STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035016	A. Building B. Wing	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Handmaker Home for the Aging	2221 North Rosemont Boulevard Tucson, AZ 85712

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42319 Based on observations, clinical record reviews, resident and staff interviews, and facility documentation, policy and procedures, the facility failed to ensure 3 residents (#5, 24, 40) were free from preventable falls. The deficient practice put the residents at increased risks for serious injury and harm. Findings include: -Regarding Resident #5: Resident #5 was admitted [DATE] with diagnoses of metabolic encephalopathy, Parkinson's, Dementia, and anxiety disorder. A MORSE fall scale (Fall Assessment tool) was conducted on 7/25, 7/31, 8/7, 8/13, 8/16 and 9/3/2024. All assessments include the resident was high risk for falling. A care plan focus dated 7/26/24 included that the resident is at high risk for falls related to confusion, deconditioning, history of falls and was unaware of safety needs. Interventions include following facility fall protocol, encouraging non skid socks while ambulating or in wheelchair, and placing the call light in reach and prompt response to requests for assistance. A progress note dated 7/29/2024 included that the resident was extremely restless, unable to redirect, and unable to sit still for more than a few minutes at a time. This note included that the resident attempts to use her wheelchair as a walker and that a provider was notified, however no interventions were noted. An incident note dated 7/31/24 included that this resident was found sitting on the foot of the bed holding tissue to the wound on her right head. This note included that injuries were found including right hand pain with slight edema noted in the small finger area, slight pain in the neck area, left eye was slightly larger than the right with neuro checks, and a forehead right side 1.5 inch laceration very deep cut, and a hematoma. This note included that the resident was sent out for a CT. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Health Status Note dated 7/31/2024 included that the resident returned from the ER and that hospital papers report concussion, contusion of the right hand including fingers with possible fracture of pinky finger. This note includes the resident had a laceration on L side of her head with 4 sterile strips and dried blood down the R side of her face and her right pinky finger and palm purple and swollen. This noted included the resident continues to be restless and constantly standing up and has to be reminded to sit down. An Admission Minimum Data Set (MDS) dated [DATE] included severe cognitive impairment and that the resident required partial to moderate assistance for chair to bed transfers. This assessment included that the resident had a fall prior to admission and had a fall with major injury since admission. A care plan focus dated 8/1/24 included that the resident had an unwitnessed fall on 7/31/24 with major injury. However, interventions include to continue interventions and to send to the emergency room (ER). However, no new interventions were noted after return from the ER. A care plan focus dated 8/8/24 included that the resident had an unwitnessed fall on 8/7/24 with no injury. Interventions include to continue with fall risk intervention. However, no new fall interventions were noted. An Incident Note dated 8/16/2024 included that the resident had just walked through the nurses station carrying and a blanket a jacket, and staff was calling her to come back, and that at that time they heard a thud. This noted included the resident was found with blood coming from her forehead, bridge of nose and nares and a laceration about 1.5 long across the middle of her forehead, and a small laceration across the bridge of the nose which was slightly bent and bleeding. This note included her right hand was beginning to turn light blue and resident stated it hurt when touched. A General Nursing Progress Note dated 8/17/2024 included that the resident returned to facility and that a skin check revealed that the resident's right eye was droopy, left eye with black under eye, right 5th digit in a splint related to fracture, laceration to forehead with sutures intact and covered with non stick dressing. Resident c/o pain PRN administered as per order. This nurse noted that neurological checks were initiated and that the resident's eyes were slightly sluggish. A care plan focus dated 8/19/24 included that the resident had an unwitnessed fall on 8/16/24 with major injury. Interventions include to provide labs, a urinary analysis and a medication review. A Provider Visit Note dated 8/19/2024 included that Status Post Falls: the resident completed therapies, has no safety awareness, and needs a private sitter. This note was repeated on 8/22/2024. However, no documentation was noted of the implementation of a private sitter. An Incident Note dated 8/21/2024 included that this resident was found on her hands and knees on the floor in the TV/activity room, with no apparent injuries. Resident was assisted up and put into bed, neuro checks started, and that the resident was reminded not to walk around without assistance. - Regarding Resident #40: Resident #40 was admitted [DATE] with diagnoses of Dementia, history of falling, and fracture of neck of right femur. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A care plan focus dated 6/14/24 included that the resident is at high risk for falls related to deconditioning, gait/balance problems history of falls and was unaware of safety needs. Interventions include following facility fall protocol, encouraging non skid socks while ambulating or in wheelchair, and placing the call light in reach and prompt response to requests for assistance. An intervention of fall mat beside bed while in bed was added 6/18/24 An Alert Note dated 6/16/2024 included that the resident was found bedside on floor sitting right-side up, she was attempting to ambulate herself without asking for assistance and without pressing her call light. This note included that the resident doesn't seem to be aware of her physical limitations so, education was provided on the importance of pressing her call light when needing assistance transferring to and from her wheelchair/bed. This note included that the resident nodded with understanding and was assisted into her wheelchair for monitoring her and doing