STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035234	A. Building B. Wing	01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arizona State Veteran Home-Phx	4141 North S Herrera Way Phoenix, AZ 85012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50553 Based on clinical record review, facility documentation, staff interviews, and policy review, the facility failed to ensure that one resident (#79) was free from a significant medication error. The deficient practice resulted in the resident experiencing a Fentanyl overdose, requiring treatment at the hospital's Intensive Care Unit (ICU). Findings include: Resident #79 was admitted to the facility on [DATE] with diagnoses including acute on chronic right heart failure, urinary tract infection, and Parkinson's disease. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. Review of physician orders revealed the following prescribed medication: Fentanyl - Schedule II patch 72 hour; 50 micrograms per hour; amount: 50 micrograms; transdermal Special Instructions: One patch to upper arm Every 72 Hours 12:00 Start Date: January 11, 2025 Review of the care plan revealed a problem focus initiated on January 18, 2025 that the resident was at risk for adverse reaction related to medication error, with approaches in place including making sure the old medication patch is removed before placing a new patch and to have another nurse assess if the patch is not found, and to notify the provider and nurse manager of any medication errors. Review of the careplan as of January 17, 2025 revealed no evidence that a problem focus was in place to monitor the resident's Fentanyl usage or that the resident was at risk for adverse reactions related to his Fentanyl usage, prior to January 18, 2025. (continued on next page)

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

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

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Review of the Medication Administration Record for January 2025 revealed an order to administer one Fentanyl 50 microgram patch to the upper arm every 72 hours. Review of the MAR for this order revealed that a patch was applied to the resident's right chest on January 11, 2025, and that the previous patch that was on the left chest was removed. On January 14, 2025, the patch on the right chest was removed, and a new patch was placed onto the left chest. Lastly, on January 17, 2025, the nurse charted that they could not locate the previous patch, and a new patch was applied to the right upper shoulder. Review of the nursing progress notes revealed that on January 18, 2025 at 04:49AM, the resident was resting in bed with his eyes closed. Further review revealed that on January 18, 2025 at 09:59 AM the resident did not receive his morning medications because the resident was still asleep, and the nurse supervisor was made aware. The nursing note dated January 18, 2025 at 03:03PM revealed that the nurse supervisor had checked on the resident after the Certified Nursing Assistant (CNA) had notified her that the resident had slept through breakfast. The floor nurse also reported that the resident had not taken his morning medications yet. Later, at 1:45PM, the CNA again notified the nurse supervisor that the resident had not woken up, and had now slept through lunch. The nurse supervisor then assessed the resident, finding that the resident was in bed, lethargic, difficult to arouse, and with altered mental status. The resident was mouth breathing and had dry lips. The resident's vital signs were as follows: Blood pressure 78/48, pulse 76, respirations 16, O2 Saturation 84% on 2L nasal cannula, blood glucose 123. The nurse supervisor then contacted the physician, who ordered to send the resident out to the hospital. Review of the nursing progress note on January 18, 2025 at 4:01PM revealed that the nurse supervisor spoke with a nurse from the hospital emergency department, who stated that the resident was found with two Fentanyl patches on him. The nursing progress note on January 18, 2025 at 5:13PM revealed that the hospital had decided to admit the resident, with diagnoses of Fentanyl overdose, hypoxia, and acute kidney injury. The nursing progress note on January 20, 2025 at 5:26AM revealed patient is currently hospitalized , on Narcan drip but will taper off this morning, and transfer out of ICU. Interview was attempted with Resident #79, but the resident was unable to be reached since he was still admitted to the hospital. Interview was conducted on January 22, 2025 at 2:04PM with Resident #79's representative, who confirmed that Resident #79 was recently sent to the emergency room for a Fentanyl overdose. She stated that the facility nurse had explained that she had found the resident unresponsive and sent him out to the hospital, where they found two Fentanyl patches on him. The representative stated this was the only time she knew about any issues with his medications, and that the facility explained to her that the correct facility procedure is to remove the old patch before applying another patch. Interview was conducted on January 22, 2025 at 1:02PM with a Registered Nurse (RN/Staff#17), who explained that the facility process allows one nurse to administer a Fentanyl patch. He explained that the nurse should notate the location of where the previous patch was removed from and where the new patch was applied. He also stated that two nurses are required to be present when disposing of Fentanyl patches. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Interview was conducted on January 22, 2025 at 1:18PM with another RN (Staff #8), who explained the process to apply Fentanyl patches was to place the Fentanyl patch onto the resident, place Tegaderm on top, and to date and initial the dressing. She also stated that two nurses were required to apply and to waste Fentanyl patches. Interview was conducted on January 22, 2025 at 2:24PM with the Assistant Director of Nursing (ADON/Staff #12), who stated that it is the expectation of nurses to notify their supervisor if they do not find the old Fentanyl patch on a resident when changing Fentanyl patches. She elaborated that at that time, the nurse and the supervisor should both complete a full-body check of the resident to confirm the patch is really missing, and if it is, they should notify the physician. ADON explained that on January 17, 2025, the agency nurse assigned to care for resident #79 did not find the old Fentanyl patch on the resident and applied a new patch to the resident's right shoulder. She stated that the nurse did not notify the supervisor or the physician that she could not find the old patch. The ADON stated that the nightshift nurse on January 17, 2025 had found an extra Fentanyl patch on the resident's back, in addition to the patch on the resident's front side. ADON explained that the nurse removed the patch from the resident's back, as she could not read the date on the patch, but the nurse did not report this to anyone. The ADON further explained that the resident was difficult to arouse the morning of January 18, 2025, but the nurse thought this was his normal sleep pattern. When the resident did not wake for lunch, the supervisor then assessed resident #79 and sent him out to the emergency department, where he was diagnosed with a fentanyl overdose. When asked why the resident's fentanyl patches had been placed in locations other than the area specified in the orders, the ADON confirmed that the facility nurses had not been following the provider's orders for placement of the Fentanyl patch. Review of facility policy titled, Administering Medications, revealed that medications are to be administered in a safe and timely manner, and as prescribed.