

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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51006</p> <p>Based on clinical record review, staff interviews, and the facilities policy, the facility failed to ensure one resident (resident #2) was informed of the risks and benefits of and had consented to the usage of a psychotropic medication. This deficient practice could result in further violations of resident rights.</p> <p>Findings include:</p> <p>Resident #2 was admitted to the facility on [DATE] with the diagnosis that included Schizoaffective Disorder, Bipolar Type Major Depressive Disorder, Recurrent, Unspecified; Unspecified Dementia, Psychotic Disturbance, Mood Disturbance, Anxiety, Unspecified Psychosis, and Bipolar Disorder.</p> <p>A Minimum Data Set (MDS) assessment dated [DATE], revealed the resident had a BIMS (Brief Interview for Mental Status) score of 14, which indicated the resident had no cognitive impairment.</p> <p>A physician's order dated April 17, 2024, revealed an order for Sertraline 200mg (milligrams) by mouth one time a day for depression.</p> <p>Review of the Medication Administration Record (MAR) for April 2024 through October 2024 revealed the resident was administered Sertraline per the physician's orders.</p> <p>A consent for use of psychoactive medications dated July 13, 2024, revealed signature provided by the resident, however, the boxes indicating consent by checking either I do or I do not. were left blank.</p> <p>However, continued review of the clinical record revealed no evidence the resident had been informed of the risks and benefits of and consented to the usage of Sertraline.</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 medication consents should be signed on admission, and then again during their treatment if the medication was added to their regime, prior to the usage of the medication, as the risk of a resident taking psychotropic medications prior to the usage of the medication is going against the resident's right to know and provide permission to take the medication. Staff #49 further stated that a signed consent for use of psychotropic medications, signed prior to the admission of the medication, could not be located for Resident #2.</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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's policy titled, 'Use of Psychotropic Medication Policy' included, Residents and/or representatives shall be educated on the risks and benefits of psychotropic drug use, as well as alternative treatments/non-pharmacological interventions.</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>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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>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>(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>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>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>(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 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51006</p> <p>Based on clinical record review and staff interviews, the facility failed to ensure one Resident (#2) with a diagnosis of a serious mental illness was referred to the appropriate state-designated mental health or intellectual disability authority for review. The deficient practice could result in necessary specialized services not being provided in accordance with professional standards.</p> <p>Findings include:</p> <p>Resident #2 was admitted to the facility on [DATE] with the diagnosis that included Schizoaffective Disorder, Major Depressive Disorder, Dementia, Psychotic Disturbance, Mood Disturbance, anxiety, psychosis, Bipolar Disorder with Psychotic Features.</p> <p>A Minimum Data Set (MDS) assessment dated [DATE], revealed the resident had a BIMS (Brief Interview for Mental Status) score of 14, which indicated the resident had no cognitive impairment</p> <p>A physician's order dated April 1, 2024, revealed an order for Seroquel 100mg (milligrams) by mouth one time at bedtime for bipolar disorder.</p> <p>A physician's order dated April 1, 2024, revealed an order for Seroquel 50mg by mouth one time a day for bipolar disorder.</p> <p>A physician's order dated April 17, 2024, revealed an order for Sertraline 200mg by mouth one time a day for depression.</p> <p>A physician's order dated October 8, 2024, revealed an order for Depakote 500mg by mouth three time a day for bipolar disorder.</p> <p>Further review of Resident #2's chart revealed no evidence that a Pre-Admission Screening and Resident Review (PASARR) Level 1 screening had been completed.</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 PASARR's should be completed as soon as possible and at that time of admission. Staff #49 stated that to the best of t heir knowledge, the expectation is that the PASARR is completed before being admitted to a facility. Staff #49 reported that there is no consistency with PASARR completion and that to the best of her knowledge, they should be done by social services.</p> <p>In regards to Resident #2's PASARR screening provided by the facility on October 24, 2024 during the interview mention above, this document revealed that staff #49 signed the document on the date of October 24, 2024. Following the review of the document, Staff #49 stated, oh wow that is my signature, well I guess I reviewed this PASARR. Staff #49 stated that their determination was based off of the resident's medical history and notes, and that the PASARR screening could have been completed sooner as it does not meet the facilities expectations, stating that the potential risks is inappropriate monitoring of Resident #2's medication and behavior.