

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  035016	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/24/2024
NAME OF PROVIDER OR SUPPLIER  Handmaker Home for the Aging		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50166</p> <p>Based on clinical record review, resident and staff interviews, and policy review, the facility failed to ensure two residents (#222) was free from abuse by another resident (#169). This deficient practice could result in further incidents of resident to resident abuse.</p> <p>-Resident #222 was initially admitted to the facility on [DATE] with diagnoses that included unspecified dementia, bipolar disorder, major depressive disorder, paroxysmal atrial fibrillation, and chronic obstructive pulmonary disease.</p> <p>A care plan revised on October 22, 2021 revealed a focus related to a history of behavior problems with an intervention to place her in a secured memory care unit and administer medications as ordered.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that resident #222 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated intact cognitive impairment. The assessment also revealed that the resident was exhibiting behavioral symptoms including physical, verbal, and behaviors not directed towards others on one to three days, and utilized a wheelchair for mobility.</p> <p>A progress note for dated April 9, 2022 revealed an altercation between Resident's #222 and #169 that was reported to a Registered Nurse (RN/Staff#158) while she passed medications. Resident #222 reported to the RN that she was hit several times in the stomach area earlier that day by Resident #169. The progress note revealed that Resident #222 did not have any obvious injuries and that they would continue to monitor the resident' skin for changes.</p> <p>A progress note dated April 11, 2022 revealed that the Resident (Resident #169) who assaulted her (Resident #222) was immediately removed and sent out to the hospital for evaluation and treatment. It has been determined that this resident will not be returning to the facility.</p> <p>Review of Resident #222's vitals for April of 2022 revealed an increased pain level one day following the physical altercation with Resident #169.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the clinical records for Resident #222 revealed no evidence of a skin assessment by the facility following the physical altercation with Resident #169, but there was evidence of a weekly body check on April 15, 2022 indicating a normal body condition with a slight pink area from brief on the left groin area.</p> <p>-Regarding Resident #169:</p> <p>Resident #169 was initially admitted to the facility on [DATE] with diagnoses that included unspecified dementia with behavioral disturbance, psychotic disorder with hallucinations, generalized anxiety disorder, and major depressive disorder.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a BIMS score of 03, which indicated severe cognitive impairment. The assessment also revealed that the resident was exhibiting behavioral symptoms including physical and verbal on four to six days, and needed staff assistance to move from sitting to standing.</p> <p>A care plan initiated on March 30, 2022 revealed a focus related to behavioral problems, elopement, and wandering. Goals were made to have fewer episodes of behavioral problems and to maintain her safety by intervening, removing the resident when she exhibited behaviors, and identifying her wandering patterns.</p> <p>A behavior progress note dated April 7, 2022 revealed that the resident was in another resident's face and would not step back. The note indicated that the other resident asked Resident #169 to step back several times but she kept repeating no. The resident told Resident #169 get out of my face now and both residents were getting angry. The note relayed that Resident #169 would not leave the other resident alone and almost hit her.</p> <p>A progress note dated April 7, 2022 revealed that the resident was wandering the whole shift, picking plates and cups out of the garbage, wandering into others rooms and taking their stuff, and was easily upset when trying to redirect her.</p> <p>A progress note dated April 9, 2022 revealed that the resident almost turned a table over onto three other residents and she was screaming I am going to kill you and I am going to kill myself, and was repeatedly threatened staff and residents.</p> <p>A progress note dated April 9, 2022 revealed that Resident #169 was in the faces of several residents screaming they are going to kill you while drawing back her fist to hit another resident but was stopped by staff.</p> <p>A progress note dated April 9, 2022 revealed that Resident #169 was found in another resident ' s room screaming in her face.</p> <p>A progress note dated April 11, 2022 revealed that Resident #169 was sent out on April 9, 2022 as a result of the incident that took place in which Resident #169 punched Resident #222 and a police report was filed.</p> <p>Review of an outside SA agency report revealed that the incident was reported on April 9, 2022 at 12:06 p.m That report relayed that the incident occurred on April 9, 2022 at 8:10 a.m</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the SA complaint reporting system revealed the facility reported the incident on April 9, 2022 at 12:29 p.m. The report relayed that Resident #222 reported to the RN (Staff #158) at 11:00 a.m. that Resident #169 hit her in the stomach multiple times. The report revealed that Resident #169 had been very aggressive and threatening to staff and residents between the hours of 7:45-9 a.m. and that Resident #169 was sent to the emergency room .