STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035016	A. BUILDING _____ B. WING _____	**01/08/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HANDMAKER HOME FOR THE AGING	**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)
F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews and policy review, the facility failed to have documentation of advanced directives for one resident (#10) and obtain physician orders once obtained, and failed to obtain physician orders in accordance with the advance directive for one resident (#171). Findings include: -Resident #10 was admitted to the facility on (MONTH) 30, (YEAR) and readmitted to the facility on (MONTH) 10, (YEAR), with [DIAGNOSES REDACTED]. An admission Minimum Data Set (MDS) assessment dated (MONTH) 8, (YEAR) revealed the resident had a Brief Interview for Mental Status score of 3, which indicated severe cognitive impairment. Review of the clinical record on (MONTH) 5, 2019 revealed no documentation regarding advance directives for resident #10. There were also no physician orders for any advance directives. An interview was conducted with two licensed practical nurses (LPN/staff #52/staff #53) on (MONTH) 6, 2019 at 2:50 p.m. The nurses stated that they were unable to locate advance directive information for resident #10. Staff #52 stated that the nurses usually get a new order when a resident returns from the hospital, because the directive could change at anytime. Staff #52 stated that she would need to have the responsible party for the resident sign the form and that she would contact the responsible party right away. Review of the clinical record on (MONTH) 7, 2019 revealed advance directives had been obtained for resident #10. The advance directives were obtained from the resident's responsible party by telephone on (MONTH) 6, 2019 and included for a Do Not Resuscitate (DNR) status. Further review of the physician orders on (MONTH) 7, 2019 revealed there was no physician order for [REDACTED].>-Resident #171 was admitted to the facility on (MONTH) 31, (YEAR), with [DIAGNOSES REDACTED]. A review of the clinical record revealed an Advanced Directive form indicating the resident was a DNR status, which was signed by the resident's power of attorney on (MONTH) 2, 2019. However, review of the physician orders on (MONTH) 7, 2019 revealed there were no orders for a DNR status. An interview was conducted with two licensed practical nurses present (LPN/staff #52/staff #53) on (MONTH) 6, 2019 at 2:50 p.m. Staff #52 stated that there is an Advance Directive for a DNR on the paper chart which was signed on (MONTH) 2, 2019, but there is no physician's order at present. An interview was conducted on (MONTH) 8, 2019 at 12:17 p.m. with the Director of Nursing (DON/staff #160). She stated that Social Services interview residents or responsible parties and obtains advance directives on admission, or shortly after admission. Staff #160 stated if the resident desires a DNR status, Social Services will inform nursing so they can contact the provider to get an order in place and obtain the orange card (Prehospital Medical Care Directive). She also stated there should be a physician's order for a DNR. Review of the facility's policy regarding Advance Directives revealed the facility will respect advance directives in accordance with state law and facility policy and that the Director of Nursing or designee will notify the attending physician of advance directives. so that appropriate orders can be documented in the resident's medical record and plan of care.
