STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035284	A. Building B. Wing	01/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arizona State Veteran Home-Tucson	555 East Ajo Way Tucson, AZ 85713

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48932 Based on interviews and record review, the facility failed to provide documentation of transfer notification for one resident. This had the potential for Residents and/or their representative to be unaware of their rights. Resident #6 was admitted to the facility on [DATE] with diagnoses that included Calculus of the Kidney, hypertension, Chronic Obstructive Pulmonary Disease (COPD), Mood disorder, and obesity. Review of resident #6's Electronic Health Record (EHR) indicated the resident was hospitalized on [DATE], September 20, 2023, November 13, 2023, and December 21, 2023. There was no evidence of a transfer notice being provided to the resident and/or their representative. Review of the discharge Minimum Data Set (MDS), dated [DATE] revealed the resident was not assessed for a Brief Interview for Mental Status (BIMS). The staff assessment indicated the resident's cognitive skills for daily decision making was independent. An interview was conducted with Social Services (staff #137) on January 4, 2024 at 1:50 PM. Staff #137 stated that when a resident is sent to the hospital, a bed hold form is reviewed with the resident or Power of Attorney (POA). If the form is not able to be signed prior to residents leaving, he would go to the hospital to review and have it signed by the resident. Staff #137 indicated that no other form is reviewed with residents during this period. An interview was conducted with medical records staff (staff #143) on January 5, 2024 at 12:00 PM. Staff #143 indicated the documentation of notification of transfer would be done in writing in the form of a progress note indicating the family and the primary provider was notified of the transfer. Staff #143 was not able to locate documentation in the EHR indicating transfer notification was provided for resident #6. An interview was conducted with the Director of Nursing (DON) on January 5, 2024 at 1:23 PM. The DON was asked to locate documentation indicating a notice of transfer was completed in resident #6's EHR. DON stated the documentation was not there and confirmed that this did not meet their expectation. Their expectation was if the resident was their own person, the family would not be notified of the transfer, however in this case the family should have been notified of the transfer. The DON stated that the risk of not notifying the family of the transfer was the family would be unaware of the transfer.

