

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035059	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2024
NAME OF PROVIDER OR SUPPLIER Haven of Scottsdale		STREET ADDRESS, CITY, STATE, ZIP CODE 3293 North Drinkwater Boulevard Scottsdale, AZ 85251	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47910</p> <p>Based on review of documentation, interviews with staff and residents and review of the facility policy, the facility failed to ensure two residents are free from verbal abuse (#5 and #30). The deficient practice could lead to psychosocial harm for residents.</p> <p>Findings include:</p> <p>- Resident #5 was admitted on [DATE] with a diagnosis of traumatic subdural hemorrhage without loss of consciousness, subsequent encounter, essential (primary) hypertension, acute pain due to trauma, gout, unspecified.</p> <p>Review of the care plan dated November 6, 2024, revealed that resident #5 was at risk for falls. An intervention included that the staff would anticipate and meet the residents needs and make sure the residents call light is within reach and encourage the resident to use it for assistance as needed. Additional interventions included; a psychosocial well -being problem related to admission and allow the resident time to answer questions and verbalize feelings, perceptions and fears.</p> <p>A grievance report was completed by resident #5 on November 8, 2024. It stated that resident #5 expressed CNA (Certified Nursing Assistant/ staff #67. The grievance report states the resident self-toiled per her preference and went back to bed and that at some point CAN #67 entered the room and answered the call light, assisted the resident with being scooted up in bed. Per the report the resident had reported CAN # 67 had entered the room abruptly and was throwing stuff on the floor to get to the resident to adjust in bed. The report also states resident #5 reporting CNA #67 was loud, but could not recall what was said. The report indicates the resident requested a nurse and also reported that her call light was out of reach.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated November 11, 2024, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, which revealed no cognitive impairment, no indicators for mood or behaviors. Further review of the MDS revealed resident required Setup or clean-up assistance with toileting hygiene, substantial/maximal assistance with lower body dressing. Supervision or touching assistance with roll left and right, sit to lying, sit to stand, toilet transfer, walk 10 feet. Resident required partial/moderate assistance with lying to sitting on side of bed.</p> <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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with resident #5 on November 20, 2024 at 9:30 a.m. Resident #5 stated I had just arrived that day and was placed in the room with another resident. I had gone to the bathroom and went back bed after turning on the call light and waiting 15-20 minutes- I just couldn't wait any longer to go. It was about 2 in the morning- the other resident had turned on the call light. Resident #5 stated she was rude-yelling at me and standing over me saying I was supposed to have someone help me to the bathroom. I told her I couldn't wait any longer, that I had waited 15-20 minutes. Resident stated that CNA # 67 called her and resident #30 trouble makers and was arguing with them for no reason Resident #5 stated she was very angry-you could tell the way she was screaming- she said you wasted my time coming in here and told her well you want help so bad? and threw the call light under my bed. Resident #5 stated the nurse went in the room and asked what is going on because he could hear all the screaming and yelling in the hallway. Resident #5 stated CNA #67 was very agitated. I felt afraid, I felt unsafe and didn't know what was going to happen to me. Resident #5 stated the nurse asked staff #67 to leave the room and told residents #5 and #30 she would not return to their room. Resident #5 stated Executive Director (ED/Staff # 12) went in and completed a report and told her the matter was taken care of and asked her if she now felt safe. Resident #5 stated she felt safe when informed staff #67 would no longer a provide her care.</p> <p>- Resident #30 was admitted to the facility on [DATE] with a diagnosis of fracture of unspecified part of neck of right femur, subsequent encounter for closed fracture with routine healing, interstitial pulmonary disease, unspecified, chronic respiratory failure with hypoxia, unspecified fracture of upper end of right humerus, subsequent encounter for fracture with routine healing, need for assistance with personal care.</p> <p>Review of the MDS assessment, dated July 11, 2024, revealed a BIMS score of 15 which revealed no cognitive impairment.</p> <p>Review of the care plan dated July 19, 2024 revealed that resident #30 was at risk for pain.</p> <p>A grievance report was completed by resident #30 on November 8, 2024, involving an incident with staff #67 on November 7, 2024. It stated patient reported that on night of admission patient's roommate had put on her call light and that CNA#67 entered the room abruptly at approximately 0200 and that the CNA was loud and speaking loudly for the time of day while providing care for resident while in bed. The grievance report states resident could not verbalize what the CNA was saying other than than telling her to stop being an intrusion while care was being provided to resident #5.