STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035284	A. BUILDING _____ B. WING _____	05/23/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0583 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Keep residents' personal and medical records private and confidential.** Based on observations, staff interviews, and review of policies and procedures, the facility failed to ensure confidential resident information was not visible in a resident dining area. The deficient practice violates residents' rights to privacy and confidentiality of personal and medical information. Findings include: During an observation conducted on (MONTH) 22, 2019 at 1:50 p.m., Daily BM (bowel movement) Per Shift documentation was observed on a counter in the residents dining area on the 300 unit, side C. The documentation was in a visible area to both residents and visitors as it was next to a basket of fruit which was available to the residents and also near an Always Available menu posted on the wall for residents. A resident was observed in the dining area at this time and two residents passed by this area in their wheelchairs. The Daily BM Per Shift documentation revealed whether or not ten residents had bowel movements or not on (MONTH) 21 and 22, 2019. The documentation also revealed whether or not a resident had a medium or large bowel movement and if they did not have a bowel movement. The bowel movement documentation was listed next to the room number of each resident. The ten resident rooms listed on the Daily BM Per Shift documentation were located on the perimeter of the dining room. On the wall outside of the ten rooms was the names of the residents who resided in the rooms. An interview was conducted with a Licensed Practical Nurse (LPN/staff #119) on (MONTH) 22, 2019 at 2:17 p.m. Staff #119 stated that the bowel movement documentation is not normally left out on the counter in the dining area. Staff #119 stated that the bowel movement documentation should have been kept in a drawer in the kitchen serving area. Staff #119 further stated that the CNAs (Certified Nursing Assistants) document residents' bowel movements on the Daily BM Per Shift sheet and turned it in to the licensed nurse at the end of their shift so that they can keep track of when a resident had a bowel movement. An interview was conducted with the Director of Nursing (DON/staff #15) on (MONTH) 22, 2019 at 3:07 p.m. Staff #15 stated that she would remind staff to not leave the bowel movement documentation in a public area. Review of the facility's policy Confidentiality of Information revealed Our facility shall treat all resident information confidentially. The facility will safeguard all resident records, whether medical, financial, or social in nature, to protect the confidentiality of the information .
F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, staff interviews, and review of policies, the facility failed to ensure that one of four residents (#23) was administered medications according to professional standards of quality. The deficient practice could result in residents not receiving physician ordered medications. Findings include: Resident #23 was admitted to the facility on (MONTH) 26, 2014, with [DIAGNOSES REDACTED]. Review of an annual assessment for self-administration of medication dated (MONTH) 20, 2019, revealed the resident did not want to self-administer medications and preferred staff to administer medications. The assessment included the resident was unable to open each medication container(s) and pour pills out of a bottle or punch medications out of a card/package. The policy further included the resident was not able to swallow medications without altering the dispensed form. Review of the summary of physician's orders [REDACTED]. During a medication administration observation conducted with a Licensed Practical Nurse (LPN/staff #116) on (MONTH) 22, 2019 at 10:46 a.m., the LPN was observed to crush one tablet of [MEDICATION NAME] and mixed it with a spoonful of pudding in a small plastic cup. She placed the cup and spoon on a table next to the resident in his room and left the room. The LPN did not observe the resident taking the medication. Immediately following the observation, an interview was conducted with the LPN. The LPN stated that she left the medication at the resident's bedside because the resident prefers to take his medication himself. She further stated the resident did not like to take his medication in front of other people and that she was confident the resident would take the medication.A follow-up interview was conducted with staff #116 on (MONTH) 22, 2019 at 11:56 a.m. She stated that while she was in the resident's room administering eye drops, she observed the empty cup and spoon which confirmed the resident took the [MEDICATION NAME]. The LPN stated the resident likes to take his time when taking medications and that is why she allowed him to self-administer. An interview was conducted with the Director of Nursing (DON/staff #15) on (MONTH) 22, 2019 at 12:03 p.m. She stated that if a resident requested to self-administer medications, the protocol would include assessing the resident for safety and allowing the resident to keep the medication at the bedside. She stated that this situation was not a true self-administration, because the medication had been verified and prepared by the nurse and it is not kept at the bedside. She further stated that the nurse returned to the resident's room to verify the resident had taken the medication. Review of the facility's policy for Administering Medications revealed medications shall be administered in a safe and timely manner, and as prescribed. The policy also revealed residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely. The facility's policy regarding Self-Administration of Drugs revealed residents who wished to self-administer their medications may do so, if it is determined that they are capable of doing so. The staff and practitioner will perform a more specific skill assessment including the resident's ability to remove medications from a container. The policy also included that if the staff determines a resident cannot self-administer medications, the nursing staff will administer the resident's medications.
