

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035303	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2025
NAME OF PROVIDER OR SUPPLIER Arizona State Veteran Home - Yuma		STREET ADDRESS, CITY, STATE, ZIP CODE 6051 East 34th Street Yuma, AZ 85365	

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 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 facility documentation and policy, the facility failed to ensure a drug regimen free from unnecessary medications for one resident (# 8). The deficient practice may result in medication-related problems such as adverse drug reactions and side effects.</p> <p>Findings include:</p> <p>Resident #8 was admitted to the facility on [DATE] with the diagnoses that diabetes, hypertension, chronic kidney disease-stage 4 (severe), macular degeneration, and muscle weakness.</p> <p>An investigation of the Facility Reported Incident (FRI) with the alleged event date of February 24, 2024 was investigated during a survey complaint investigation conducted on January 21, 2024 through January 22, 2024. The allegation of facility failed to ensure the resident did not experience an avoidable fall was unsubstantiated. During the course of the investigation, it was discovered the resident experienced additional falls and balance instability during his residency, requiring medication changes.</p> <p>The annual Minimum Data Set (MDS) dated [DATE] revealed a Brief Mental Interview Status score of 15, indicating the resident is cognitively intact. The assessment also indicated the resident uses a walker to assist with mobility.</p> <p>An order for Diltiazem HCL 150 mg one half tablet twice a day, hold if pulse is less than 60 beats per minute, was initiated on September 14, 2024. The following doses were administered outside of parameter:</p> <ul style="list-style-type: none"> -December 5, 2024 7:30 a.m. at 59 bpm -December 15, 2024 7:30 a.m. at 59 bpm. - January 7, 2025 7:00 p.m. at 57 bpm. -January 19, 2025 7:00 p.m. at 54 bpm. - January 21, 2025 at 07:30 a.m. at 55 bpm. <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 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on January 22, 2025 at 9:25 with the resident. The resident believes he has fell about three times since he has been at the facility, because of his blood pressure going to low. The resident stated he is confident about the ongoing changes in his blood medication and is optimistic about the blood pressure becoming stable. The resident stated that the kidney doctor has been managing his blood pressures for the past two years, but it is now to the point where the cardiologist is needing to intervene. The resident feels his body builds up a tolerance to blood pressure medications, which is why they need to be changed so often. The resident is unaware of any issues or incidents with the administration of his medication, and voiced confidence in the facility's staff to administer his medications correctly, especially since he has to take so many.</p> <p>A joint interview was conducted on January 22, 2025 at 12:30 p.m. with the facility compliance officer (Staff # 10) and the Director of Nursing (Staff # 3). The documentation was reviewed by both parties and for the occurrences of medications outside of parameter, neither stated they were able to locate documentation supporting use outside of the physician orders. Both parties agreed that medications, especially blood pressure medications can increase the risk of falls in a resident, so close monitoring and following orders in especially important for resident safety. They both agree to provide further education and evaluation on the importance of following drug orders and will also discuss in their next QAPI meeting.</p> <p>The Acute Change in Condition policy revealed that the physician will help identify medications and medication combinations that are associated with adverse consequences that could cause significant changes in condition.</p> <p>The Administering Medications policy dictates that vital signs, if necessary is checked/verified for each resident prior to administering medications.</p> <p>The Adverse Consequences and Medication Errors policy defined a medication error as the administration of drugs not in accordance with physician's orders. The policy also defined a significant medication-related error as requiring medication discontinuation or dose modification. In addition, the Quality Assurance and Performance Improvement (QAPI) is responsible for investigating, implementing, and evaluating medication administration errors.</p> <p>The Managing Falls and Fall Risk policy include medication side effects and orthostatic hypotension as conditions that may contribute to the risk of falls.</p>		