F 0640 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, facility documents and the Resident Assessment Instrument (RAI) manual, the facility failed to ensure that a Minimum Data Set (MDS) assessment was transmitted, within 14 days after completion for one resident (#2). Findings include: Resident #2 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of the clinical record revealed a discharge MDS assessment was completed and dated 8/6/18. Review of the MDS transmittal report revealed that the discharge MDS assessment dated [DATE] had not been transmitted. An interview was conducted on 1/08/2019 at 11:23 a.m., with the MDS Coordinator (staff #116). Staff #116 stated the MDS assessments are completed by reviewing each chart, checking history and physicals, reviewing all physician orders [REDACTED]. Staff #116 stated when a resident is a planned discharged , a MDS-return not anticipated is completed. Staff #116 stated that she will open the discharge MDS like a regular assessment and will verify there are no errors. Staff #116 said that either the Assistant Director of Nursing (staff #117) or the Director of Nursing (staff #160) will sign off when the MDS is complete. Staff #116 stated the MDS would then be ready for transmission to CMS (Centers for Medicare/Medicaid Services). Staff #116 provided the MDS transmission report and stated that the discharge MDS dated [DATE] did not get transmitted. Staff #116 stated that the facility has 20 days to transmit a completed MDS. Staff #116 stated the facility policy is to use the RAI manual to ensure MDS accuracy and transmission. An interview was conducted on 1/8/2019 at 1:01 p.m. with the Director of Nursing (staff #160), who stated the expectation for the MDS nursing staff is to ensure that each MDS is completed and transmitted to CMS, within the required timeframe. Staff #160 stated the facility uses the RAI manual for all MDS expectations. Review of the RAI manual revealed that discharge MDS assessments must be submitted within 14 days of the MDS completion date.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews and review of the Resident Assessment Instrument (RAI) manual, the facility failed to ensure that Minimum Data Set (MDS) assessments were accurate for two residents (#'s 36 and 52). Findings include:

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

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F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) -Resident #36 was admitted on (MONTH) 1, (YEAR), with [DIAGNOSES REDACTED]. Review of the [DIAGNOSES REDACTED].#36 revealed that resident #36 had an onset of pneumonia on (MONTH) 24, (YEAR). Review of a quarterly Minimum Data Set (MDS) assessment dated (MONTH) 20, (YEAR) revealed documentation of an active [DIAGNOSES REDACTED]. However, review of the clinical record revealed that resident #36 had a history of [REDACTED]. An interview was conducted on 1/8/2019 at 11:23 a.m. with the MDS Coordinator (staff #116). Staff #116 stated the MDS assessments are completed by reviewing each chart, checking the history and physical, reviewing all physician orders [REDACTED]. Staff #116 stated the electronic chart is also reviewed for a 7-day look-back period, which includes all progress notes, current diagnoses, medications and treatments. Staff #116 stated that current [DIAGNOSES REDACTED]. Staff #116 stated if it was a non-active diagnoses, it would not be included on the MDS. An interview was conducted on 1/08/2019 at 1:01 p.m. with the Director of Nursing (staff #160), who stated the expectation for the MDS nursing staff is to ensure that each MDS is accurate and completed within the required timeframe. -Resident #52 was admitted to the facility on (MONTH) 7, (YEAR), with [DIAGNOSES REDACTED]. Review of the MDS assessment dated (MONTH) 14, (YEAR), revealed the resident did not receive an antipsychotic medication in the past seven days or since admission. However, the MDS assessment also included the following in the Antipsychotic Medication Review section: since admission the resident had received antipsychotic medications on a routine basis only, and that a Gradual Dose Reduction (GDR) had not been attempted. Review of the physician's orders [REDACTED].