F 0757 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review, the facility failed to ensure one of six sampled residents (#101) was free from unnecessary drugs, by failing to administer a medication in accordance with the timeframe. The deficient practice could result in residents receiving medications that may not be necessary. Findings include: Resident #101 was readmitted to the facility on (MONTH) 3, 2019, with [DIAGNOSES REDACTED]. Review of the hospital discharge summary dated (MONTH) 3, 2019, revealed the resident was to receive Mupirocin 2% topical nasal ointment twice a day [MEDICAL CONDITION] ([MEDICAL CONDITION]-resistant Staphylococcus Aureus) eradication from

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035284	A. BUILDING _____ B. WING _____	05/23/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) (MONTH) 3 - 12, 2019. Review of the clinical record revealed a nursing progress note dated (MONTH) 3, 2019 that the resident's admission medications were verified with the resident's physician at the facility. Additional review of the clinical record revealed a physician's order dated (MONTH) 3, 2019 for Mupirocin 2% nasal ointment twice a day [MEDICAL CONDITION] eradication. The order did not include administering the medication from (MONTH) 3 - 12, 2019. Review of the Medication Administration Record [REDACTED]. An interview was conducted on (MONTH) 23, 2019 at 3:38 p.m. with a Licensed Practical Nurse (LPN/staff #116). After reviewing the hospital discharge summary and the clinical record, the LPN stated that the Mupirocin 2% ointment was to be administered for 10 days and that the physician's order did not include the ten days. During an interview conducted with the Director of Nursing (DON/staff #15) on (MONTH) 23, 2019 at 4:04 p.m., the DON stated hospital discharge orders are transcribed by the facility's admitting nurse, house supervisor, or nurse supervisor. The DON stated the orders are reviewed, the physician is contacted to verify the orders, and staff document the verification in a nurse progress note. Review of the facility's policy titled Reconciliation of Medications on Admission revised (MONTH) (YEAR), revealed the purpose of this procedure is to ensure medication safety by accurately accounting for the resident's medications, routes and dosages upon admission or readmission to the facility. Information needed to reconcile the medication list included the approved medication reconciliation form, discharge summary from the referring facility, admission order sheet, and the most recent MAR indicated [REDACTED]. The policy stated to review the list carefully to determine if there are discrepancies/conflicts.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and policy review, the facility failed to ensure that expired medications in one of four medication storage rooms were not available for resident use. The deficient practice could result in expired medications being administered to residents. Findings include: During a medication storage room observation conducted on (MONTH) 23, 2019 at 10:53 a.m. on the 200 unit with a Licensed Practical Nurse (LPN/staff #116), the following was observed: -Four boxes containing [MEDICATION NAME] of [MEDICATION NAME] sulfate solution for nebulization with an expiration date of (MONTH) 18, (YEAR). These boxes were stacked on top of other boxes of [MEDICATION NAME] sulfate solution that were not expired. -One culture swab kit with an expiration date of (MONTH) (YEAR) which was stored in the same box as other culture swab kits that were not expired. -One box containing [MEDICATION NAME] of [MEDICATION NAME] sulfate solution for nebulization with an expiration date of (MONTH) 19, 2019, which was stacked on top of other boxes of [MEDICATION NAME] sulfate solution that were not expired. An interview was conducted with staff #116 following this observation. The LPN stated that the boxes of [MEDICATION NAME] were additional stock that was kept in the medication room because they were too bulky for all of them to fit in the medication cart. She further stated that she would not expect to find expired medications in the medication supplies that were intended for resident use. An interview was conducted with the Director of Nursing (DON/staff #15) on (MONTH) 23, 2019 at 2:01 p.m. The DON stated that nurses are responsible for checking the expiration dates on medications and placing the expired medications in the return bins that are in the medication rooms. She stated that the medication rooms are used for storing medication. She stated that the nurses check expiration dates before taking medications from storage and putting them in the medication carts. The DON stated that if a medication is not frequently used, there is the potential for the medication room to contain expired medications, but that the nurse should check the medication expiration date before placing it in the medication cart. Review of the facility's policy for storage of medication revealed the following: -The nursing staff would be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. -The facility would not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs would be returned to the dispensing pharmacy or destroyed. -Drugs should be stored in an orderly manner in cabinets, drawers or carts.
F 0943 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.** Based on personnel file reviews, staff interviews, and review of policies, the facility failed to ensure 2 of 12 sampled staff (#9 and #12) were provided training on abuse, neglect, exploitation, misappropriation of resident property, and dementia management. The deficient practice could result in staff not being educated regarding abuse, neglect, exploitation, misappropriation of resident property, and dementia management. Findings include: -Review of the personnel file for staff #9 (Physical Therapist) revealed staff #9 was contracted to provide therapy services for the facility effective (MONTH) 17, 2013. However, further review of the file revealed no evidence that staff #9 had received training on abuse, neglect, exploitation, misappropriation of resident property, and dementia management. -Review of the personnel file for staff #12 (Speech Therapist) revealed staff #12 was contracted to provide therapy services for the facility effective (MONTH) 17, 2012. Further review of the personnel file revealed no evidence that staff #12 had received training on abuse, neglect, exploitation, misappropriation of resident property, and dementia management. An interview was conducted on (MONTH) 22, 2019 at 11:06 a.m. with the Business Office Manager (staff #24). Staff #24 stated that staff #9 and staff #12 were contracted by a previous company that they longer contract with. She stated the facility contracts from a different company now. She stated that this current company hired staff #9 and staff #12 but did not obtain/retain their personnel files from the previous company. Staff #24 stated that because the current company did not obtain/retain the files, they have no documentation of training. She acknowledged that the current company should have personnel files for the two contracted staff. Staff #24 further stated that it was their responsibility to ensure the two contracted staff members received training. During an interview conducted on (MONTH) 22, 2019 at 02:15 p.m. with the Director of Nursing (DON/staff #15), the DON stated that they provide a separate training for contracted staff. The DON stated the contracted staff training requirements are the same as the requirements for the facility staff. Another interview was conducted with the DON on (MONTH) 23, 2019 at 2:38 p.m. The DON stated that they have no documentation for staff #9 and staff #12 stating that they received training for abuse, neglect, exploitation, misappropriation of resident property and dementia. Review of the facility's policy titled Abuse Prevention Program revised (MONTH) (YEAR), revealed employees will be trained upon hire and each year thereafter to recognize and report incidents or suspicions of abuse, neglect or mistreatment, or the misappropriation of funds. The facility's policy regarding Dementia - Clinical Protocol, revealed nursing assistants will receive initial training in the care of residents with dementia and related behaviors. In-services will be conducted at least annually thereafter. The policy also revealed performance reviews will be conducted annually and in-service education will be based on the results

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035284	A. BUILDING _____ B. WING _____	**05/23/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0943 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) of the reviews.