities installed, maintained, and clean	☐	☐
56. In	Adequate ventilation and lighting; designated areas used	☐	☐
Smoke Free			
57. In	Complies with Smoke Free Arizona 36-601.01	☐	☐
Pima County Code for Mobile Food Establishments ONLY			
58.	A1. Exterior	☐	☐
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PIMA COUNTY
HEALTH DEPARTMENT

FOOD SAFETY INSPECTION REPORT

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Establishment	Address
SAPPHIRE OF TUCSON NURSING & REHAB	2900 E MILBER STTUCSON AZ 85714

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pork stock/WIR	41	baked potato/WIR	41

OBSERVATIONS AND CORRECTIVE ACTIONS

PIC = Person in charge RTE = Ready to eat TCS = Time/temperature control for safety

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PREVIOUS OBSERVATIONS

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Item P /Pf/ C — Violations cited below were observed during a previous inspection. A pattern of non-compliance may result in Probationary status per PCC 8.08.060B

No previously cited observations

ACTIONS TAKEN

Notice of Violation Issued

First Routine Inspection packet provided

Incentive Program handout provided.

CLOSING COMMENTS

This inspection would have resulted in an EXCELLENT rating, however, at this time, all ROUTINE INSPECTIONS will be given an EDUCATIONAL rating.

This facility has been issued a Notice of Violation during this inspection for expired since 1/31/22.

Person in Charge (Print Name): Vibelle Martin

Person in Charge (Signature): [signature] **Date** 06/15/2022

Inspector (Print Name): Paul Bristol, Environmental Health Specialist I

Inspector (Signature): [signature] **Date** 06/15/2022

INSPECTION ADDITIONAL DETAILS

Notice of Inspection Rights Provided? Yes

PIMA COUNTY
HEALTH DEPARTMENT

FOOD SAFETY INSPECTION REPORT

As Governed by Pima County Code 8.08 3950 S. Country Club Rd, Ste 2301 Tucson AZ 85714 Phone 520-724-7908, Fax 520-724-9597	Permit# 3180926	Date 06/15/2022

Establishment	Address
SAPPHIRE OF TUCSON NURSING & REHAB	2900 E MILBER STTUCSON AZ 85714

Does this Inspection Require a Foodborne Illness Investigation Response? 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 revisit 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 the State participation requirements to operate a nursing home in the State of Arizona.

Enclosed is the **State Revisit Report form** which indicates the licensee to be **in substantial compliance** based on an allegation of compliance and acceptable 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,

Monica Miller

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

\mm

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 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) COMPLETE DATE
{Y 000}	Initial Comments The offsite follow-up was conducted on November 18, 2022 for the State compliance and complaint survey. Revised complaint list includes the following: AZ00186165, AZ00185501, AZ00183624, AZ00185486, AZ00184360, AZ00184924, AZ00183904, AZ00174056, AZ00175032, AZ00175165, AZ00175053, AZ00175670, AZ00175355, AZ00174830, AZ00183514, AZ00178990, AZ00177917, AZ00177644, AZ00176706, AZ00176005, AZ00175521, and AZ00174512. No deficiencies were cited.	{Y 000}		

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

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)
035292	A. Building B. Wing	11/18/2022

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 Cary	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 2, 2022

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 September 15, 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 provide all in-service records to include:**
  - **What was taught**
  - **When it was taught**
  - **Sign-in sheets of those who attended**
  - **Any copies of monitoring adults being done up to youir Allegation of Compliance date**

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 **November 12, 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: Bureau of Long Term Care, 150 North 18th Avenue, Suite 440, Phoenix, Arizona 85007 at (602) 364-2690.

Sincerely,

Megan Whitby

Megan Whitby
Interim Long Term Care Bureau Chief

MW: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 _____	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) COMPLETE DATE
Y 000	Initial Comments The State compliance survey was conducted September 12, 2022 through September 15, 2022, in conjunction with the investigation of Complaints: AZ00186165, AZ00185696, AZ00185501, AZ00183624, AZ00185486, AZ00184360, AZ00184924, AZ00183904, AZ00174056, AZ00175032, AZ00175165, AZ00175053, AZ00175670, AZ00175355, AZ00174830, AZ00183514, AZ00178990, AZ00177917, AZ00177644, AZ00176706, AZ00176005, AZ00175521, and AZ00174512. The census was 156. 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.**	
Y 339	R9-10-403.C.2.b. Administration R9-10-403.C. An administrator shall ensure that: R9-10-403.C.2. Policies and procedures for physical health services and behavioral health services are established, documented, and implemented to protect the health and safety of a resident that: R9-10-403.C.2.b. Cover the provision of physical health services and behavioral health services; This RULE is not met as evidenced by: Based on observations, clinical record review, staff interviews, and facility policies, the facility failed to implement their policies to ensure services provided to one resident (#16) met professional standards of quality care.	Y 339	***Y339*** 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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 11-11-22