</p> <p>Review of the facility incident investigation revealed a statement from the previous DON indicating that the RN (Staff #158) was in the room when the event occurred and saw Resident #169 standing close to the resident, but was unaware that Resident #222 had been hit. The statement revealed that Resident #169 was aggressive and threatening towards staff and other residents from 7:30-9:00 a.m. The facility incident investigation also revealed a statement from the RN (Staff #158) who relayed that the resident who was found in Resident #222's room earlier that day had been screaming and hitting her several times in the stomach. The RN pulled back the blanket and examined her stomach to find no injuries.</p> <p>Review of the undated facility reportable event revealed a resident-to-resident abuse incident with law enforcement and an other state agency revealed that the family, and ombudsman contacted on April 9, 2022. The report revealed that there were no witnesses to the incident, Resident #169 had been sent to the hospital for evaluation and stabilization, and Resident #222 was being monitored for bruising.</p> <p>An interview was conducted on October 22, 2024 at 1:10 p.m. with the RN (Staff #158), who stated that she remembered Resident #169. Staff #158 stated that she had no reason to doubt because resident #169 exhibited behaviors and was running a hole into the unit. The RN stated that on April 9, 2022, the staff were shutting all the resident doors with residents inside to keep them safe from Resident #169 and that the resident had turned a table over with patients' food on it. The RN stated that when they called the Assistant Director of Nursing (ADON) she could hear the screaming over the phone and directed them to call the police. The RN stated that the police did not want to take Resident #169 so the facility contacted the family instead to transfer the resident out of the facility and to the emergency room . The RN stated that after everything stopped, Resident #222 reported early in the morning that the resident had hit her. The RN stated that the table turning incident occurred at about 7:30 a.m. and that the resident to resident altercation occurred at 8:30 a.m</p> <p>An interview was conducted on October 22, 2024 at 2:48 p.m. with the Administrator (Admin/Staff#205) who stated that the facilities expectation for handling resident to resident altercations was whatever the regulation requires, and if that expectation was not followed, residents could be injured. Behaviors would continue, other residents could get involved, and any number of things could happen. She did not recall the incident and stated she was not in this role at the time.</p> <p>Review of the facility policy titled, Abuse, Neglect, and Exploitation, revealed that the facility will develop and implemented written policies that prohibit and prevent abuse. The policy also revealed that abuse should have been reported to the state agency within two hours. The policy defines abuse as the willful infliction of injury, physical harm, pain or mental anguish, and it includes verbal abuse, physical abuse, and mental abuse. The policy defines physical abuse as including but not limiting hitting, slapping, punching, biting, and kicking. The policy also revealed that the facility should have identified, corrected, and intervened in situations in which abuse was more likely to occur.</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50166</p> <p>Based on clinical record review, resident and staff interviews, and policy review, the facility failed to ensure that abuse policies were implemented for two resident to resident abuse incidents, one involving resident (#222) and(#169); and the other involving residents (#223) and (#49). This deficient practice could result in further instances of resident to resident abuse.</p> <p>-Regarding Residents #222 and #169</p> <p>-Resident #222 was initially admitted to the facility on [DATE] with diagnoses that included unspecified dementia, bipolar disorder, major depressive disorder, paroxysmal atrial fibrillation, and chronic obstructive pulmonary disease.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that resident #222 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated intact cognitive impairment. The assessment also revealed that the resident was exhibiting behavioral symptoms including physical, verbal, and behaviors not directed towards others on one to three days, and utilized a wheelchair for mobility.</p> <p>-Resident #169 was initially admitted to the facility on [DATE] with diagnoses that included unspecified dementia with behavioral disturbance, psychotic disorder with hallucinations, generalized anxiety disorder, and major depressive disorder.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a BIMS score of 03, which indicated severe cognitive impairment. The assessment also revealed that the resident was exhibiting behavioral symptoms including physical and verbal on four to six days, and needed staff assistance to move from sitting to standing.</p> <p>Progress notes dated April 7, 2022 revealed that the resident was in another resident's face and would not step back. The note indicated that the other resident asked Resident #169 to step back several times but she kept repeating no. The resident told Resident #169 get out of my face now and both residents were getting angry. The note relayed that Resident #169 would not leave the other resident alone and almost hit her. The progress notes also revealed that the resident was wandering the whole shift, picking plates and cups out of the garbage, wandering into others rooms and taking their stuff, and was easily upset when trying to redirect her.</p> <p>A progress note for dated April 9, 2022 at 9:37 a.m. revealed an altercation between Resident's #222 and #169 that was reported to a Registered Nurse (RN/Staff#158) while she passed medications. Resident #222 reported to the RN that she was hit several times in the stomach area earlier that day by Resident #169. The progress note revealed that Resident #222 did not have any obvious injuries and that they would continue to monitor the resident's skin for changes.