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with resident #30 on November 20, 2024 at 9:48 a.m. with resident #30. Resident #30 stated the following My roommate had just come into the room [ROOM NUMBER]-4 hours before and had not become acclimated to the staff before bedtime. she turned had turned on her light to go to the bathroom and no one came- so she took herself -she really had to go and couldn't wait. the aide finally got there - she had already gone back to bed and the aide woke us up with her screaming- inconsiderate of her time then started arguing that she was running her ragged. saying this to the other resident when I intervened- she was yelling at her and out of control- I told her that the lady had just arrived and didn't know nothing- CNA description- skinny AA-I think her name is [NAME] or [NAME] .has her hair twisted high on her head -she started arguing- blaming both of us for turning on the call light, we asked for the nurse- it was male nurse that came- I'm sure the whole building heard her-she said it was a wasted trip. we both asked that she not care for us anymore and that she not come into our room. The nurse put someone else on duty- she has not been back- It made me angry that she was verbally abusive to both of us. Management came and spoke to us the next day- the day after that a man came and spoke to us, he said he was the manager of the whole facility. I told him she used a very loud tone, that she was angry and out of control, she was flailing her arms- she got very close to the other resident, right in her face in a very intimidating way- towering over and screaming at her. I didn't notice if anything was done with her call light, I was worried about the way she towering over my roommate. she didn't scare me, but it looked like my roommate was and wanted to cry- My experience with her as an was that she was always rushing and did not want to do her work, especially at night- this all happened at night approximately 2-3 in the morning. I made a demand that she needed to be fired. I know what is right and what is wrong- I was a CNA before myself- you don't do what she did to people.</p> <p>On November 20, 2024 at 12:00p.m. resident #30 was informed that her allegations of verbal abuse had been reported to administration. Resident #30 stated they should have known that it was verbal abuse by everything I told them. I told them same thing I told you from the night things happened and how she yelled and screamed at me and [NAME]</p> <p>On November 20, 2024 at 12: 07p.m Executive Director (ED/Staff # 12) and Director on Nursing (DON/Staff #33) brought in paperwork and asked if this surveyor would inform them what was said by the resident. Informed them they would need to complete their own investigation- (ED/Staff # 12) did state that the report was called in due to the online system being down. Both (ED/Staff # 12) and (DON/Staff #33) stated the prior complaints involving CNA staff #67 were taken as grievances and they did not feel what was reported by the residents, as reportable verbal abuse and failed to report the verbal abuse. Each of the three prior complaints involved the same staff member for allegations of verbal abuse.</p> <p>An attempt was made to contact (LPN/Staff#43) on November 20, 2024 at 1:22 p.m with no response.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A telephonic interview was conducted on November 20, 2024 at 1:24 p.m. with (CNA/ staff #33). CNA #33 stated she was hired July 2024. CNA #33 stated she was aware that something had happened regarding the resident with a neck brace on D hall and CNA #67. She stated she was asked by (LPN/Staff #43) to swap room with CNA #67 because she was arguing in front of the residents at night and did not care. Staff #33 stated she really has a mouth about the residents and is very critical of them by complaining to the residents about what they should be doing. CNA #33 stated she never wants to help them or answer their call lights. CNA # 33 stated she has had to calm down residents lots of times because she uses very strong words with them because they are not able to help themselves. CNA #33 stated CNA #67 has a bully type attitude, especially with the residents that are not able to help them selves she never wanted to do the work or help them. CNA #33 stated CAN #67 would always ask to swap residents because of not wanting help the residents. CNA#33 stated when CAN #67 did not work the residents were happier. She stated there were a lot of residents who did not want CNA #67 to provide their care. She stated staff # 43 would always have to talk to CNA #67 because she could be heard the way she would speak to the residents. Stating she was not kind and would talk loudly about the residents in the hallway. CNA #33 stated she would always report CNA #67 attitude and the way she spoke to the residents to LPN #43 and LPN #61 and felt they would take care of the issue because they were in charge. CNA #33 stated I would talk to them every night she worked. CNA #33 stated she informed the LPN staff #43 that she considered CNA #67 as verbally abuse in the ways she would make the resident's feel by criticizing them to their face. CNA #33 stated she completed abuse training at Banner hospital.</p> <p>An attempt was made to contact alleged perpetrator, (CNA/Staff #67) on November 20, 2024 at 2:02 p.m with no response.</p> <p>An interview was conducted on November 20, 2024 at 2:54 PM with Licensed Practical Nurse (LPN/Staff #61). Staff #61 stated that he received reported concerns from residents that felt she took forever to answer their call lights and, in the way, she spoke to them. Many of the residents thought she was too loud and disrespectful. LPN # 61 stated the complaints that he received from staff was that she was that she became easily frustrated with the residents. LPN #61 stated that both he and LPN# 43 had multiple conversations with CNA #67 regarding her attitude. LPN # 61 stated he was called into the room of residents #5 and #30. He stated resident #30 informed him that she felt CNA #67 shouldn't be a nurse and further stated that CNA #67 was screaming at Resident #5. He stated resident #5 informed him that CNA #67 was loud and rude further stating that the resident was visibly upset. He stated resident #30 informed him he no longer wanted CNA #67 in their room because of her behavior with resident #5. LPN #61 stated he reported the incident to the Director on Nursing (DON/Staff #33) due to concerns for abuse and because #67 had slammed the resident's door after he had entered their room and of the complaints from staff and other residents. LPN#61 stated he has reported previous concerns to the DON regarding staff #67.