ADHS LICENSING SERVICES

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Y 339	Continued From page 1 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: -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.	Y 339	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

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 _____	09/15/2022

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Y 339	Continued From page 2 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 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	Y 339		

ADHS LICENSING 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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Y 339	Continued From page 3 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 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	Y 339		

ADHS LICENSING SERVICES

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Y 339	Continued From page 4 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 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	Y 339		

ADHS LICENSING SERVICES

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Y 339	Continued From page 5 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 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.	Y 339		
Y 342	R9-10-403.C.2.e. Administration R9-10-403.C. An administrator shall ensure that: R9-10-403.C.2. Policies and procedures for physical health services and behavioral health services are established, documented, and implemented to protect the health and safety of a resident that: R9-10-403.C.2.e. Cover infection control; This RULE 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 implement their policy regarding designating a qualified individual as the Infection Preventionist (IP) on an ongoing basis. Findings include: During an interview conducted on September 14,	Y 342	***Y342*** 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.	

ADHS LICENSING SERVICES

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Y 342	Continued From page 6 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 created an online training course that can orient individuals to this role in nursing homes.	Y 342		
Y 629	R9-10-406.E.1. Personnel R9-10-406.E. An administrator shall ensure that a personnel member or an employee or volunteer who has or is expected to have direct interaction with a resident for more than eight hours a week provides evidence of freedom from infectious tuberculosis: R9-10-406.E.1. On or before the date the individual begins providing services at or on the behalf of the nursing care institution, and	Y 629		

ADHS LICENSING SERVICES

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Y 629	Continued From page 7 This RULE is not met as evidenced by: Based on personnel record reviews, staff interviews, facility documentation and policy review, the facility failed to ensure one employee (staff #143) had current evidence of freedom from infectious tuberculosis (TB). Findings include: Review of the personnel record for a Registered Nurse (RN/staff #143) revealed a hire date of February 2022. A TB Skin Test Consent Form dated 05/25/21 indicated staff #143 received a tuberculin purified protein derivative (PPD) skin test. The form indicated a negative result was read on 05/27/21 by a Licensed Practical Nurse (LPN). However, further review of staff #143's personnel file did not include an up to date TB skin test. On 09/15/22 at 11:23 a.m., an interview was conducted with the Director of Human Resources (staff #82). She stated that before, or the week an employee starts, new employees are required to have TB screening. She stated that 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. She stated that staff #143's TB status did not meet her expectations. An interview was conducted on 09/15/22 at 11:46 a.m. with the acting Director of Nursing (DON/staff #141). She stated that new employees are required to provide proof that they are free	Y 629	***Y629*** 1.Staff #143 is a contracted staff. The facility is no longer using the services of this contracted staff. 2. Audit was conducted by DON/designee on contracted staff. Audit included an up-to-date TB skin test. Completed on 10/10/2022. 3. Meeting with HR, staffing coordinator, infection preventionist and nursing leadership on requirement to have evidence of staff being free from infectious tuberculosis (TB) prior to start date. 4. Weekly audits for four weeks will be conducted by DON/designee to ensure that contracted agencies (therapy, nursing agencies, providers) have submitted evidence of freedom from infectious tuberculosis (TB) prior to start date. Results of the audits will be presented to the QAPI committee for review and recommendation x 3 months.	11/18/22 12/9/22

ADHS LICENSING SERVICES

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Y 629	Continued From page 8 from TB prior to their shift on the first day. She stated that the risks of not providing the verification would include infectious TB. She stated that this did not meet her expectations. A policy titled Health Requirements and Notice of Employee Reportable Health Conditions included upon hire, employees must undergo a TB screening. Annual TB screening is mandatory and timely completion of all annual health requirements is your responsibility. Failure to timely complete these requirements may result in disciplinary action such as placing you on unpaid leave until you have fully complied, up to and including discharge.	Y 629		
Y 641	R9-10-406.F.3.d. Personnel R9-10-406.F. An administrator shall ensure that a personnel record is maintained for each personnel member, employee, volunteer, or student that includes: R9-10-406.F.3. Documentation of: R9-10-406.F.3.d. Orientation and in-service education as required by policies and procedures; This RULE is not met as evidenced by: Based on personnel file review, staff interviews, and policy reviews, the facility failed to ensure one staff (#143) personnel record contained documentation of training regarding abuse, neglect, exploitation, misappropriation of resident property, and dementia management.	Y 641	***Y641*** 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