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Progress notes dated April 9, 2022 at 7:44 a.m. revealed that the resident almost turned a table over onto three other residents and she was screaming I am going to kill you and I am going to kill myself, and was repeatedly threatened staff and residents. The progress notes also revealed that Resident #169 was in the faces of several residents screaming they are going to kill you while drawing back her fist to hit another resident but was stopped by staff. The progress notes also revealed that Resident #169 was found in another resident ' s room screaming in her face.</p> <p>A progress note dated April 11, 2022 at 2:30 p.m. revealed that Resident #169 was sent out on April 9, 2022 as a result of the incident that took place in which Resident #169 punched Resident #222 and a police report was filed.</p> <p>Review of the SA complaint system form revealed the facility reported the incident on April 9, 2022 at 12:29 p.m. The report relayed that Resident #222 reported to Staff #158 at 11 a.m. that Resident #169 hit her in the stomach multiple times. The report revealed that Resident #169 had been very aggressive and threatening to staff and residents between the hours of 7:45-9 a.m. and that Resident #169 was sent to the emergency room .</p> <p>Review of the facility incident investigation revealed a statement from the previous DON indicating that the RN (Staff #158) was in the room when the event occurred and saw Resident #169 standing close to the resident, but was unaware that Resident #222 had been hit. The facility incident investigation also revealed a statement from the RN (Staff #158) who relayed that the resident who was found in Resident #222 ' s room earlier that day had been screaming and hitting her several times in the stomach. The RN pulled back the blanket and examined her stomach to find no injuries.</p> <p>An interview was conducted on October 22, 2024 at 1:10 p.m. with the RN, Staff #158, who stated that she remembered Resident #169. The RN stated that on April 9, 2022, the staff were shutting all the resident doors with residents inside to keep them safe from Resident #169 and that the resident had turned a table over with patients' food on it and when they called the Assistant Director of Nursing (ADON) she could hear the screaming over the phone and directed them to call the police. The RN stated that Resident #222 reported early in the morning that the resident had hit her.</p> <p>An interview was conducted on October 22, 2024 at 2:11 p.m. with the Director of Nursing (DON/Staff#49). Staff #49 recalled Resident #222 and an investigation from a couple years ago, but she did not recall the details. Staff #49 stated that the facility expects that staff follow the abuse policies and if the facility ' s abuse policies were not followed, there is potential for continued abuse, it could be detrimental to residents mental and physical wellbeing, and could cause harm.</p> <p>An interview was conducted on October 22, 2024 at 2:48 p.m. with the Administrator (Admin/Staff#205) who stated that the facility ' s expectation for handling resident to resident altercations was whatever the regulation requires, and if that expectation was not followed, residents could be injured. Behaviors would continue, other residents could get involved, and any number of things could happen. The administrator stated that the facilities expectation would be to follow their abuse policies and if they are not, there could be negative outcomes to residents.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility policy titled, Abuse, Neglect, and Exploitation, revealed that the facility should have developed and implemented written policies that prohibited and prevented abuse. The policy also revealed that abuse should have been reported to the state agency within two hours. The policy defines abuse as the willful infliction of injury, physical harm, pain or mental anguish, and it includes verbal abuse, physical abuse, and mental abuse. The policy defines physical abuse as including but not limiting hitting, slapping, punching, biting, and kicking. The policy also revealed that the facility should have identified, corrected, and intervened in situations in which abuse was more likely to occur.</p> <p>51006</p> <p>regarding resident #223 and resident #49</p> <p>-Resident #223 was admitted on [DATE] with diagnosis of Atherosclerosis of Aorta, Schizophrenia, Unspecified, Unspecified Dementia, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, And Anxiety, Essential (Primary) Hypertension, And History of Falling. Resident #272 was discharged on [DATE].</p> <p>A review of a admission Medicare Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated intact cognition.</p> <p>A review of a progress note dated February 26, 2023 and timed at 5:10 PM revealed Resident #223's involvement in the incident, indicating that the incident occurred.</p> <p>A review of the intake information for AZ00191964 revealed that the Facility Reported Incident (FRI) was submitted on February 26, 2023 at 5:59 PM. This review revealed that a Certified Nursing Assistant (CNA) observed Resident #49 hit Resident #223.</p> <p>A review of a progress note dated February 26,2023 and timed at 9:55 PM revealed that Resident #49 was coughing at the dining table when Resident #223 came over and told Resident #223 to stop coughing. Resident #49 hit Resident #223 and staff separated them. Resident #223 reported they were not hurt.</p> <p>A record request was submitted on October 22, 2024 and timed at 1:03 PM to request their 5-day report and additional investigation notes for the incident that occurred on February 26, 2023. At 1:22 PM, progress notes related to an incident on February 26, 2023 were provided. During this exchange of documents, point of contact/marketing coordinator/assistant administrator (Staff #18) reported and provided a signed 807 stating that the facility does not have any additional information regarding a 5-day report or an internal investigation. in regards to the incident that occurred on February 26, 2023.