neurological checks. A care plan focus dated 6/18/24 included that the resident had an unwitnessed fall on 6/16/24 with no injury. Interventions include to continue with fall risk intervention and low bed. A General Nursing Progress Note dated 8/3/2024 included that resident was observed lying on floor and that the writer and two staff members assessed resident and assisted back into bed and that the resident denies any pain or discomfort at time of fall. This note included that the neurological assessment and vitals were within normal limits and incident was reported to the physician. A MORSE fall scale dated 8/3/2024 included that this resident was at high risk for falling. A care plan focus dated 8/5/24 included that the resident had an unwitnessed fall on 8/4/24 with no injury. Interventions included to continue with fall risk interventions, however, no new fall risk interventions were put in place. Review of the care plan did not include a fall with major injury or interventions regarding this fall. A Discharge return anticipated Minimum Data Set (MDS) dated [DATE] included and that the resident required substantial/maximal assistance for chair to bed transfers. This assessment included that the resident had a fall prior to admission and had 2 falls with no injury and a fall with major injury since admission. However, no care plan was noted for the fall with major injury. An incident note dated 8/6/24 included that neuro checks remained baseline for 6-2 shift and included that the resident was not present infacility during the entirety of the 2-10 shift. However, review of the clinical record did not include why the resident was not present in the facility. A General Nursing Progress Note dated 8/7/2024 included that this resident was returning to unit from the hospital and that per report the resident has a mid-shaft fracture to the right leg; also a hematoma/bruise on the right anterior skull. This note included the resident wearing a brace on the right leg and that the resident was resting in bed and the bed was in lowest position with fall mat in place and frequent checks to ensure comfort and safety and had new orders for tylenol, tramadol and a lidocaine 4% patch. -Regarding Resident #24: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #24 was admitted [DATE] with diagnoses of Dementia, Parkinson's disease and Major Depressive Disorder. A MORSE fall scale was conducted on 4/5, 4/6, 4/7, 4/14, 4/23, 7/6 and 7/9/2024. All assessments include the resident was high risk for falling. A care plan dated 4/7/24 included that the resident is high risk for falls related to Parkinson's, weakness, and poor safety awareness and included interventions include and placing the call light in reach and prompt response to requests for assistance, encouraging non skid socks while in wheelchair, to be evaluated and treated as ordered or as needed and following facility fall protocol. An intervention for bed in the lowest position and fall mat beside bed while in bed were added 4/8/24. A Quarterly MDS dated [DATE] included that this resident was not cognitively impaired and was dependent for bed to chair transfers. This MDS included that the resident had not had falls since the prior assessment. A care plan focus dated 08/16/2024 included the resident had an unwitnessed fall with minor injury on 8/16/24 with an intervention to Monitor/document /report as needed for 72 hours to the Doctor for Pain, bruises, change in mental status, New onset: confusion, sleepiness, inability to maintain posture, agitation. However, no further interventions were added for after the 72 hours. An Alert Note dated 8/16/2024 included that a Certified Nursing Assistant (CNA) notified the writer that resident was found on the ground laying on back with head under the bed, bed was raised fully in the air by the resident, and the resident complained of neck and head pain. This note included that a neurological evaluation had been performed 30 minutes earlier and that the bed had been placed in the lowest position. An observation was conducted on 9/4/24 at 12:48 P.M. and again at 2:15 P.M. of resident 24's room. No fall mat was observed by the bedside. An interview was conducted on 9/4/2024 at 12:52 P.M. with a CNA (staff #17) who said that resident #24 and #40 were fall risks and that sometimes there was a sticker to indicate that and it was found by the head of the bed. She observed resident #40's room and said that there was no sticker. She said that fall risks need to be looked at more often and checked when they can. An interview was conducted on 9/4/2024 at 1:03 P.M. with a CNA (staff #12) who said that they knew who was a fall risk because the shift before would tell them. This CNA said that some residents have bands on their arms or signs in the room but not all of them. This CNA said that they can access the resident's care plan in the computer to check to see who is a fall risk. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 9/4/24 at 1:26 P.M. with a Registered Nurse (RN/staff #6) who said that if someone falls that they assess range of motion right away. She said that if the resident is showing changes then they would report immediately to the Doctor. She said if the resident keeps falling, then they will do the care plan and see if the floor mat is needed. This nurse stated the DON and assistant DON update the care plan. She said that if residents fall repeatedly, they should have signs so everyone knows. This nurse observed the rooms for residents #24 and resident #40 and stated that there was no signs and that she will get signs put up. Resident #40 had her bed in lowest position with the fall mat, however resident #40 did not have a fall mat. An interview was conducted on 9/4/2024 at 2:56 with the Director of Nursing (DON/staff #34) who said that after a resident falls 2 times then they assess to see what the resident needs whether it is physical therapy, occupational therapy or restorative and that they have a group of interventions. This DON reviewed the interventions for these resident's falls and stated that they are not new interventions and that her expectation is that they will implement new interventions. A procedure titled Fall Prevention Program updated 9/2024 included that each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. This Program included that when any resident experiences a fall, the facility will review the resident's care plan and update as indicated and will document all assessments and actions.