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on November 20, 2024 at 3:2 PM with (DON/staff #33). Staff #33 stated she became aware of the grievance regarding residents #30 and #5 during a standup meeting. She denied LPN #61 reporting any concerns to her regarding CNA#67 treatment of residents #30 and #5. She stated she received the information from ED/ Staff #12. DON/staff #33 the process for reporting concerns for abuse are reported to her or to the ED/ Staff #12 who is also the Abuse Coordinator. She stated staff receive training on how to report any allegations for abuse or neglect during orientation training, the online education system and that she also provides staff with abuse education as often as she is able. The DON stated verbal abuse is when someone makes a statement to a resident and how that makes them feel-not necessarily calling them names, but how it makes the patient feel. the intent to hurt the resident's feelings and them perceiving it that way. She stated she would consider screaming at a resident as verbal abuse. She stated ED/ Staff #12 determines what is considered a grievance or something that is reportable. That it is all about what the resident is saying and the severity of the situation. The DON stated grievances are conducted through the facility grievance forms which are completed by family, the resident or by staff, but has found them to be vague not always documenting the resident's verbatim statements. She stated the risks associated with this is that information can be missed as to what actually happened. [NAME] #33 stated Social Services Director/Staff #17 interviews the residents who have filed grievances. The DON stated she has had concerns with staff #17 documentation for an investigation and has educated her. The DON stated staff # 17 is supervised by ED/Staff 12, but is unaware if he had any concerns with the documentation of grievances or investigations. DON/staff #12 stated she was a witness to the follow-up questions regarding residents #30 and #5, the issue with the call light, what was actually reported and review of the camera footage; and based on the information the grievance was resolved. DON/staff #33 stated she did not feel that the residents had reported abuse it was about the intent, given the history the the facility had with CNA #67.</p> <p>An interview was conducted on November 20, 2024 at 3:45 PM with Executive Director (ED/Staff #12). Staff # 12 stated he was notified of the grievance regarding residents #30 and #5 on November 7, 2024 and the grievance was filed by LPN# 61 and given to Social Services. He stated the process for allegations depends on the severity based on the grievance and that he makes the decision when an allegation is processed as a grievance or allegation for abuse. He stated part of the process is to have conversations with residents and staff. He stated he did not have a conversation with LPN #61, but that the DON/staff #33 had, following the reported incident. He stated he spoke to both residents and they reported to him they no longer wanted CNA #67 to provide them care, due to her noise level, being abrupt and causing a lot of ruckus. He stated resident #5 had reported that CNA #67 seemed rushed and bothered and had told her she should not have gone to the bathroom alone. He stated CNA #67 as terminated due to her unprofessionalism, being abrupt and there was no excuse to not have empathy for the patients.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of employee file for CNA #67 revealed a letter dated 11/10/2024 from CNA #67 of intent to end employment with Haven Healthcare effective 11/24/2024. Further review of the employee file revealed a corrective action form dated 09/30/2024 that CNA #67 had been inappropriate to various residents. The report states four different residents had reported CNA #67 making rude statements and rushing them through care treatments. One of the residents reported CNA#67 had replied you're just trying to get a old black woman to wipe your ass after the resident had requested assistance with toileting. Another resident had reported CNA #67 had got mad and rude after needing to change the resident's sheets after urine had spilled from the bedpan. One resident reported CNA #67 would not help, because she said the resident is independent. This comment lead to the resident feeling uncomfortable. The corrective action form also states CNA#67 informing residents their call lights are not answered due to the building being short staffed. CNA#67 was placed on written warning with staff coaching/counseling.</p> <p>Review of a Corrective Action Form for CNA #67 dated 11/7/2024 revealed a termination for CNA #67 for professional conduct violation citing CNA#67 had unprofessional communication with resident #30 who had filed a grievance that CNA #67 was very rude to her. The grievance determined CNA #67 had demonstrated poor bedside manner and lacked empathy while providing care. The corrective action form states CNA #67 had been counseled twice about her communication with residents.</p> <p>The facility's abuse policy dated 2017, version 0319 states By definition, abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, neglect, and mental abuse including facilitated or enabled through the use of technology.</p> <p>- Verbal Abuse includes but not limited to: yelling, screaming, cursing, bossing around/demanding, insulting, to race or ethnic group, intimidating.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47910</p> <p>Based on review of documentation, interviews and review of the facility policy, the facility failed to report alleged abuse for two residents (#5 and #30). The deficient practice could lead to continued abuse for residents.