ADHS LICENSING 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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(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 641	Continued From page 9 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 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.	Y 641		

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Y 641	Continued From page 10 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.	Y 641		
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 the clinical record review, facility documents, staff interviews and facility policy, the facility failed to ensure three residents (#s 38, 510, and 132) received treatment that supported their abilities and strengths. 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	Y1077	***Y1077*** 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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Y1077	Continued From page 11 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 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.	Y1077		

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Y1077	Continued From page 12 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. 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	Y1077		

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Y1077	Continued From page 13 -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 -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	Y1077		

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Y1077	Continued From page 14 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 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	Y1077		

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Y1077	Continued From page 15 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 and personal hygiene. This includes bathing, dressing and grooming.	Y1077		
Y1471	R9-10-414.B.1. Comprehensive Assessment; Care Plan R9-10-414.B. An administrator shall ensure that a care plan for a resident: R9-10-414.B.1. Is developed, documented, and implemented for the resident within seven calendar days after completing the resident's comprehensive assessment required in subsection (A)(1); This RULE is not met as evidenced by: Based on clinical record review, staff interviews, and review of policy and procedure, the facility failed to ensure a care plan for one resident's (#19) was developed for diabetes management and related insulin use. 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.	Y1471	*Y1471* 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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Y1471	Continued From page 16 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/ -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.	Y1471		

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Y1471	Continued From page 17 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 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.	Y1471		
Y1477	R9-10-414.B.3.b. Comprehensive Assessment; Care Plan	Y1477		

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Y1477	Continued From page 18 R9-10-414.B. An administrator shall ensure that a care plan for a resident: R9-10-414.B.3. Ensures that a resident is provided nursing care institution services that: R9-10-414.B.3.b. Assist the resident in maintaining the resident's highest practicable well-being according to the resident's comprehensive assessment. This RULE is not met as evidenced by: Based on observation, clinical record review, staff interviews, and policy review, the facility failed to assist one resident (#16) in maintaining the resident's highest practicable well-being, by failing to ensure the resident received care and treatments to promote healing and prevention 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.	Y1477	***Y1477*** 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. 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.	11/18/22 12/9/22

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Y1477	Continued From page 19 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. 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	Y1477		

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Y1477	Continued From page 20 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 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	Y1477		

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Y1477	Continued From page 21	Y1477		

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 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

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 _____	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) COMPLETE DATE
Y1477	Continued From page 22 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. 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.	Y1477		
Y2335	R9-10-423.B.4.a. Food Services R9-10-423.B. A registered dietitian or director of food services shall ensure that: R9-10-423.B.4. A resident is provided: R9-10-423.B.4.a. A diet that meets the resident's nutritional needs as specified in the resident's comprehensive assessment and care plan;	Y2335	***Y2335*** 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

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 _____	09/15/2022

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

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Y2335	Continued From page 23	Y2335		

This RULE 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 provided a diet that consistently met the resident's nutritional needs in regards to the resident's food allergies.

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 09/15/22at 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.

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.

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 _____	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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Y2335	Continued From page 24 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 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	Y2335		

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 _____	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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Y2335	Continued From page 25 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.	Y2335		

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: September 12, 2022
Survey Event ID: LYYB11			
Inspector/Team Coordinator: Erlinda (Lin) Tucker			
Accompanied By: Melinda Spiwak, Samantha Potter, Lisa Bashford, Carrie Gebler, Carey Sexton, Anthony Valente			

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: Long Term Care, at 150 N. 18th Ave., Suite 440, Phoenix, Arizona 85007-3242, Phone: (602) 364-2690, FAX: (602) 324-0993, E-Mail: ltc.licensing@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: 9-12-2022

☐ 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: ET Tucker — Date: 09/12/2022

☒ Copy left with Administrator/Director/Agency Representative

QUALITY RATING CERTIFICATE

ARIZONA DEPARTMENT OF HEALTH SERVICES NURSING CARE INSTITUTION

Issued To: Sandstone of Tucson Rehab Centre

The above-named facility has met licensure requirements, has been licensed for one year or more and, therefore, has received the following quality rating as required by R910919.