</p> <p>(continued on next page)</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's policy titled, 'Resident Assessment - Coordination with PASARR Program' revealed that any resident who had not been screened will be screened by the facility within 40 calendar days of admission, using the state's Level 1 Screening Tool for evaluation and determination of a Level II screening. This policy revealed that a record of the pre-screening should have been in the resident's medical record.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50553</p> <p>Based on clinical record review, staff and resident interviews, and observation of current facility practice, the facility failed to ensure nutritional status was assessed and managed in accordance with facility policy for one resident (#60). The deficient practice could result in a decline in nutritional status being missed and untreated for other residents.</p> <p>Resident #60 was admitted to the facility on [DATE] with diagnoses including major depressive disorder, muscle weakness (generalized), and essential hypertension.</p> <p>Review of the Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident had no cognitive impairments. The MDS also revealed the resident had no issues with swallowing or chewing food, and no weight loss or weight gain had been noted.</p> <p>Review of the care plan, initiated July 3, 2024, revealed a focus that the resident had nutritional risk related to abdominal aortic aneurysm, depression, HTN, and adult malnutrition score 7. Interventions for this area of focus included to obtain weights as ordered.</p> <p>Review of the mini nutritional assessment (MNA) dated July 1, 2024 revealed a score of 7, indicating the resident was malnourished at the time of the assessment.</p> <p>Review of physician orders revealed an order dated July 1, 2024 to weigh the resident weekly for 4 weeks. Further review of physician orders revealed another order dated July 7, 2024 instructing staff to weigh the resident monthly. Additionally, several orders to re-weigh the resident were noted in August 2024 and September 2024.</p> <p>Review of weights revealed that the resident had weighed 145 pounds on July 1, 2024 when first admitted to the facility. A second weight was obtained on July 7, 2024, revealing another weight of 145 pounds. However, further review of the clinical record revealed no further weight readings obtained for resident #60.</p> <p>Review of the Multidisciplinary Conference dated October 3, 2024 revealed dietary notes, including a statement of no new weights since July 5, 2024.</p> <p>An interview was conducted with resident #60 on October 21, 2024 at 11:56a.m. who reports that he believed he had lost a lot of weight while being a resident at the facility.</p> <p>An interview was conducted on October 24, 2024 at 8:05a.m. with a Registered Nurse (RN/Staff #82) who stated that residents are weighed monthly by Certified Nursing Assistants (CNA), and they are recorded in the electronic health record (EHR).</p> <p>(continued on next page)</p>

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<p>F 0692</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 24, 2024 at 11:41 a.m. with the Director of Nursing (DON/Staff #49) and Assistant Administrator/Marketing Coordinator (Staff #18). Staff #18 stated that residents are weighed at least monthly and according to physician orders. The DON elaborated that Certified Nursing Assistants (CNAs) should chart the weights in the EHR, and she would expect to see at least monthly weights recorded.</p> <p>Review of the facility policy titled Weight Monitoring Policy indicates that newly admitted residents should have weights checked weekly for 4 weeks. The policy states residents with weight loss should have weekly weights completed. This policy also indicates that all other residents should have monthly weights obtained.</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51159</p> <p>Based on clinical record review, staff interviews and facility documentation, the facility failed to ensure one resident (# 32) received dialysis care consistent with professional standards. This deficient practice could result in residents not being provided with necessary treatment in accordance with professional standards.</p> <p>Findings include:</p> <p>Resident #32 was admitted on [DATE] with diagnoses including stage 4 chronic kidney disease, dependence on renal dialysis, respiratory failure, and type 1 diabetes.</p> <p>A Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. Active diagnoses included renal insufficiency or end-stage renal disease (ESRD), and dependence on renal dialysis.</p> <p>A Care plan dated February 13, 2024, revealed that the resident needs dialysis for renal failure and interventions included: to monitor/document/report for any signs/symptoms of infection to the access site.</p> <p>Review of physician orders revealed no evidence of an order for dialysis care and treatment, including the name of the dialysis facility and days to receive dialysis.</p> <p>Further review of the physician's order revealed an order dated February 13, 2024 to weigh resident after dialysis every Monday/Wednesday/Friday.</p> <p>However, the MDS assessment revealed no evidence that the resident received hemodialysis on admission, or while a resident at this facility.</p> <p>Review of a post-dialysis form sent back with the resident after dialysis dated October 11, 2024 revealed:</p> <p>- Resident for Dialysis Follow-up Instructions for Health Care Institutions, included that the dialysis access site should be observed every 30 minutes for 4 hours, any change in condition should be reported to the dialysis facility, and for palpation for thrill and bruit of access site every 8 hours.</p> <p>However, further review of the clinical records revealed no evidence of assessment/monitoring of the access site after dialysis every 4 hours, or palpation for thrill and every 8 hours.</p> <p>(continued on next page)</p>		