#52. Review of the Medication Administration Record [REDACTED]. An interview was conducted on (MONTH) 8, 2019 at 11:23 a.m., with the MDS Coordinator (staff #116). She stated the facility follows the instructions in the RAI manual to ensure MDS accuracy. She stated the information in the MDS regarding a resident's medications would come from reviewing the resident's MAR. She stated that since the resident had not received an antipsychotic medication, the Antipsychotic Medication Review section of the MDS assessment should have been coded to reflect that antipsychotics were not received. An interview was conducted on (MONTH) 8, 2019 at 1:01 p.m., with the Director of Nursing (DON/staff #160). She stated her expectation was that each MDS assessment should be accurate. She stated accuracy should be determined by both MDS nurses double checking their work. She stated that if a resident was not taking an antipsychotic, the MDS assessment should record zero days of antipsychotic use, followed by a statement that antipsychotics were not received in the Antipsychotic Medication Review section. She stated that when all three areas of documentation matched, the MDS assessment would be accurate. Review of the RAI manual revealed the following requirements: The MDS assessment must accurately reflect the resident's status; A registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals; and the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation and staff interviews, the facility failed to provide adequate supervision for one resident (#268) with known aggressive behaviors. Findings include: -Resident #268 was admitted to the facility on (MONTH) 13, (YEAR), with [DIAGNOSES REDACTED]. Review of the admission Minimum Data Set (MDS) assessment for resident #268 dated (MONTH) 20, (YEAR), revealed the resident scored a 3 on the Brief Interview for Mental Status (BIMS), which indicated severe cognitive impairment. The MDS also documented that the resident had physical behavioral symptoms against others that significantly interfered with the resident's care and put others at significant risk for injury. An activities note dated (MONTH) 21, (YEAR) stated the resident became agitated during bingo and began throwing bingo cards in the direction of other residents. An activities note dated (MONTH) 22, (YEAR) stated that resident #268 hit a staff member on the arm. Review of a care plan dated (MONTH) 23, (YEAR) revealed the resident exhibited behaviors of physical aggression such as hitting and kicking, during routine care. Interventions included to intervene before agitation escalates, guide resident away from the source of distress, provide one-on-one interaction, staff to re-approach the resident later or have a different staff member attempt to assist the resident, and if the resident becomes aggressive, staff should ensure her safety and give her time to calm down. A nursing note dated (MONTH) 25, (YEAR) included that resident #268 hit three staff members in the stomach and tried to kick them. Review of the behavior monitoring record for (MONTH) and (MONTH) (YEAR) revealed 4 episodes of resident #268 yelling out and 5 episodes of the resident striking out at staff. A physician's orders [REDACTED]. A nursing note dated (MONTH) 24, (YEAR) at 1:08 a.m., stated the resident was awake, roaming the halls and refusing care. The resident's pants were half on/half off and the resident was removing her clothes in the middle of the hall. A nursing note dated (MONTH) 18, (YEAR) included the resident was verbally aggressive with staff in a common area where other residents were present. The note also stated the resident tried to ram her wheelchair in the direction of another resident. Review of the resident's care plans revealed no evidence that they were updated to address the resident's aggressive behaviors toward other residents. Further review of the clinical record revealed there was no documentation that the resident was provided increased supervision, despite documentation of aggressive behaviors toward residents. A nursing note dated (MONTH) 25, (YEAR) revealed that resident #268 was extremely agitated, was screaming loudly, and swinging out, when a female resident was walking by, the resident hit her in the chest/abdomen area. The note also included that resident #268 was immediately removed from the area, staff continued to keep her away from other residents, and she began to wander in the hallway screaming loudly and speaking inaudible words. Review of the facility's investigative report regarding the incident on (MONTH) 25, (YEAR), revealed resident #268 was seen striking another resident as the resident walked by her. Per the clinical record, the resident was discharged to the hospital on (MONTH) 28, (YEAR) for continued/worsening altered mental status. An interview was conducted on (MONTH) 8, 2019 at 9:32 a.m., with a Licensed Practical Nurse (LPN/staff #52). She stated she witnessed the event between the two residents, and she was the author of the nursing note that documented the event. She stated that another resident was walking by as resident #268 was very agitated. She stated the arm of resident #268 was flailing when it struck the other resident. She stated neither resident was injured during the event.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record reviews and staff interviews, the facility failed to ensure there was adequate

