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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **035295**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **09/11/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE CENTER AT TUCSON	**5020 EAST GLENN STREET 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 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 review, staff interview, the Resident Assessment Instrument (RAI) manual, and policy review, the facility failed to ensure a discharge Minimum Data Set (MDS) assessment was coded accurately for one of three sampled residents (#56). The deficient practice could result in inaccurate discharge tracking information. Findings include: Resident #56 was admitted to the facility on (MONTH) 29, 2019, with [DIAGNOSES REDACTED]. A Nursing Note dated (MONTH) 4, 2019 revealed the resident was very excited about going home in the morning. Review of the Discharge Note dated (MONTH) 5, 2019 revealed the resident was discharged to home. However, review of the discharge MDS assessment dated (MONTH) 5, 2019 revealed the resident was discharged to an acute hospital. An interview was conducted with the MDS coordinator (staff #70) on (MONTH) 10, 2019 at 12:21 p.m. Staff #70 stated the nursing notes indicated that the resident was discharged home. Staff #70 further stated that the discharge MDS assessment was coded discharge to an acute hospital in error. The RAI manual instructs to review the clinical record including the discharge plan and discharge orders for documentation of a resident's location. Review of the facility's policy MDS, undated, included .All staff members responsible for completion of the MDS and transmission processes in accordance with the MDS RAI (resident assessment instrument) manual .
F 0883 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement policies and procedures for flu and pneumonia vaccinations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy and procedure, the facility failed to ensure that one of five sampled residents (#24) was administered the pneumococcal vaccine. The deficient practice could maximize the risk of residents acquiring, transmitting, or experiencing complications from pneumococcal disease. Findings include: Resident #24 was admitted to the facility on (MONTH) 13, 2019, with [DIAGNOSES REDACTED]. The admission nursing note dated (MONTH) 13, 2019 revealed the resident was alert and oriented to person, place, time, and situation. Review of a pneumococcal immunization consent form dated (MONTH) 13, 2019 revealed the resident was educated on the risks and benefits of pneumococcal vaccines and gave permission to administer the pneumococcal vaccines. The admission physician's orders [REDACTED]. Review of the Medication Administration Record [REDACTED]. A nurse note dated (MONTH) 14, 2019 revealed the vaccine was not administered due to N/A (not available) on order. However, further review of the clinical record from (MONTH) 13 through (MONTH) 11, 2019 revealed no evidence the resident was administered the pneumococcal vaccine. An interview was conducted on (MONTH) 11, 2019 at 10:50 a.m. with the Licensed Practical Nurse (LPN/staff #106) who wrote the note on (MONTH) 14, 2019 regarding the pneumococcal vaccine. The LPN stated the pneumococcal vaccine was not available on (MONTH) 14, 2019 and that she notified the pharmacy the same day. She stated that maybe the vaccine had not yet arrived from the pharmacy and that she would follow up on it. An interview was conducted on (MONTH) 11, 2019 at 11:08 a.m. with another LPN (staff #69). The LPN said they do not keep pneumococcal vaccines in stock. She stated the vaccine would have to be ordered from the pharmacy once the physician wrote the order. An interview was conducted on (MONTH) 11, 2019 at 11:09 a.m. with the Director of Nursing (DON/staff #15). He stated pneumococcal vaccines are not kept in stock. The DON stated the vaccines are ordered individually and usually arrives from the pharmacy within 2 days. The DON further stated that during clinical record review, it was discovered the resident had not received the pneumococcal vaccine. He stated the vaccine was re-ordered from the pharmacy yesterday. Review of the facility's policy for Pneumococcal Vaccination revealed that each resident's pneumococcal immunization status would be determined upon admission or soon afterwards, and would be documented in the resident's medical record. Informed consent would occur prior to vaccination. The policy included the vaccine would be administered according to the standing order to all residents who met vaccination criteria.

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.