</p> <p>-Resident #49 was admitted on [DATE] with the diagnoses of Syncope And Collapse, Difficulty In Walking, Not Elsewhere Classified, Muscle Weakness (Generalized), Need For Assistance With Personal Care, Anxiety Disorder, Unspecified And Essential (Primary) Hypertension.</p> <p>Review of a quarterly Medicare Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated no cognitive impairment.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the SA complaint system revealed that the facility reported the incident and was submitted on February 26, 2023 at 5:59 PM. This review revealed that a Certified Nursing Assistant (CNA) observed Resident #49 hit Resident #223.</p> <p>A review of a progress note dated February 26, 2023 and timed at 9:55 PM revealed that Resident #49 was coughing at the dining table when Resident #223 came over and told Resident #223 to stop coughing. Resident #49 hit Resident #223 and staff separated them. Resident #223 reported they were not hurt.</p> <p>A review of a progress note dated February 26, 2023 and timed at 5:10 PM revealed Resident #49's involvement in the incident, indicating that the incident occurred.</p> <p>A record request was submitted on October 22, 2024 and timed at 1:03 PM to request their 5-day report and additional investigation notes for the incident that occurred on February 26, 2023. At 1:22 PM, progress notes related to an incident on February 26, 2023 were provided. During this exchange of documents, point of contact/marketing coordinator/assistant administrator (Staff #18) reported and provided a signed 807 stating that the facility does not have any additional information regarding a 5-day report or an internal investigation, in regards to the incident that occurred on February 26, 2023.</p> <p>Review of the facility policy titled, Abuse, Neglect, and Exploitation, revealed that the facility should have followed their developed and implemented written policies that prohibit, prevent, and investigate abuse, neglect and exploitation. The policy defines abuse as the willful infliction of injury, physical harm, pain or mental anguish, and it includes verbal abuse, physical abuse, and mental abuse. The policy defines physical abuse as including but not limiting hitting, slapping, punching, biting, and kicking. The policy also revealed that abuse should have been reported to the state agency within two hours. The policy also revealed that the facility should have identified, corrected, and intervened in situations in which abuse was more likely to occur. The policy also revealed that the the administrator is to follow up with government agencies to confirm the initial report is received, and again within 5 working days of the incident to report the investigation of the incident. The policy also revealed that the facility should have provided a completed and thorough documentation of the investigation of an incident.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50166</p> <p>Based on clinical record review, resident and staff interviews, and review of facility policy, the facility failed to ensure that an incident involving abuse between resident (#222) and resident (#169) was reported accurately and in a timely manner, and, that an investigation of an allegation of abuse is reported within five (5) working days for two residents (#223 &amp; #49). The deficient practice could result in further incidents of resident to resident abuse and allegations of abuse not being reported to the SA timely and accurately.</p> <p>Regarding Resident #222 and Resident #169:</p> <p>-Resident #222 was initially admitted to the facility on [DATE] with diagnoses that included unspecified dementia, bipolar disorder, major depressive disorder, paroxysmal atrial fibrillation, and chronic obstructive pulmonary disease.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that resident #222 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated intact cognitive impairment.</p> <p>-Resident #169 was initially admitted to the facility on [DATE] with diagnoses that included unspecified dementia with behavioral disturbance, psychotic disorder with hallucinations, generalized anxiety disorder, and major depressive disorder.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a BIMS score of 03, which indicated severe cognitive impairment.</p> <p>Progress notes for resident #169 dated April 9, 2022 at 7:44 a.m. revealed that the resident almost turned a table over onto three other residents and she was screaming I am going to kill you and I am going to kill myself, and was repeatedly threatened staff and residents. The progress notes also revealed that Resident #169 was in the faces of several residents screaming they are going to kill you while drawing back her fist to hit another resident but was stopped by staff. The progress notes also revealed that Resident #169 was found in another resident's room screaming in her face.</p> <p>A progress note for resident #222 dated April 9, 2022 at 9:37 a.m. revealed an altercation between Resident's #222 and #169 that was reported to a Registered Nurse (RN/Staff#158) while she passed medications. Resident #222 reported to the RN that she was hit several times in the stomach area earlier that day by Resident #169. The progress note revealed that Resident #222 did not have any obvious injuries and that they would continue to monitor the resident ' s skin for changes.