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<p>F 0698</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 24, 2024 at 09:27 AM with Registered Nurse (RN/Staff #82), who stated that the facility process is to receive physician orders for dialysis, to check the dialysis access site, and to follow the dialysis post-care instructions. She also stated that if they do not have physician orders to send a resident for dialysis, the facility would not know that a resident is supposed to receive dialysis treatment. The RN stated that residents receiving dialysis should have their vitals checked before leaving the facility and they should be recorded in the vital signs section of the clinical record. She also stated that dialysis access site assessments should be completed before and after dialysis, and be documented on nursing progress notes. The RN reviewed the clinical record and stated there were no physicians orders for dialysis, and no evidence that the access site was assessed pre/post dialysis. The RN further stated that any instructions received from the dialysis center regarding post care treatment orders should be followed. The RN reviewed the nursing progress notes and stated that there was no evidence in the record regarding the resident's dialysis, including the time he was picked up for transport, when he returned or assessments of the dialysis access site pre or post dialysis. The RN further reviewed the clinical record and confirmed the Dialysis Follow-up Instructions for Health Care Institutions were received on October 11, 2024. She further stated that the post dialysis instructions had not been followed, and that this did not meet the facility expectations. She further stated that the risk of sending out a resident for dialysis without order could result in treatment without orders.</p> <p>An interview was conducted on October 24, 2024 at 01:39 PM with the Director of Nursing (DON/staff #49) who stated she would expect there be physician orders for a resident to be sent out for dialysis care/treatment, and that dialysis sites be assessed post dialysis. The DON reviewed the clinical record and stated that there was no evidence of post dialysis notes or physician orders for dialysis. She further stated that the risk of not assessing residents post dialysis could result in the resident bleeding out.</p> <p>A request was made for the facility's dialysis care and treatment policy on October 24, 2024. However the facility did not provide a policy, and wrote on the request form that there was no policy in regards to dialysis care and treatment.</p> <p>Review of the facility policy titled, Comprehensive Care Plans, included that it is the facility policy to develop and implement a comprehensive care plan ofr each resident to meet a resident's medical needs. The policy revealed the care plan objectives will be utilized to monitor the resident's progress and will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. Qualified staff are responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions.</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 & Alzheimer's crisis intervention, sexual harassment, harassment and discrimination, privacy & 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 & 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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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NAME OF PROVIDER OR SUPPLIER Handmaker Home for the Aging		STREET ADDRESS, CITY, STATE, ZIP CODE 2221 North Rosemont Boulevard Tucson, AZ 85712	
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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>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51159</p> <p>Based on clinical record review, facility documentation, staff interview, policy review, the facility failed to ensure to include procedures that medication were recorded accurate to professional standard of care.</p> <p>During an observation on October 14, 2024 at 7:25AM on Unit [NAME] medication cart the Narcotic Count Sheet sheet revealed that there were days where Out-Going Nurse signature was missing with an In-coming nurse signature missing. The record was not recorded properly in the the following days for:</p> <p>September 5, 2024 at 10:00 PM - 06:00 AM</p> <p>September 6, 2024 at 10:00 PM - 6:00 AM</p> <p>October 22, 2024 at 10:00 PM - 6:00 AM</p> <p>October 24, 2024 at 2:00 PM - 10:00 PM</p> <p>October 24.2024 at 10:00 PM - 6:00 AM</p> <p>An interview was conducted on October 14, 2024 at 7:25AM with Licensed Practical Nurse (LPN/Staff # 76). The LPN stated that when administering narcotics one nurse will sign as out-going Nurse and the other nurse will sign as In-coming Nurse. (LPN/ Staff #76) stated that medications were not recorded properly for the above listed days. The LPN concluded that medication not recorded properly would not follow the facility expectations.</p> <p>An interview was conducted on October 24, 2024 at 1:07 PM with the DON (DON/staff #49) The DON stated the expectation is there should be one nurse sign in as Out- Going nurse and a second nurse would sign in as In-Coming Nurse this would be done together . The DON also stated that the two nurses would count the medication together. The DON concluded that the risk of medication not being accurately recorded is that there would be no proof that medication was counted.</p> <p>Review of a facility policy titled Medication Administration stated that for controlled substances they are signed the narcotic book.</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51103</p> <p>Based on clinical record review, interviews, and review of policies and procedures, the facility failed to reduce or discontinue anticoagulant therapy for Resident #325 in the presence of adverse consequences. This deficient practice can result in harm related to unnecessary medications.