</p> <p>Findings include:</p> <ul style="list-style-type: none"> - Resident #5 was admitted on [DATE] with a diagnosis of traumatic subdural hemorrhage without loss of consciousness, subsequent encounter, essential (primary) hypertension, acute pain due to trauma, gout, unspecified. <p>Review of the care plan dated November 6, 2024, revealed that resident #5 was at risk for falls. An intervention included that the staff would anticipate and meet the residents needs and make sure the residents call light is within reach and encourage the resident to use it for assistance as needed. Additional interventions included; a psychosocial well -being problem related to admission and allow the resident time to answer questions and verbalize feelings, perceptions and fears.</p> <p>A grievance report was completed by resident #5 on November 8, 2024. It stated that resident #5 expressed CNA (Certified Nursing Assistant/ staff #67. The grievance report states the resident self-toiled per her preference and went back to bed and that at some point CAN #67 entered the room and answered the call light, assisted the resident with being scooted up in bed. Per the report the resident had reported CAN # 67 had entered the room abruptly and was throwing stuff on the floor to get to the resident to adjust in bed. The report also states resident #5 reporting CNA #67 was loud, but could not recall what was said. The report indicates the resident requested a nurse and also reported that her call light was out of reach.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated November 11, 2024, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, which revealed no cognitive impairment, no indicators for mood or behaviors. Further review of the MDS revealed resident required Setup or clean-up assistance with toileting hygiene, substantial/maximal assistance with lower body dressing. Supervision or touching assistance with roll left and right, sit to lying, sit to stand, toilet transfer, walk 10 feet. Resident required partial/moderate assistance with lying to sitting on side of bed.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with resident #30 on November 20, 2024 at 9:48 a.m. with resident #30. Resident #30 stated the following My roommate had just come into the room [ROOM NUMBER]-4 hours before and had not become acclimated to the staff before bedtime. she turned had turned on her light to go to the bathroom and no one came- so she took herself -she really had to go and couldn't wait. the aide finally got there - she had already gone back to bed and the aide woke us up with her screaming- inconsiderate of her time then started arguing that she was running her ragged. saying this to the other resident when I intervened- she was yelling at her and out of control- I told her that the lady had just arrived and didn't know nothing- CNA description- skinny AA-I think her name is [NAME] or [NAME] .has her hair twisted high on her head -she started arguing- blaming both of us for turning on the call light, we asked for the nurse- it was male nurse that came- I'm sure the whole building heard her-she said it was a wasted trip. we both asked that she not care for us anymore and that she not come into our room. The nurse put someone else on duty- she has not been back- It made me angry that she was verbally abusive to both of us. Management came and spoke to us the next day- the day after that a man came and spoke to us, he said he was the manager of the whole facility. I told him she used a very loud tone, that she was angry and out of control, she was flailing her arms- she got very close to the other resident, right in her face in a very intimidating way- towering over and screaming at her. I didn't notice if anything was done with her call light, I was worried about the way she towering over my roommate. she didn't scare me, but it looked like my roommate was and wanted to cry- My experience with her as an was that she was always rushing and did not want to do her work, especially at night- this all happened at night approximately 2-3 in the morning. I made a demand that she needed to be fired. I know what is right and what is wrong- I was a CNA before myself- you don't do what she did to people.</p> <p>On November 20, 2024 at 12:00p.m. resident #30 was informed that her allegations of verbal abuse had been reported to administration. Resident #30 stated they should have known that it was verbal abuse by everything I told them. I told them same thing I told you from the night things happened and how she yelled and screamed at me and [NAME]</p> <p>Review of SA database revealed that the allegation of abuse was not reported to the state agency within the required timeframe.</p> <p>On November 20, 2024 at 12: 07p.m Executive Director (ED/Staff # 12) and Director on Nursing (DON/Staff #33) brought in paperwork and asked if this surveyor would inform them what was said by the resident. Informed them they would need to complete their own investigation- (ED/Staff # 12) did state that the report was called in due to the online system being down. Both (ED/Staff # 12) and (DON/Staff #33) stated the prior complaints involving CNA staff #67 were taken as grievances and they did not feel what was reported by the residents, as reportable verbal abuse and failed to report the verbal abuse. Each of the three prior complaints involved the same staff member for allegations of verbal abuse.</p> <p>The facility's abuse policy dated 2017, version 0319 states By definition, abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, neglect, and mental abuse including facilitated or enabled through the use of technology.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035059	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2024
NAME OF PROVIDER OR SUPPLIER Haven of Scottsdale		STREET ADDRESS, CITY, STATE, ZIP CODE 3293 North Drinkwater Boulevard Scottsdale, AZ 85251	

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Verbal Abuse includes but not limited to: yelling, screaming, cursing, bossing around/demanding, insulting, to race or ethnic group, intimidating.</p>