</p> <p>Review of the progress notes revealed that the timeline reported to the SA incident reporting system does not coincide with the timeline of the facility documentation. The progress notes indicated that the incident was first reported to the facility on [DATE] at 9:37 a.m., the SA facility-reported incident indicated that the event was not reported to the facility until April 9, 2022 at 11:00 a.m., and the APS report indicated that the event occurred on April 9, 2022 at 8:10 a.m</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility incident investigation revealed a statement from the previous DON indicating that the RN (Staff #158) was in the room when the event occurred and saw Resident #169 standing close to the resident, but was unaware that Resident #222 had been hit. The statement revealed that Resident #169 was aggressive and threatening towards staff and other residents from 7:30-9:00 a.m. The facility incident investigation also revealed a statement from the RN (Staff #158) who relayed that the resident who was found in Resident #222 's room earlier that day had been screaming and hitting her several times in the stomach. The RN pulled back the blanket and examined her stomach to find no injuries.</p> <p>Review of an undated reportable event report revealed a resident-to-resident abuse incident with law enforcement, APS, the family, and an ombudsman contacted on April 9, 2022. The report revealed that there were no witnesses to the incident, and Resident #222 was being monitored for bruising.</p> <p>Review of an outside SA report revealed that the incident was reported on April 9, 2022 at 12:06 p.m The outside SA report relayed that the incident occurred on April 9, 2022 at 8:10 a.m</p> <p>Review of the SA incident reporting system intake form revealed the facility reported the incident on April 9, 2022 at 12:29 p.m. The report relayed that Resident #222 reported to Staff #158 at 11:00 a.m. that Resident #169 hit her in the stomach multiple times. The report revealed that Resident #169 had been very aggressive and threatening to staff and residents between the hours of 7:45-9 a.m. and that Resident #169 was sent to the emergency room .</p> <p>An interview was conducted on October 22, 2024 at 12:56 p.m. with a registered nurse (RN/Staff #158), who stated that residents hitting other residents was an automatic reportable offense and should be reported immediately. The RN was unsure of the timeframe for reporting resident to resident altercations, but she thought it was 24 hours. The RN stated that on April 9, 2022, the staff were shutting all the resident doors with residents inside to keep them safe from Resident #169 and that the resident had turned a table over with patients' food on it and when they called the Assistant Director of Nursing (ADON) she could hear the screaming over the phone and directed them to call the police. The RN stated that Resident #222 reported early in the morning that the resident had hit her.</p> <p>An interview was conducted on October 22, 2024 at 2:11 p.m. with the Director of Nursing (DON/Staff#49) who stated that the timeframe for reporting allegations of abuse was within 24 hours, but they should be reporting right away. Staff #49 recalled Resident #222 and an investigation from a couple years ago, but she did not recall the details.</p> <p>An interview was conducted on October 22, 2024 at 2:48 p.m. with the Administrator (Admin/Staff#205) who stated that the timeline for reporting allegations of abuse was two hours for the state and that the facility investigation should start after that. Staff #205 stated that the facilities expectation for handling resident to resident altercations is whatever the regulation requires, and if that expectation is not followed, residents could be injured. Behaviors would continue, other residents could get involved, and any number of things could happen. She did not recall the incident and stated she was not in this role at the time.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility policy titled, Abuse, Neglect, and Exploitation, revealed that the facility should have developed and implemented written policies that prohibited and prevented abuse. The policy also revealed that abuse should have been reported to the state agency within two hours. The policy defines abuse as the willful infliction of injury, physical harm, pain or mental anguish, and it includes verbal abuse, physical abuse, and mental abuse. The policy defines physical abuse as including but not limiting hitting, slapping, punching, biting, and kicking. The policy also revealed that the facility should have identified, corrected, and intervened in situations in which abuse was more likely to occur.</p> <p>51006</p> <p>In regards to resident #223 and resident #49</p> <p>-Resident #223 was admitted on [DATE] with diagnosis of Atherosclerosis of Aorta, Schizophrenia, Unspecified, Unspecified Dementia, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, And Anxiety, Essential (Primary) Hypertension, And History of Falling. Resident #272 was discharged on [DATE].</p> <p>A review of a admission Medicare Minimum Data Set (MDS) assessment dated [DATE], revealed a BIMS (Brief Interview for Mental Status) of 12, which indicates mild cognitive impairment.</p> <p>-Resident #49 was admitted on [DATE] with the diagnoses of Syncope and Collapse, Difficulty In Walking, Not Elsewhere Classified, Muscle Weakness (Generalized), Need For Assistance With Personal Care, Anxiety Disorder, Unspecified And Essential (Primary) Hypertension.</p> <p>Review of a quarterly Medicare Minimum Data Set (MDS) assessment dated [DATE], revealed a BIMS (Brief Interview for Mental Status) of 15, which indicated no cognitive impairment.</p> <p>A review of the SA Complaint system revealed the facility reported incident was submitted on February 26, 2023 at 5:59 PM. This review revealed that a Certified Nursing Assistant (CNA) observed Resident #49 hit Resident #223.</p> <p>A review of a progress note dated February 26, 2023 and timed at 5:10 PM revealed Resident #223's involvement in the incident, indicating that the incident occurred.</p> <p>A review of a progress note dated February 26,2023 and timed at 9:55 PM revealed that Resident #49 was coughing at the dining table when Resident #223 came over and told Resident #223 to stop coughing. Resident #49 hit Resident #223 and staff separated them. Resident #223 reported they were not hurt.</p> <p>A record request was submitted on October 22, 2024 and timed at 1:03 PM to request their 5-day report and additional investigation notes for the incident that occurred on February 26, 2023. At 1:22 PM, progress notes related to an incident on February 26, 2023 were provided. During this exchange of documents, point of contact/marketing coordinator/assistant administrator (Staff #18) reported and provided a signed 807 stating that the facility does not have any additional information regarding a 5-day report or an internal investigation, in regards to the incident that occurred on February 26, 2023.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility policy titled, Abuse, Neglect, and Exploitation, revealed that the facility should have followed their developed and implemented written policies that prohibit, prevent, and investigate abuse, neglect and exploitation. The policy defines abuse as the willful infliction of injury, physical harm, pain or mental anguish, and it includes verbal abuse, physical abuse, and mental abuse. The policy defines physical abuse as including but not limiting hitting, slapping, punching, biting, and kicking. The policy also revealed that abuse should have been reported to the state agency within two hours. The policy also revealed that the facility should have identified, corrected, and intervened in situations in which abuse was more likely to occur. The policy also revealed that the administrator is to follow up with government agencies to confirm the initial report is received, and again within 5 working days of the incident to report the investigation of the incident. The policy also revealed that the facility should have provided a completed and thorough documentation of the investigation of an incident.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50553</p> <p>Based on clinical record review, staff interviews, and policies and procedures, the facility failed to ensure that a comprehensive person-centered care plan with interventions was developed for one resident (#225). This deficient practice could result in further care plan's not being updated timely in accordance with professional standards.</p> <p>Resident #225 was initially admitted to the facility on [DATE]. She was later readmitted to the facility on [DATE] with diagnoses including COPD, acute and chronic respiratory failure with hypoxia, and history of falling.</p> <p>Review of the Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS also revealed that the resident was taking an anticoagulant medication.</p> <p>Review of the comprehensive care plan, initiated August 20, 2024, revealed no focus regarding anticoagulant usage or interventions regarding anticoagulant usage.</p> <p>Review of physician orders revealed an order dated August 22, 2024 for Lovenox Injection 40mg/0.4mL once a day for deep vein thrombosis (DVT) prophylaxis.</p> <p>Review of nursing progress notes revealed an entry on September 30, 2024 which revealed that Resident #225 began vomiting coffee-ground emesis multiple times. Further review of the progress notes revealed that the resident was seen by the physician the same day as her symptoms began. The physician noted that there were concerns for possible upper gastro-intestinal (GI) bleeding, and ordered for Lovenox and Aspirin to be held.</p> <p>Review of the Treatment Administration Record (TAR) revealed that on September 30, 2024, there were no symptoms of bleeding recorded under the order to monitor for signs and symptoms of bleeding/hemorrhaging/ bruising.</p> <p>An interview was conducted on October 24, 2024 at 08:05 AM with a Registered Nurse (RN/Staff #82) who cared for resident #225 when she began showing symptoms of a possible GI bleed. Staff #82 stated that during her shift, resident #225 vomited once, and described the emesis as coffee ground emesis. She reports that she alerted the doctor and gave Zofran, which was effective to prevent further vomiting. She reported no further concern during her shift.</p> <p>Interview was conducted on October 24, 2024 at 11:41AM with the Director of Nursing (DON/Staff #49) who stated that she considered anticoagulants a high-risk medication, and expected her floor staff to monitor for symptoms of bleeding, including rectal bleeds and bruising. She stated that she did not know if the facility policy required these medications to be care-planned, but she believed it probably should be.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of facility policy titled, High Risk Medication - Anticoagulants Policy revealed that the resident's plan of care shall alert staff to monitor for adverse consequences and that the plan of care shall include interventions to minimize the risk of adverse consequences.</p>

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>51006</p> <p>Based on interviews, personnel record review, facility assessment review, and facility policies, the facility failed to ensure 2 out of 6 sampled nursing staff (staff #6 and #82) possessed the competencies and skills needed to care for residents' needs. The deficient practice could result in delayed care and inadequate care for residents.</p> <p>Findings include:</p> <p>Review of the Facility Assessment with an updated date of August 2024, stated that the staff competencies needed to care for residents would hand hygiene, infection control procedures, bloodborne pathogens and exposure, resident rights and elder justice, communicating respectfully weight the residents, prohibition of photo/audio recordings, social media, emergency preparedness, workplace violence, dietary needs and kosher restrictions, dementia &amp; Alzheimer's crisis intervention, sexual harassment, harassment and discrimination, privacy &amp; HIPAA compliance, emergency procedures and fire safety, bullying-abuse, staff sensitivity towards residents, fire safety, medication administration, medication error prevention, understanding and managing pain, ergonomics and safe lifting, fall prevention, trauma0informed care, cultural competency, dementia management, dementia &amp; Alzheimer', resident to resident aggression, understanding the elements of a compliance program, quality-care-fraud, freedom from abuse and neglect and exploitation, gift giving and accident prevention.</p> <p>-Review of the personnel record for a Registered Nurse (RN/staff #82), revealed a hire date of June 29, 2023, for full time employment. The personnel record contained no evidence on freedom from abuse, neglect and exploitation, and as well as gift giving since date of hire.</p> <p>-Review of the personnel record for a Certified Nursing Assistant (CNA/staff #6) revealed a hire date of July 7, 2023. The personnel record contained no evidence on freedom from abuse, neglect and exploitation, and as well as gift giving since date of hire.</p> <p>An interview was conducted on October 23, 2024 at 9:58 a.m., Human Resource Coordinator (Staff #119) to review staffing personnel. Staff #119 stated that the facilities expectation is to ensure that all training is completed annually, and that any staff that has not completed the training will be pulled off the schedule until they complete the training.</p> <p>During an interview conducted on October 24, 2024 at 12:31PM with the interim Director of Nursing (DON/Staff #49), Staff #49 stated that the facilities expectation is to ensure that all training is completed annually, and that any staff that has not completed the training will be pulled off the schedule until they complete the training and can provide documentation that the training has been completed.</p> <p>Review of the facility's policy regarding Continuing Education revealed that failure to complete required training in a timely manner will result in disciplinary action, which can result in being removed from the work schedule until required trainings are completed.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's policy regarding Abuse, Neglect, and Exploitation revealed that existing staff will receive annual education through planned in-services and as needed, as well as the what topics should be discussed with during the in-services.</p>

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<p>F 0743</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a resident does not develop patterns of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless unavoidable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51103</p> <p>Based on interviews, closed record review and facility policy, the facility failed to ensure a sampled resident (#219) received behavioral health services when resident reported concerns and grievances to staff for one of one sampled resident. This deficient practice can result in lasting emotional disturbance for the resident.</p> <p>Findings include,</p> <p>Resident #219</p> <p>Resident was admitted to the facility on [DATE], with the diagnoses that included rheumatoid arthritis, spinal stenosis, status post gallbladder removal, and muscle weakness.</p> <p>The admission Minimum Data Set (MDS)assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated no cognitive impairment.</p> <p>A Social Service note dated November 20, 2020 revealed She is very pleasant and cooperative towards others. She does not have a psychiatric related diagnosis. She is her own person and makes her own decisions.</p> <p>A progress note from a provider dated November 24, 2020 revealed resident statement of Oh, it's nice to meet you! I'm doing okay. I'm not having much pain right now.</p> <p>An activity progress note dated November 25, 2020 revealed resident was given an activity pack, and coloring pages. She was also happy to receive a large print mystery book to pass the time. One on one chat lasted from 1:40pm to 2:00pm.</p> <p>A provider progress note dated November 27, 2020 revealed stating to the provider I don't think I'm getting the right medications, and that I haven't had a shower since got here. Do you think I can get one soon?</p> <p>On November 27, 2020 the Daily Skilled Charting Mood Easily frustrated by other residents or small things not going as she expected.</p> <p>On December 1, 2020 Provider Progress Note resident reported to the provider I think I'd be better off at home. I don't trust the aides here. And I'm still not getting the actual Lyrica like I'm supposed to. I still haven't gotten a shower.</p> <p>I can be doing everything I need to do at home. They aren't doing anything more for me here.</p> <p>I got so upset yesterday. It was the aide's birthday yesterday, and he was on the phone all day long. No one got served drinks with their meals. I mean, what am I supposed to do?</p> <p>(continued on next page)</p>