</p> <p>Findings include:</p> <p>-Resident #325 was admitted to the facility October 16, 2024, with the diagnoses of atrial fibrillation with thrombophilia (low platelet count), a history of colon cancer, and muscle weakness.</p> <p>According to the admission Minimum Data Set (MDS), dated [DATE] resident scored 15 on the Brief Interview Mental Status (BIMS) suggested resident was cognitively intact.</p> <p>A physician's order was written on October 16, 2024 to report to provider if signs and symptoms of bleeding, hemorrhage, or bruising occurred.</p> <p>A progress note dated October 19, 2024 stated dark stools were noted in toilet that day at 21:00. However, the morning and evening doses of Apixaban were given on the following day October 20, 2024, despite the abnormal finding.</p> <p>The provider progress note dated October 21, 2024 at 09:48 ordered to hold the Apixaban due to the dark stools, and to consult with the inhouse gastroenterologist.</p> <p>In a nurse progress noted dated October 21, 2024, at 10:32 the resident reported to nurse that she was having dark stools all week, and believed she had a bleed. The nurse collected a hemocult with a positive result. The nurse in addition notified the DON and provider. The afternoon dose of Apixaban was held on October 21, 2024.</p> <p>The medication administration record (MAR) on October 22, 2024, revealed the morning dose was refused by the resident, and the second dose was withheld at 19:28 due to a dark stool issue that same day. On October 23, 2024, the MAR revealed the morning dose of Apixaban 5 mg was given.</p> <p>An interview was conducted with Resident #325 on October 21, 2024 at 9:25 a.m. The resident stated she is a retired Registered Nurse and that she has been having some dark stools the past couple of days. She stated she informed the nurse, so they are supposed to get back to her after they talk to the provider about holding the Apixaban. The resident is nervous about her stools because she had a gastrointestinal (GI) bleed in the past.</p> <p>On October 22, 2024 at 9:00 a.m. an interview was conducted with a Certified Nursing Assistant (CNA/Staff #157) The CNA stated they been employed at facility for three years. The CNA stated when a resident is on a blood thinner, it is the CNA's responsibility to monitor for signs of abnormal bleeding with includes looking for abnormal bruising. They also make sure to check bowel movements for signs of bleeding like darkness, and odor. She further stated if the CNA has any concerns of abnormal bleeding, they will immediately report findings to the nurse.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview conducted with Licensed Practical Nurse (LPN/Staff #122) On October 22, 2024 at 9:30 am. The LPN stated direct care staff look for signs of bleeding such as tarry stools, bruising, and resident reports. She further stated a resident history of gastrointestinal bleed on anticoagulant is monitored closely. Any positive findings are then reported to the provider and DON. Typically, they will perform a stool sample test for blood, do a blood count, and follow any additional orders.</p> <p>An additional interview with Resident #325 on October 22, 2024 at approximately 11:40 a.m., resident stated she refused medication due to fear that she is having a GI bleed again because of the way her bowel movements looked. Resident further stated they are looking into this.</p> <p>In an interview conducted with the Director of Nursing (DON/Staff #49) on October 23, 2024 at 1:00 p.m., The DON stated that when stools are dark the physician is to be contacted especially if a resident is on blood thinners. She further elaborated that blood thinner therapy you look for things like bruising and bleeding. Upon chart review, DON unable to locate any evidence DON and provider were contacted regarding stools in toilet on October 19, 2024 and states per protocol the provider should have been contacted for further Apixaban orders. The DON acknowledged correct facility procedure on October 21, 2024. However the order could have been written a little clearer. The DON was also unable to locate any documentation for the Apixaban restart on October 23, 2024 to show if provider was aware or approved.</p> <p>A telephone interview with the facility contracted Pharmacist (Staff #206) on October 24, 2024 at 12:34 p.m. The Pharmacist revealed that giving an anticoagulant such as Apixaban to a resident that reports dark stools is a red flag. The pharmacist stated when that occurs the physician should have been contacted. He further stated in regards to the increased bleeding risk for a resident taking both Apixaban and Fluoxetine is a risk/benefit analysis approved by the provider.</p> <p>In a policy entitled High Risk Medications-Anticoagulants Policy, the staff should monitor for risks associated with anticoagulants include bleeding and hemorrhaging for efficacy and safety.</p> <p>In a policy entitled Medication Administration Policy, administering staff is instructed to report and document any adverse side effects or refusals.</p> <p>In a policy entitled Notification of Changes Policy, circumstances that require a need to alter treatment require notification.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51159</p> <p>Based on observations, clinical record review, staff interview, and policy review, the facility failed to ensure the medication error rate did not exceed 5%. The medication error rate was 6.9%. The deficient practice could result in additional medication errors.</p> <p>Finding include:</p> <p>-Resident #32 was admitted on [DATE] with diagnoses including stage 4 chronic kidney disease, respiratory failure, and type 1 diabetes.</p> <p>The Minimum Data Set assessment dated [DATE] revealed a Briefs Interview for Mental Status (BIMS) score of 14, which indicated intact cognition.