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F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) monitoring for adverse side effects for three residents (#10, #52 and #171) on [MEDICAL CONDITION] medications and failed to monitor target behaviors for one resident (#52) on an antidepressant medication. Findings include: -Resident #10 was admitted on (MONTH) 30, (YEAR) and readmitted on (MONTH) 10, (YEAR), with [DIAGNOSES REDACTED]. A review of the admission Minimum Data Set (MDS) assessment dated (MONTH) 8, (YEAR) revealed a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. The MDS also included the resident received antipsychotic medication 7 of 7 days and antidepressant medication 6 of 7 days of the lookback period. A review of the resident's care plan regarding the use of [MEDICAL CONDITION] medications included a goal that the resident would remain free of complications related to [MEDICAL CONDITION] drugs. Interventions were to monitor for side effects and effectiveness each shift and to monitor/document/report as needed any adverse reactions of [MEDICAL CONDITION] medications such as: unsteady gait, tardive dyskinesia, shuffling gate, rigid muscles, shaking, frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, [MEDICAL CONDITION], social isolation, blurred vision, diarrhea, fatigue, [MEDICAL CONDITION], loss of appetite, weight loss, muscle cramps, nausea, vomiting and behavioral symptoms not usual to the person. The physician orders [REDACTED]. The orders did not include to monitor for adverse effects of these medications. Review of the Pharmacist New Admission Medication Review dated (MONTH) 10, (YEAR) revealed a recommendation to the physician/prescriber which stated [MEDICATION NAME] and [MEDICATION NAME] in combination may increase the risk of serotoni[DIAGNOSES REDACTED], if either drug is increased in dose/frequency, monitor for adverse events. A review of the Nurse Practitioner hospital discharge follow up note dated (MONTH) 11, (YEAR) revealed a medication review and an assessment of major [MEDICAL CONDITION], with a plan to follow response to medications and circumstances. Further review of the clinical record revealed a form titled, Side Effects Monthly Flow Sheet for (MONTH) 2019. The form included instructions to use the form for the following medication classes: antianxiety, antidepressant, antipsychotic and sedative/hypnotic. This form also included the side effects/adverse effects of each of these drug classes, with areas to document if any adverse effects. This form was blank. In addition, there was no clinical record documentation that the resident was being monitored for adverse effects of the [MEDICAL CONDITION] medications in (MONTH) (YEAR) and (MONTH) 2019. -Resident #171 was admitted on (MONTH) 31, (YEAR), with [DIAGNOSES REDACTED]. A review of the physician orders [REDACTED]. The orders did not include to monitor for any adverse effects of the medications. A baseline care plan identified a focus area related to a mood problem. Interventions included to administer medications as ordered, and to monitor/document for side effects and effectiveness. Review of the clinical record revealed there was no documentation that the resident was consistently monitored for adverse side effects related to the use of [MEDICAL CONDITION] medications. An interview was conducted with Licensed Practical Nurse (LPN/staff #53) on (MONTH) 6, 2019 at 1:30 p.m. Staff #53 stated the nurses are to document on the Side Effects Monthly Flow Sheets that are placed in the book. She said that she was not sure who was responsible to place the forms in the book. She also stated that she was unable to find documentation that resident #10 and #171 were being consistently monitored for adverse effects of [MEDICAL CONDITION] medications. -Resident #52 was admitted to the facility on (MONTH) 7, (YEAR), with [DIAGNOSES REDACTED]. Review of a physician's orders [REDACTED]. An informed consent was obtained for the use of [MEDICATION NAME] on (MONTH) 10, (YEAR). Review of the admission Minimum Data Set (MDS) assessment dated (MONTH) 14, (YEAR), revealed the resident scored a 9 on the Brief Interview for Mental Status (BIMS), which indicated moderate cognitive impairment. The MDS assessment further documented that the resident had received an antidepressant for seven out of the past seven days. Review of the resident's care plans revealed there was no plan developed to address the use of an antidepressant medication. According to the Medication Administration Record [REDACTED]. However, there was no clinical record documentation from (MONTH) 9, (YEAR) through (MONTH) 6, 2019 that the resident had been monitored for any target behaviors related to depression, or that the resident was consistently monitored for adverse side effects related to an antidepressant medication. An interview was conducted on (MONTH) 7, 2019 at 9:24 a.m., with a Registered Nurse (RN/staff #104). She stated that when a resident receives an antidepressant, the nurse would be expected to verify an appropriate [DIAGNOSES REDACTED]. Staff #104 said the nurse would also be expected to monitor and document target behaviors related to antidepressant use each shift on the behavior sheets. She stated there was no behavior sheet or monitoring for resident #52, but there should have been since the resident was taking [MEDICATION NAME]. She stated the behavior sheets were normally initiated on admission and kept in the behavior binder, but she did not know the process for how the sheets were started and placed in the binder. An interview was conducted on (MONTH) 8, 2019 at 11:16 a.m., with the Director of Nursing (DON/staff #160). She stated it was the responsibility of the admitting nurse or the MDS coordinator to initiate behavior monitoring sheets and side effect monitoring sheets for residents taking antidepressants. She stated it was the responsibility of nurses who were administering antidepressant medications to monitor for and document the resident's target behaviors and side effects. She stated documentation should be done on the behavior and side effect sheets kept in the behavior binders on the units. She stated that there were no side effect monitoring sheets for resident #52 in the behavior binder, and they should have been there. She also said the facility did not have a policy for [MEDICAL CONDITION] medication administration, only a policy specifically for antipsychotic medication administration.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record reviews, staff interviews, review of the Center for Disease Control (CDC) guidelines and policy and procedures, the facility failed to implement infection control measures for one resident (#222) on contact isolation precautions and failed to ensure infection control measures were implemented regarding catheters for two residents (#41 and #321). Findings include: -Resident #222 was admitted (MONTH) 4, 2019, with [DIAGNOSES REDACTED]. Review of the physician's orders [REDACTED]. Physician orders [REDACTED]. A nursing progress note dated (MONTH) 4, 2019 at 3:30 p.m. revealed the resident was placed on isolation precautions. A care plan dated (MONTH) 5, 2019 revealed the resident had [MEDICAL CONDITION]. Interventions included the following: Contact Isolation: wear gowns and masks when changing contaminated linens; educate resident, family and staff regarding preventive measures to contain the infection; place in private room with contact isolation precautions and disinfect all equipment before leaving the room. An observation was conducted on (MONTH) 5, 2019 at 11:03 a.m., outside of resident #222's room. A visitor was observed inside the resident's room and was wearing a gown that was not secured, and was slipping off her shoulders. The visitor also only had one glove on her right hand. The visitor was observed moving items on and off the bedside table with both hands. During the observation, the visitor stepped into the hallway over the threshold, two times with the unsecured gown and one glove still on, and then re-entered the room. At one point, the visitor removed the gown and one glove, and placed them into the red biohazard bag by the door and exited the room. The visitor did not wash her hands prior to leaving the room. The visitor then picked up her personal items from the top of the isolation cart which was outside of the resident's room, and proceeded to leave the building without washing her hands. An interview was conducted on (MONTH) 5, 2019 at 11:42 a.m. with a Licensed Practical Nurse (LPN/ staff #85), who stated that when a resident is placed on isolation, there is a lot of education done with staff and visitors prior to entering the isolation room. Staff #85 stated that both staff and visitors are educated to put on a gown and gloves, secure the gown, and are taught proper removal of the gown and gloves. Staff #85 stated that staff and visitors are also educated to wash their hands with soap and water prior to exiting the room, because hand sanitizer is not effective. An observation was conducted on (MONTH) 5, 2019 at 12:09 p. m. of a Certified Nursing Assistant (CNA/staff #150) who put on a gown but did not secure it and donned gloves. Staff #150 briefly spoke to resident #222, then removed the gown and gloves

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) and placed them into the red biohazard. Staff #150 then used hand sanitizer and exited the room. Staff #150 did not wash her hands with soap and water prior to exiting the room. Immediately following the observation, staff #150 stated that because she did not touch anything in the room, the hand sanitizer was acceptable to use. An observation was conducted on (MONTH) 5, 2019 at 12:21 p.m., outside of resident #222's room. At this time, the resident's call light was on. The administrator (staff #147) was observed to walk into resident #222's room carrying a notebook, without donning a gown or gloves. Staff #147 then set the notebook on the resident's bedside table which was next to the resident and then reached over the resident to turn off the call light. Staff #147 conversed with resident #222, then picked up the notebook from the bedside table and walked out of the room, without washing his hands. Immediately following the observation, an interview was conducted with staff #147 who stated that the facility policy for entering a contact isolation room is to put on a gown and gloves, prior to entering the isolation room. Staff #147 said that before exiting the room, remove the gown and gloves, dispose of them in the red biohazard bag inside the room, and wash your hands with soap and water. Staff #147 stated that hand sanitizer would not be acceptable to use when leaving an isolation room. Staff #147 stated he did not do any of those things when he entered and exited the room. Staff #147 then proceeded to apply hand sanitizer to his hands, however, did not wash his hands with soap and water. An interview was conducted on (MONTH) 7, 2019 at 10:13 a.m. with a LPN (staff #151), who stated that when a resident is on contact isolation precautions, the person entering the room should use hand sanitizer prior to applying a gown and gloves, and tie the gown around their neck and waist to secure the gown. Staff #151 said that before exiting the room, the gown and gloves should be removed and placed into the red biohazard bag inside the room, then wash their hands with soap and water. Staff #151 stated that soap and water will ensure the [MEDICAL CONDITION] spores are killed, as hand sanitizer is not effective. An interview was conducted on (MONTH) 8, 2019 at 8:39 a.m. with the Director of Nursing (staff #160), who stated when a resident is on isolation precautions, an isolation cart is set up outside of the resident's room. Staff #160 stated for contact isolation precautions, all people who enter the room, including staff and visitors are to put on a gown and gloves, prior to entering the room every time they enter. Staff #160 said that prior to leaving the room, the person should remove the gown and gloves and dispose of them in the designated biohazard trash bag. Staff #160 stated the person should then wash their hands with soap and water and exit the room, without touching anything else in the room. Review of the facility's Infection Control policy revealed the purpose is to minimize as far as possible, the risks of harm to staff, residents, volunteers, family members and visitors, which may arise through pathogens being passed from one person to another. Staff and residents are most likely sources of infectious agents and are also the most common susceptible hosts. Other people visiting the premises may be at risk of both infection and transmission. The facility ensures effective implementation of infection control. Hand washing and hand care are considered the most important measures in infection control. Effective infection control is central to providing high quality support for residents and a safe work environment for the facility's employees, board members and visitors. Infection control is integral to resident support, not an additional set of practices. Risks of infections are regularly assessed, identified, and managed and mechanisms are put in place for compliance with infection control procedures. Review of a policy regarding Transmission-Based Precautions revealed it is our policy to take appropriate precautions to prevent transmission of infectious agents. Transmission-based precautions are additional controls based on a particular infectious agent and the agent's mode of transmission. These precautions are to be used in adjunct with standard precautions. The policy further included an order for [REDACTED]. Healthcare personnel caring for residents on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment. Donning personal protective equipment (PPE) upon entry and discarding before exiting the room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination (e.g. [MEDICAL CONDITION], norovirus and other intestinal tract pathogens). Review of the CDC guidelines revealed that [MEDICAL CONDITION] is a spore forming bacterium that causes inflammation of the colon known as [MEDICAL CONDITION]. [MEDICAL CONDITION] spores are shed in feces and transferred to patients mainly via the hands of people who have touched a contaminated surface or item. For the prevention of transmission of [MEDICAL CONDITION] in healthcare settings, use contact precautions for patients with known or suspected [MEDICAL CONDITION]. The guidelines included to use gloves and gowns when entering patient rooms and during care and for all interactions that may involve contact with patient or potentially