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

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 42319 1) Based on clinical record review, staff interviews and facility policy, the facility failed to ensure that medication side effects were monitored and documented for 2 residents (#84, #60) Findings include: Resident #84 was admitted with diagnoses of depression A care plan included that veteran displays inappropriate hand gestures and cursing towards staff and peers; 8/30/2023 Psychotropic meeting per wife with history of behaviors (no specific). 12/8/2023 verbal Aggressive Behavior towards peer. This care plan also included that this resident receives antidepressant medication : Sertraline for depression, dated 6/8/23. Sertraline increased 100 mg to 125 mg, 10/5/2023. Then increased to 150 mg. on 12/12/2023. Added Mirtazapine 7.5 mg PO QHS due to poor intake, then increased the Mirtazapine increased to 15 mg on 10/5/2023. This care plan included to monitor and report signs of sedation, hypotension, or anticholinergic symptoms. A physician's order dated 12/12/23 included Mirtazapine tablet 7.5 mg increased to 15 mg for a diagnosis of depression as evidenced by self-isolation, irritability, and reduced appetite at bedtime. A Medication Administration Record (MAR) included that this medication had been given as ordered for December 2023 and January, 2024. However, review of the clinical record did not find documentation that this resident was monitored for side effects of Mirtazapine. A physician's order dated 10/5/23 included Sertraline tablet 100 mg, increased to 150 mg for a diagnosis of depression as evidenced by self-isolation, flat affect, irritability, and sleep disturbance one time a day. A Medication Administration Record (MAR) included that this medication had been given as ordered for October through December 2023 and January 2024. However, review of the clinical record did not find documentation that this resident was monitored for side effects of Mirtazapine or Sertraline. An interview was conducted on 1/4/24 at 11:35 AM with a Licensed Practical Nurse (LPN/staff #9) who said that psychotropic side effect monitoring should be in the order so there is be a place to chart if there are side effects. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 1/4/24 at 12:20 PM with a LPN (staff #201) who said that monitoring psychotropic side effects is found in an order to follow up on side effects. This staff reviewed the medication orders for resident #84 and said that she did not see monitoring for side effects of this medication. She said that either the nurse entering the order or sometimes the providers will put their own orders in. 47911 2) Based on clinical record review, staff interviews and review of policy and procedure, the facility failed to ensure that medication side effects were monitored and documented for 2 residents (#60, #84). The deficient practice could result in unmonitored adverse side effects. Findings Include: Resident #60 was admitted o June 17, 2023 with diagnosis including vascular dementia, surgical after-care post ORIF of the left hip, chronic obstructive pulmonary disease, systolic congestive heart failure, atherosclerotic heart disease, ischemic cardio-myopathy, atrial fibrillation type II diabetes hypertension, chronic kidney disease, major depressive disorder-recurrent, and post-traumatic stress disorder. A review of the MDS (minimum data set), for resident #60, dated December 8, 2023 revealed a BIMS (brief interview of mental status sore) of 4, indicating severe impact on cognition. A review of the medical record revealed an open-ended physician's order for Fluoxetine 10 mg, 1 tablet per day for depression with an effective date of December 13, 2023. The order noted that the medication was prescribed for depression as evidenced by self-isolation. A review of the MAR (medication administration record) and TAR (treatment administration record) for December 2023 and January 2024 revealed no evidence of side-effect monitoring for resident #60. An interview was conducted on January 4, 2024 at 3:39 PM with staff #103, LPN (licensed practical nurse). Staff #103 stated that nurses monitor and chart the side-effects for residents receiving antidepressants. The LPN stated that a doctor's orders would be in place for the monitoring of medication side-effects; however, no evidence of an order for mediation side-effects was evident in the medical record for resident #60. She further stated that if based on the monitoring an issue was identified that the doctor would be notified immediately. Staff #103 then reviewed the resident electronic health record and stated that she was unable to locate an order for medication side-effect monitoring or charting in the MAR/ TAR for side-effects of the anti-depressant medication for resident #60. An interview was conducted on January 4, 2024 at 3:43 PM with staff #81, RN (registered nurse) and staff #38, ADON (assistant director of nursing). The ADON reviewed with electronic health record for resident #60 and stated that no orders for medication side-effect monitoring were present in the record. She further stated that the record showed no evidence that side effects were being monitored. Staff #38 stated that she would ensure that it is added this date. She further stated that the expectation is that orders are present for monitoring the side-effects of applicable medications and that side-effects are charted by nursing staff. Staff #81 stated that the risk to the resident could include suicidal ideations, lethargy and overall change in behavior. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on January 5, 2024 at 11:03 AM with the Director of Nursing (DON/staff #140). The DON reviewed the medical record for resident #60 and stated that she did not see evidence of medication side-effect monitoring, although she stated that it had been documented in the care plan. She stated that the risk to the resident could include possibly not knowing the effectiveness of the medication and documentation thereof. A review of the facility psychotropic medication use policy, with a July 2022 revise date, revealed that psychotropic medication management includes adequate monitoring for efficacy and adverse consequences; however, there was no evidence in the medical record for Fluoxetine monitoring for efficacy and adverse consequences for resident #60.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47911 Based on observations, staff interview, and policy review, the facility failed to maintain a clean and sanitary kitchen and properly store food products. The deficient practice could result in a potential for food borne illness. The resident census was 96. Findings include: During an initial walk-through of the kitchen on January 2, 2024 at 8:23 A.M a cell phone was observed sitting on a food preparation counter. Staff #120 (dining services director) removed the cell phone, once it had been brought to his attention. Additionally, during the initial walk-through staff #120 was observed walking through the kitchen without wearing a hairnet. In the food storage area, 2 dented cans were observed in the 'ready to use' area of the kitchen and not stored separately in the area specified for dented cans. These consisted of one can of marinara and another can of mushroom soup. An interview was conducted on January 4, 2024 at 7:57 A.M. with staff #120 (Dietary services director). Staff #120 stated that the expectation is that phones are not left on food service preparation areas, and that hairnets are worn at all times in the kitchen. He stated that the risk for items such as cell phones on food preparation counters and not wearing a hairnet could include contamination of food. He further stated that the expectation is that dented cans are not utilized and that the risk for having dented cans in the ready to use area could include foodborne illness. An interview was conducted on January 4, 2024 with staff #67 (administrator). Staff #67 stated that the expectation is that everyone in the kitchen and handling food needs to wear a hairnet, as hair could otherwise get in to the food. Staff #67 further stated that there should be no cell phones in the kitchen area as these could convey germs. He stated dented cans should not be utilized and the risk could conceivably include botulism. A review of the facility policy entitled preventing foodborne illness with a revision date of November 2022 revealed that hairnets or caps are to be worn when cooking, preparing or assembling food to keep hair from contacting exposed food, clean equipment, utensils or linens. The policy further revealed that employees will demonstrate knowledge and competency of safe food handling practice.