</p> <p>A care plan initiated on September 09, 2024 revealed a focus for Diabetes Mellitus Type 1 with interventions for diabetes medication as ordered by doctors, and to monitor and document for side effects and effectiveness.</p> <p>A Physician's orders dated August 31, 2024 for Insulin Lispro Injection solution given based on the sliding scale. 60-199= 0 Units, Nofity MD if FSBS is less than 60, 200-249= 2 Units , 250 - 299= 4 Units, 300- 249= 6 Units, 350-400= 8 Units, 401-450 = 10 Units, Notify provider for blood glucose over 451, subcutaneously before meals and at bedtime for diabetes mellitus type 2.</p> <p>During a medication admission observation conducted on October 22, 2024 at 12:11 p.m. with Registered Nurse (RN/staff #112) . The RN was observed administering 3 units of insulin Lispro injection to resident # 32. (RN/ Staff#112) was then observed to document in the on progress notes that the resident received 3 units of insulin lispro.</p> <p>An interview was conducted on October 22, 2024 at 12:11PM with the Registered Nurse (RN/ Staff #112) The RN stated that she should have administered the resident 8 units but she administered 3 units.</p> <p>An telephonic interview was conducted on October 23, 2024 at 9:29AM with Doctor of Medicine (MD/Staff #207) The MD stated that he was not aware that this resident was given 3 units of insulin on October 22, 2024. The MD further stated the expectation for medication should follow written orders.</p> <p>An additional interview was conducted on October 23, 2024 at 10:15AM with the Registered Nurse (RN/staff #112) who stated the facility policy is to follow physician orders. She stated the October 2024 Medication Administration Record (MAR) and Treatment Administration Record (TAR) for this order you will follow the sling scale. The RN stated that during the time of this medication administration the resident blood sugar was 389. The RN further stated that she did not call the provider before administrating resident with 3 units instead of 8 units. The RN (Staff #112) stated the risk of not administering insulin as ordered could result in increased blood sugar, and would be a medication error.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Resident # 422 was admitted to the facility on [DATE] with a diagnosis that included Idiopathic Gout, Hypothyroidism, and major depressive disorder.</p> <p>A review of the Physician order dated on October 18, 2024 revealed an order for Carvedilol Oral Tablet 6.25mg (Milligrams).</p> <p>A review of the Medication Administration Record revealed a discontinued order of Carvedilol Oral Tablet 12.5mg.</p> <p>During a medication administration conducted on October 23,2024 at 7:41am with an Licensed Practical Nurse (LPN/staff #111) The LPN (licensed Practical Nurse) administered one capsule 12.5mg Carvedilol for resident #422.</p> <p>An interview was conducted on October 23, 2024 at 10:32AM with the Licensed Practical Nurse (LPN/staff #111) The LPN stated that the facility process when giving medication is to follow the physicians orders. The LPN stated that resident # 422 blood pressure was 173/71 when administering Carvedilol Oral Tablet 12.5mg. The LPN further stated the medication that should have been administered to resident #422 and should have administered Carvedilol Oral Tablet 6.25mg. The LPN stated that she did not look at the date for when administering Carvedilol Oral Tablet 12.5mg. The LPN stated that she will monitor residents and let the doctor know about this. The LPN stated that this medication should have been taken off the cart and put in the med storage room. The LPN concluded that the risk of this would be an overdose.</p> <p>A Medication Error Report was completed by the facility in regards to staff #111 administrating Carvedilol Oral Tablet 12.5 mg to resident #422.</p> <p>An interview was conducted on October 24, 2024 at 01:07 PM with the Director of Nursing (DON/Staff #49). The DON stated that the facility process is to follow physician's orders as written. The DON stated they would expected that a call was made to the provider about resident #32 medication administration. The DON stated that the risk for residents can cause high blood pressure. The DON concluded that when staff administered residents with the wrong dosage that would not meet with facility expectations.</p> <p>A Review of the facility policy titled Medication Administration revealed that medication administration must be for the right resident, right dosage, right drug, right route, right documentation, and right time.</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51159</p> <p>Based on observation, record review, staff interview, and review of policy and procedures the facility failed to ensure that one of one sampled residents (#32) was free from significant medication errors. The deficient practice could result in residents receiving unnecessary medication.</p> <p>Findings include:</p> <ul style="list-style-type: none"> -Resident #32 was admitted on [DATE] with diagnoses including stage 4 chronic kidney disease, respiratory failure, and type 1 diabetes. <p>A quarterly Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated no cognitive impairment.</p> <p>A care plan initiated on September 09, 2024 revealed a focus for Diabetes Mellitus Type 1 with interventions that included to administer diabetes medication as ordered, and to monitor and document for side effects and effectiveness.</p> <p>A Physician's order dated August 31, 2024 for Insulin Lispro Injection solution as per sliding scale.</p> <ul style="list-style-type: none"> -If 60-199= 0 Units, Notify MD if FSBS is less than 60, -200-249= 2 Units -250 - 299= 4 Units -300- 249= 6 Units -350-400= 8 Units -401-450 = 10 Units <p>-Notify provider for blood glucose over 451, subcutaneously before meals and at bedtime for DM2.</p> <p>During a medication administration observation conducted on October 22, 2024 at 12:11 p.m. with a Registered Nurse (RN/staff #112), the RN was observed to administer 3 units of insulin Lispro injection to Resident #32. The RN was then observed to document on a progress notes that resident received 3 units of insulin lispro.</p> <p>Review of the October Medication Administration Record (MAR) dated October 22, 2024, revealed the resident's blood sugar was 398 at 11:30 a.m, and further revealed the resident received 8 units of insulin Lispro.</p> <p>Review of the clinical record revealed no evidence that the physician was informed that the resident received 3 units of Lispro Insulin rather than the ordered 8 units.</p> <p>(continued on next page)</p>		