COMPONENTS	CRITERIA MET	
	Yes	No
I. Nursing Services	15	10
II. Resident Rights	25	0
III. Administration	25	0
IV. Environment and Infection Control	15	0
V. Food Services	10	0
TOTAL CRITERIA MET	90	10

QUALITY PERFORMANCE SCALE	
"A"	
"B"	
"C"	
"D"	

"A": 90 to 100 points

"B": 80 to 89 points

"C": 70 to 79 points

"D": 69 or fewer points

License Effective:

From: To:

Issued:

Number: NCI-

Recommended By

Issued By Assistant Director

Quality Rating Evaluation

Facility: Phone:

Address:

Survey Date: Contact Person:

Nursing Services:

Criteria:	Pts.	Criteria Met? YES	NO
The nursing care institution is implementing a system that ensures residents are provided nursing services to maintain the resident's highest practicable physical, mental, and psychosocial well-being according to the resident's comprehensive assessment and care plan.	15	5	10
The nursing care institution ensures that each resident is free from medication errors that resulted in actual harm.	5	5	0
The nursing care institution ensures the resident's representative is notified and the resident's attending physician is consulted if a resident has a significant change in condition or if the resident is in an incident that requires medical services.	5	5	0

Points Yes 15

Points No 10

Comments:

Resident Rights:

Criteria: Criteria Met?

	Pts.	YES	NO
The nursing care institution is implementing a system that ensures a resident's privacy needs are met.	10	10	0
The nursing care institution ensures that a resident is free from physical and chemical restraints for purposes other than to treat the resident's medical condition.	10	10	0
The nursing care institution ensures that a resident or the resident's representative is allowed to participate in the planning of, or decisions concerning treatment including the right to refuse treatment and to formulate a health care directive.	5	5	0

Points Yes 25

Points No 0

Comments:

Administration:

Criteria:	Pts.	Criteria Met? YES	NO
The nursing care institution has no repeat deficiencies that resulted in actual harm or immediate jeopardy to residents that were cited during the last survey or other survey or complaint investigation conducted between the last survey and the current survey.	10	10	0
The nursing care institution is implementing a system to prevent abuse of a resident and misappropriation of resident property, investigate each allegation of abuse of a resident and misappropriation of resident's property, and report each allegation of abuse of a resident and misappropriation of resident's property to the Office of Long Term Care Licensure and as required by A.R.S. § 46-454.	5	5	0
The nursing care institution is implementing a quality management program that addresses nursing care institution services provided to residents, resident complaints, and resident concerns, and documents actions taken for response, resolution, or correction of issues about nursing care institution services provided to residents, resident complaints, and resident concerns.	5	5	0
The nursing care institution is implementing a system to provide social services and a program of ongoing recreational activities to meet the resident's needs based on the resident's comprehensive assessment.	1	1	0
The nursing care institution is implementing a system to ensure that records documenting freedom from infectious pulmonary tuberculosis are maintained for each personnel member, volunteer, and resident.	1	1	0
The nursing care institution is implementing a system to ensure that a resident is free from unnecessary drugs.	2	2	0
The nursing care institution is implementing a system to ensure a personnel member attends in-service education according to policies and procedures.	1	1	0

Points Yes 25

Points No 0

Comments:

Environment and Infection Control:

Criteria:

	Pts.	Criteria Met? YES	NO
The nursing care institution environment is free from a condition or situation within the nursing care institution's control that may cause a resident injury.	5	5	0
The nursing care institution establishes and maintains a pest control program.	1	1	0
The nursing care institution develops a written disaster plan that includes procedures for protecting the health and safety of residents.	1	1	0
The nursing care institution ensures orientation to the disaster plan for each staff member is completed within the first scheduled week of employment.	1	1	0
The nursing care institution maintains a clean and sanitary environment.	1	1	0
The nursing care institution is implementing a system to prevent and control infection.	5	5	0
An employee washes hands after each direct resident contact or where hand washing is indicated to prevent the spread of infection.	1	1	0

Points Yes 15

Points No 0

Comments:

Food Services:

Criteria:

	Pts.	Criteria Met? YES	NO
The nursing care institution complies with 9 A.A.C. 8, Article 1, for food preparation, storage and handling as evidenced by a current food establishment license	1	1	0
The nursing care institution provides each resident with food that meets the resident's needs as specified in the resident's comprehensive assessment and care plan.	3	3	0
The nursing care institution obtains input from each resident or the resident's representative and implements recommendations for meal planning and food choices consistent with the resident's dietary needs	2	2	0
The nursing care institution provides assistance to a resident who needs help in eating so that the individual's nutritional, physical, and social needs are met.	2	2	0
The nursing care institution prepares menus at least one week in advance, conspicuously posts each menu, and adheres to each planned menu unless an uncontrollable situation such as food spoilage or non-delivery of a specified food requires substitution.	1	1	0
The nursing care institution provides food substitution of similar nutritive value for residents who refuse the food served or who request a substitution.	1	1	0

Points Yes 10

Points No 0

Comments: