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	03/19/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47911 Based on a closed clinical record review, interviews, facility documentation, and review of facility policy, the facility failed to ensure that abnormal respiratory rates for resident #7 were monitored and that a change in condition was relayed to the physician. The deficient practice could result in resident injury if abnormal vitals are neglected. Findings include: Resident #7 was admitted on [DATE] with diagnosis including chronic obstructive pulmonary disease, atrial fibrillation, obstructive sleep apnea, scoliosis, kyphosis-cervical region, heart failure, asthma, type 2 diabetes, morbid obesity, muscle weakness and reduced mobility. It was noted that the resident died on [DATE] while at the facility. A review of the admission MDS (minimum data set) dated [DATE] revealed a BIMS (brief interview of mental status) score of 15. The MDS further revealed no evidence of delirium, psychosis or behaviors. An admit summary note on [DATE] revealed that the resident had been admitted to Banner hospital for shortness of breath, congestive heart failure exacerbation. A provider visit note dated [DATE] revealed that the resident was being admitted for strengthening therapies post hospitalization for sepsis, pneumonia and heart failure. A progress note entry on [DATE] revealed that the resident was at 92% for oxygen saturation on room air while at rest. It was further noted that the resident was alert but was making claims of abnormal readings on her personal pulsometer. A review of the resident's vital signs revealed a respiratory rate of 28 breaths per minute on [DATE] at 07:37A.M. and at 3:12 P.M. The electronic health record further revealed triggered warnings, noting that the reading was high and exceeded 25. A further review of the resident's record revealed no evidence that the physician was notified of the respiratory rate. A telephone call was placed to LPN (licensed practical nurse, staff #101) on [DATE] at 10:56 A.M. -a message was left on voicemail requesting a call back; however, no return call was received. (continued on next page)

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

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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A telephone call was placed to LPN, staff #73 on [DATE] at 10:58 A.M.-a message was left on the voicemail requesting a call back. No return call was received. An interview was conducted on [DATE] at 11:36 A.M. with RN (registered nurse, staff # 3). Staff #3 stated that she was not there when the resident had passed away, but stated that she knew the resident would refuse to wear her CPAP (continuous positive airway pressure) and was on oxygen during the day. An interview was conducted on [DATE] at 12:31 P.M. with CNA (certified nursing assistant, staff #22). The CNA stated that respiratory rate is checked as part of the vitals. The CNA further stated that respirations outside of ,d+[DATE] per minute would require notification to the nurse on duty. She stated that a reading of 28 respirations per minute would be considered abnormal and would require the nurse to be notified. An interview was conducted on [DATE] at 12:33 P.M. with RN, staff #3. The RN stated that a normal respiratory rate is generally between ,d+[DATE] breaths per minute. Staff #3 stated that if it is outside of the normal range, it should be re-checked. If the re-check was still abnormal, the provider should be notified. Staff #3 reviewed the residents medical record and stated that she did not see evidence of documentation that the abnormal respiratory rate was communicated to the provider. An interview was conducted on [DATE] at 2:01 P.M. with DON (director of nursing, staff #10). The DON stated that normal respiration would fall between ,d+[DATE]. She stated that above 24 or lower than 14 would require physician notification. Staff #10 stated that the expectation for the procedure would be as follows, the CNA would notify the nurse if the respiratory readings were abnormal and the nurse would then notify the doctor. She stated that her expectation would be that the physician notification would be documented in the electronic health record. Staff #10 reviewed the record for resident #7 and stated that the respiratory rate was out of parameters twice on [DATE] and that physician notification should have taken place. She stated that there was no indication in the electronic health record that the physician had been notified. Staff #10 stated that the risk to the resident could be increased anxiety and a potential for hospitalization . A review of the facility policy entitled Notification of Changes Policy updated on October, 2024 revealed that the purpose of the policy is to ensure the facility promptly informs the resident, consults the resident's physician and notifies, consistent with his/ her authority, the resident's representation when there is a change requiring notification. The policy further states that circumstances requiring notification include a significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status The policy titled Abuse, Neglect and Exploitation updated on [DATE] included the definition of Neglect which states that Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The policy included prevention of abuse, neglect and exploitation which stated the facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property and exploitation that achieves the identification, ongoing assessment, care planning for appropriate interventions, monitoring of residents with needs and behaviors which might lead to conflict or neglect.