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<p>F 0760</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 12:11PM with a Registered Nurse (RN/Staff #112). The RN stated that she should have administered the resident 8 units but the resident requested 3 units and that is what she administered. The RN also stated that it is up to the resident to decide how many units of insulin he wanted, and that the provider is aware of this.</p> <p>An telephonic interview was conducted on October 23, 2024 at 9:29AM with the resident's physician (MD/Staff #207), who stated that he was not aware that Resident #32 was administered 3 units of Lispro insulin on October 22, 2024. He also stated that resident's can refuse medications, but the cannot decide the dosage that they receive. The physician further stated that he expected that medications be administered following the physician orders as written.</p> <p>An additional interview was conducted with the Registered Nurse (RN/staff #112) on October 23, 2024 at 10:15a.m., who stated the facility policy is to follow physician orders as written, including parameters. The RN stated that any medications administered outside of the order should be documented in the clinical record that included the time, date, resident and the physician's response. She further stated that it is important to document in the MAR accurately, including the dose administered. She reviewed the clinical record and stated that Lispro insulin orders for Resident #32 are based on a sliding scale, and that she documented on October 22, 2024 that she administered 8 units of Lispro Insulin and that was not accurate. She also stated that when a resident refused a medication she would call the provider for a change in orders. The RN further stated that on October 22, 2024 during medication administration, the resident's blood sugar was 389, and that she should have administered 8 units of Lispro Insulin per physician orders. The RN stated that she administered 3 units of Lispro Insulin, and that she did not call the provider before administering the 3 units, outside of the ordered parameters. The RN stated that this was her fault and that she did not follow the policy. The RN stated the risk of not administering insulin as order could result in increased blood sugars, the provider would not be aware, and that it would also be considered a medication error.</p> <p>An interview was conducted on October 24, 2024 at 01:07 PM with the Director of Nursing (DON/Staff #49), who stated that the facility process is to follow physician's orders as written. The DON further stated that she would expect the physician to be notified when a medication is administered outside of the order, and that it would be written in progress notes. The DON stated that it did not meet the facility policy to administer the wrong dose of insulin, and did not follow physician orders. The DON concluded that the risk for not administering insulin as ordered could result in high blood glucose.</p> <p>Review of the facility policy titled, Timely Administration of Insulin, revealed that all insulin will be administered in accordance with physician's orders. Prepare insulin doce, and before administering insulin, perform two nurse verification of correct resident, dose calculations, and correct rout of administration. Document on the medication administration record the time and location of the insulin injection.</p> <p>Review of the facility policy titled, Medication Administration Policy, revealed that medications are administered as ordered by the physician and in accordance with professional standards of practice. Ensure the six rights of administration are followed including right dosage.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51159</p> <p>Based on observations, staff interviews, and policy review, the facility failed to properly discard expired medication in the medication room. this deficient practice could result in expired medication to be administered to residents against professional standards.</p> <p>During a medication admission observation conducted on [DATE] at 7:10a.m. with Registered Nurse (RN/Staff #64), a controlled substance (Lyrica) had an unseal capsule taped behind the medication blister pack. The RN stated that it is not part of the facility best practice to have taped medication behind the medication blister pack during this observation.</p> <p>A follow up interview was conducted on [DATE] at 10:48 a.m with the Registered Nurse (RN/Staff #64) who stated that the risk of having medication taped back onto the blister pack can contaminate the medication. The RN also stated that it is not part of the facility process to have medication taped back onto the medication blister pack.</p> <p>During an Observation on [DATE] at 12:31PM with Registered Nurse (RN/Staff #82) in the Unit Rich medication room there were four expired 0.9% Sodium Chloride Injection USP 100ml bags noted.</p> <p>One out of Four 0.9% Sodium Chloride Injection USP 100ml bags revealed a used by date of [DATE]</p> <p>Three out of Four 0.9% Sodium Chloride Injection USP 100ml revealed a used by date of [DATE]</p> <p>The RN stated that these medications should have been discarded.</p> <p>An interview was conducted on [DATE] at 01:07 PM with the Director of Nursing (DON/Staff #49). The DON stated the controlled substance (Lyrica) should have been wasted. The DON stated it does not meet with the facility expectation to have medication tape on the back of the medication blister packs. The DON stated that over the counter medication would be sent back to the pharmacy. The DON stated that staff should get rid of expired medication. (DON/Staff #49) stated that risk of not discarding the medications could lead to medication to alter the action of the medication.</p> <p>The facility policy titled Storage of Medication Requiring refrigeration policy revealed that Temperature to be monitored daily to ensure proper temperature control and document on temperature log with date, time, and signature of person performing the check clearly written and Remove any expired medication from active stock and discard medication according to facility policy. The facility policy titled Storage of Medication Requiring Refrigeration policy revealed that the facility must provide safe and effective storage of all drugs</p>		

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NAME OF PROVIDER OR SUPPLIER Handmaker Home for the Aging		STREET ADDRESS, CITY, STATE, ZIP CODE 2221 North Rosemont Boulevard Tucson, AZ 85712	
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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p>51159</p> <p>Based on clinical record review, facility documentation, staff interview, policy review, the facility failed to ensure that glucometer controls were consistently completed.</p> <p>During an observation on October 23, 2024 at 12:41 p.m. with Registered Nurse (RN/staff #82) on Unit Rich with medication Cart 2 the Quality Control Record sheet had revealed that glucometer controls were not consistently completed.</p> <p>An interview was conducted on October 23, 2024 at 1:00 p.m. with the Assistant Director of Nursing (ADON/Staff #94). The ADON stated that glucometer quality controls were not consistently completed.</p> <p>An Interview was conducted on October 23, 2024 at 1:02 p.m. with the a Register Nurse (RN/Staff#112) The RN stated that the glucometer controls were not consistently completed on the following days in September 2024: 14,15,19,21,22, 26,27,28 and 29. The RN also stated glucometer controls were not consistently completed on the following days in August 2024: 1, 2, 11,25 and 31. The RN also stated glucometer controls were not completed on the following days in October 2024: 4,5,6,9,10,11,12, 13, 17,18 and 19. The RN stated that the risk of glucometer controls not being completed would not meet with the facility expectation.</p> <p>An interview was conducted on October 24, 2024 at 7:25AM with Licensed Practical Nurse (LPN/Staff #76) stated that the facility expectation would be to complete the glucomer controls. The LPN further stated the risk of lucometer controls not being completed would result in glucometers not registering properly.</p> <p>An interview was conducted on October 24, 2024 at 1:07 PM with the Director of Nursing (DON/Staff #49) The DON stated that glucometers controls are checked by night staff, and that when Glucometer controls are not completed the risk would cause inaccurate reading.</p> <p>The facility had provided a manual of the glucometers used in the facility that stated there is a 24-hour quality control reminder feature on the glucometers. When glucometer quality control is not tested there would be an icon flashing on the glucometer as a reminder.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50166</p> <p>Based on observations, staff interviews, and policy review, the facility failed to ensure that food was stored under sanitary conditions that maintained freshness in the kitchen and nourishment refrigerators. The deficient practice could result in potential foodborne illness.</p> <p>Findings include:</p> <p>On [DATE] at 10:47 a.m. the initial tour of the kitchen was conducted with the Food Services Director (FSD/Staff#109) and the Food Services Assistant Manager (FSAM/Staff#181).</p> <p>During the tour of the large walk-in refrigerator and secondary walk-in fridge, the following food items were observed to be beyond their use by dates:</p> <ul style="list-style-type: none"> -Six Gold's Horseradish sauces with a factory expiration label of [DATE]. -One block of swiss cheese labeled [DATE] to [DATE]. <p>During the initial tour of the large walk-in and secondary refrigerators on [DATE], the following items were opened and not dated or labeled according to when they were opened or expected to be discarded:</p> <ul style="list-style-type: none"> -One salsa container -One apple juice package -One sour cream container <p>Observation of the four nourishment refrigerators on the units on [DATE] revealed the following food items were beyond their use by dates:</p> <ul style="list-style-type: none"> -One sugar-free, fat-free ice cream with a factory expiration label of ,d+[DATE]. -Six milk cartons with a factory expiration label of [DATE]. -One opened milk carton with a factory expiration label of [DATE]. <p>Continued observation of the four nourishment refrigerators on the units [DATE] revealed that the following food items were opened and not dated or labeled according to when they were opened or expected to be discarded:</p> <ul style="list-style-type: none"> -One jar of salsa -One sour cream container <p>(continued on next page)</p>		

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