contaminated areas in the patients environment. The guidelines also stated that before exiting the patient room, discard gowns and gloves, and wash hands with soap and water to contain the [MEDICAL CONDITION] pathogens. -Resident #41 was admitted (MONTH) 3, (YEAR), with [DIAGNOSES REDACTED]. Review of a care plan dated (MONTH) 22, (YEAR) revealed the resident had an indwelling catheter for [MEDICAL CONDITION] bladder. The goal included the resident will have no signs or symptoms of a UTI through the next review date. Interventions included the following: -position tubing below the level of the bladder. -monitor and document for pain/discomfort due to the catheter -monitor/record/report to MD for signs or symptoms of UTI including pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, foul smelling urine, fever and chills. The quarterly Minimum Data Set (MDS) assessment dated (MONTH) 28, (YEAR) revealed the resident had a Brief Interview of Mental Status (BIMS) score of 3, indicating severe cognitive impairment. This MDS also revealed the use of an indwelling catheter. Review of the physician's orders [REDACTED]. During a random observation conducted on (MONTH) 6, 2019 at 8:31 a.m., resident #41 was in bed and the catheter bag was hanging on the bed rail, and approximately 5 inches of the catheter tubing was on the floor. Another observation was conducted on (MONTH) 6, 2019 at 2:49 p.m. of the resident in bed. The catheter bag was observed hanging on the bed rail and approximately 3-4 inches of the catheter tubing was on the floor. An interview was conducted on (MONTH) 7, 2019 at 10:13 a.m. with a Licensed Practical Nurse (LPN/staff #151), who stated that when a resident has a catheter, it is never acceptable for the catheter bag or tubing to be on the floor for infection control prevention. An interview was conducted on (MONTH) 7, 2019 at 1:56 p.m., with a Certified Nursing Assistant (CNA/staff #2). Staff #2 stated that the catheter tubing comes with a clip so it can be secured so it does not drag on the floor. Staff #2 stated that if the tubing drags on the floor, the entire tubing would have to be replaced by the nurse, because the tubing would be contaminated, as it would pick up germs from the floor, and those germs should not be transferred to the resident from the catheter tubing. An interview was conducted on (MONTH) 8, 2019 at 8:39 a.m. with the Director of Nursing (staff #160), who stated that catheter tubing should not be dragging on the floor for infection control purposes. -Resident #321 was admitted on (MONTH) 30, (YEAR), with the [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. An observation was conducted at 11:25 a.m. on (MONTH) 5, 2019, of the resident lying in bed. The resident's catheter bag was hanging under the bed facing the door, and the catheter tubing and the catheter bag was observed touching the floor. Another observation was conducted at 12:01 p.m. on (MONTH) 6, 2019, of a certified nursing assistant (CNA/staff #171) pushing the resident in the wheelchair down the hallway to the dining room. During the transport, approximately 4 inches of the catheter tubing was observed dragging on the floor. At 12:30 p.m. on (MONTH) 6, 2019, the resident was observed in the dining room eating lunch. The catheter tubing was observed resting on the floor under the wheelchair. At 12:55 p.m. on (MONTH) 6, 2019, staff #171 was observed pushing the resident in the wheelchair down the hall from the dining room to the resident's room. The catheter tubing was again dragging on the floor. Following the observation, an interview was conducted with staff #171. He stated that he did not see an issue with the catheter tubing dragging on the floor. He stated there was no way he could secure the tubing higher and prevent it from dragging on the floor. He then stated that he could tuck the tubing in the Foley bag and proceeded to tuck the tubing in the bag.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035016	A. BUILDING _____ B. WING _____	**01/08/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HANDMAKER HOME FOR THE AGING	**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)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 4) An interview was conducted at 10:13 a.m. on (MONTH) 7, 2019, with a Licensed Practical Nurse (LPN/staff #151). She stated that the urinary catheter tubing or the Foley bag should never touch the floor. An interview was conducted with the Director of Nursing (DON/staff #160), who stated that all Foley drainage bags need to have a privacy bag and that the urinary catheter tubing should not be dragging on the ground. Review of policy and procedure for Catheter Care Urinary revealed the main goal is to prevent catheter-associated urinary tract infection. Under infection control, the policy included Be sure the catheter tubing and drainage bag are kept off the floor.