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<p>F 0743</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On December 2, 2020 the provider progress note revealed resident stating I just can't believe the way I've been treated here. They said I was the problem. I still haven't gotten a shower. Therapy thought it would be a good idea to add weights to my legs for exercises I can't handle that!, I have so much to do when I get home. I don't even know if I'll be living at may same apartment, or if I'll have to move. I'm section 8 housing, and the new owners are taking over this month. They already said they aren't going to support section 8 housing anymore.</p> <p>In that same note the provider described the resident as she becomes tearful when starting to talk about all the issues she's had since she got to this facility and that she is also upset she still has not received a shower since admission to this facility. Also upset that she is not receiving name brand Lyrica that is ordered for her, as she suffers from side effects from generic brand. Also upset that therapy had her do exercises with weights on her legs, as she reports this exacerbates her RA symptoms. Also worried about walker being delivered to home, as she reports it will be stolen before she even gets there.</p> <p>On December 2, 2020 the Daily Skilled Charting Mood Tired of the 14 days of isolation. Wanting to go home. Feels this is making her crabby/irritable/mean.</p> <p>Review of the clinical record revealed no evidence that the facility facilitated a referral for behavioral health or social services, despite multiple points of documentation indicating it was appropriate.</p> <p>In a review of the SA incident reporting system dated December 17, 2020 revealed the resident reported ongoing incidents to the facility but they disregarded it because the alleged perpetrator (AP) has been there for a long time.</p> <p>In a written response dated October 24, 2024 at 11:10 am, MDS coordinator (Staff # 135) revealed the social worker that performed the depression screening (PHQ-9) were no longer at the facility, and are unable to get those notes.</p> <p>However, a review of the clinical record revealed no follow up with social services or behavioral health services to address those verbalized grievances.</p> <p>Requested grievance and incident reporting for the time period of November 2020 - [DATE] on October 22, 2024, however, none were received from the facility for this time period.</p> <p>In an interview conducted on October 22, 2024 with Licensed Practical Nurse (LPN)/(Staff #22) the LPN stated if she was to observe any inappropriate touching or behaviors, and/or any signs of abuse such as weird verbalizations, asking specifics, guarded behaviors, change in appetite, she would immediately collect the information and report it to the Director of Nursing. She would also make sure to separate the Alleged Perpetrator (AP) from the Alleged Victim (AV).</p> <p>On October 22, 2024 at 9:56 a.m an interview was conducted with Certified Nursing Assistant (CNA/Staff #157). The CNA stated the process for reporting suspected abuse is to immediately report concerns or suspicions to the Director of Nursing (DON) and the Administrator. The CNA stated some behaviors that would be reported included 'the resident feeling scared, upset, crying, new bruising and scratches. She further stated if a resident is acting unusually scared there has to be a reason.</p> <p>(continued on next page)</p>		

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<p>F 0743</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on October 22, 2024 at 10:20 a.m with the facility Case Manager/(Staff # 92). The case manager stated if a resident is placed on isolation, this would impact the resident psychologically, so we would make sure to check in on the resident regularly. If there is any suspicion of abuse, she would report to administration right away.</p> <p>An interview was conducted with the Assistant Director of Nursing (ADON/Staff #94) on October 23, 2024 at 8:24 a.m. The ADON stated the facility process includes contacting social services, the ADON and DON, and the administrator. A couple of months ago we reported also to the ombudsmen, county, policy, provider, behavioral health and the state. She further stated we are given a two-hour window to begin investigation and get a statement from the resident.</p> <p>In an interview conducted on October 23, 2024 at 11:28 a.m. with Registered Nurse (RN)/Staff #82 stated that abuse is reported in the Point Care Click (PCC) system under risk management and open an incident report. We then choose the category of that the incident is about, for example bruising. In regards to reporting the incident, the RN stated letting the provider, DON, administrator, family representative (if appropriate) immediately and no more than 2 hours. She further stated if abuse is suspected, that person is typically suspended. The RN was asked if the abuse was not reported what would be the risk if abuse is not reported and there are no interventions done following an incident?. The RN responded the abuse would continue to the resident. The abuse can affect the resident's health, causing the resident depression and fear. Also, if the abuse continues, they can go on to hurt more residents.</p> <p>In an interview with the medical director (MD/staff #209) the DON (DON/staff #49), and the (ADON/staff #94) on October 2024 beginning at approximately 10 a.m., the marketing coordinator stated she would be surprised if any concerns of abuse were not followed up on. She further stated signs they staff know to look for include emotional changes, verbalized concerns, body language, and the nurse would also conduct a skin examination if necessary. In addition, the AP would be suspended pending the outcome of the investigation. The medical director stated they would expect their providers to report matters of concern to the facility. The medical director feels a better job could have been done documenting and they could have done a better job of documenting any facility complaints. He stated he will follow this up and provide further education to his staff.</p> <p>A Policy titled Abuse Neglect and Exploitation defined mistreatment as inappropriate treatment or exploitation of a resident.</p> <p>A policy titled Promoting/Maintaining Resident Dignity revealed that when interviews are conducted, the results will be documented and care plans will be revised if appropriate.</p> <p>A policy titled Notification of Changes revealed clinical complications include the onset of depression. The facility should inform the resident, and consult the physician.</p>		