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> -One loaf of cinnamon raisin bread -Two loaves of wheat bread -Three loaves of white bread -One large carton of oatmilk -One large carton of soy milk -One tub of butter -One orange pineapple juice -Five rainbow sherbet ice creams <p>During the initial tour, staff #109 was observed discarding all of the expired, unlabeled, and undated foods documented above.</p> <p>A brief interview was conducted with the Food services director (FSD/staff #109) on [DATE] at 11:25 a.m. who stated that the items he threw out were expired because he did not know when they were opened.</p> <p>A phone interview was conducted on [DATE] at 8:15 a.m. with the Administrator (Admin/Staff#205) The Administrator stated that the facilities process for food labeling was that each department does their own type of regs and the facilities process was whatever the food services director's policy is. Staff #205 stated that the facility 's process for discarding expired foods was also whatever the food services director's policy is, but if food looked expired or seemed expired it should have been discarded. Staff #205 stated that the risk of food not being appropriately labeled was that there was a chance it could have been expired, and she also stated that the risk of not discarding expired food was that if it were used, residents could have consumed the expired food and there was a chance of them having a stomach issue or not feeling well.</p> <p>Review of the facilities policy, Food Storage and Date Marking, revealed that food should have been dated as it was placed on the shelves, and date marking should have been utilized to indicate the date or day ready-to-eat or potentially hazardous foods should have been consumed, sold, or discarded.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51103</p> <p>Based on clinical record review, observations, interviews, and review of policy, the facility failed to appropriately implement their enhanced barrier precaution (EBP) program on two residents (#38 and #64). This deficient practice can result in harmful transmission of pathogens to other residents.</p> <p>Findings include,</p> <p>Regarding Resident #38</p> <p>Resident # 38 was admitted to the facility on [DATE] with diagnoses of paroxysmal atrial fibrillation, Type 2 Diabetes, and open wound infection of the right artificial knee.</p> <p>The admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, which suggested the resident has intact cognitive ability. The MDS also reveals the resident is receiving care for a surgical wound and is currently receiving Intravenous (IV) medications.</p> <p>The order summary report revealed the resident's peripherally inserted central catheters (PICC) interventions began on September 21, 2024</p> <p>The order summary report revealed wound care began on the right knee October 15, 2024 however, no EBP orders were noted.</p> <p>The order summary report revealed EBP's were due related to a PICC line began October 21, 2024 instead of on the admitted [DATE].</p> <p>Regarding Resident #64</p> <p>Resident # 64 was admitted to the facility on [DATE] with the diagnoses of Type 2 Diabetes with ulcers, dementia, and obstructive/reflux uropathy with an indwelling catheter.</p> <p>The Minimum Data Set (MDS) dated [DATE], revealed a Brief Mental Status (BIMS) score of 10, which suggested a moderate impairment in cognition. The MDS reported the resident has an indwelling catheter and diabetic ulcers on admission. The MDS also included the resident's issue with diabetic foot ulcers, and moisture associated skin damage.</p> <p>The order for skin impairment care was initiated on September 26, 2024.</p> <p>The order for Enhanced Barrier Precautions due to Foley catheter was initiated on October 21, 2024 instead of on the admitted [DATE].</p> <p>Observations conducted on October 21, 2024 at 8:45 a.m., 09:40 a.m., and 10:30 a.m. revealed no Enhanced Barrier Precaution sign was posted on or near resident # 38 and #64 doors. There also was not a Personal Protective Equipment (PPE) cart in close proximity either resident's room.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An observation on October 22, 2024 at 9:00 am revealed Enhanced Barrier Precaution sign was posted on resident #38 and #64 doors and a PPE cart was in close proximity to resident's room.</p> <p>In an interview with the Infection Preventionist (IP) on October 22, 2024 at approximately 9:45 a.m. revealed she completed her Infection Preventionist Training on May 30, 2021. During a facility infection control tour, the IP admitted the EBP orders should have been initiated on both resident's at admission.</p> <p>In a second meeting held with the IP on October 24, 2024 at 12:38 p.m. reiterated that the EBP signs and posters were supposed to be posted on resident #38 and #64 doors at admission. She further stated EBP should have been communicated better. The IP does not work on weekends, so the EBP orders can slip by when a resident is admitted over the weekend.</p> <p>An interview was conducted with the Director of Nursing (DON/Staff #49) on October 23, 2024 at 1:00 p.m. The DON reviewed the IP's documentation on resident #38, and stated the EBP orders should have began on admission due to his surgical wound and Picc line. The DON also reviewed documentation on resident #64, and stated the EBP orders should have began on admission with this resident since he came here with a catheter.</p> <p>In a policy titled Transmission-Based (Isolation) Precautions states transmission based precautions are to be applied to resident's who are known or suspected to be infected or colonized with certain infectious agents requiring additional controls to prevent transmission. It further states the signage that includes instructions for the use of specific personal protective equipment (PPE) will be placed in a conspicuous location. The facility is to have PPE readily available near the entrance of the resident's room.</p> <p>In a policy titled Infection Prevention and Control Program dictates the facility establish and maintain an infection prevention and control program as per accepted national guidelines.</p>		